WELCOME TO THE NAIC/CONSUMER LIAISON COMMITTEE

IN-PERSON ATTENDEES
Wi-Fi Network: **NAIC2023**; Password (case sensitive): **Summer2023**

VIRTUAL ATTENDEES

- Audio will be muted upon entry
- If virtual attendees would like to speak, please use the "Raise Hand" feature and we will let the Chair know you'd like to speak
- Enter with video on or off (your choice)
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Agenda Item #1

1. Consider Adoption of its Spring National Meeting Minutes—Commissioner Andrew R. Stolfi (OR)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Agenda Item #2

2.   Hear a Presentation from the Center for Economic Justice (CEJ) on "A Meaningful Framework for Supervision of Insurer's Use of Big Data and Artificial Intelligence"– Birny Birnbaum (CEJ) – 20 minutes

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

CENTER for
ECONOMIC
JUSTICE | FAIR ACCESS
FAIR TREATMENT

A Meaningful Framework and Regulatory Guidance for Insurers' Use of Big Data and AI

NAIC Consumer Liaison Committee

August 12, 2023

Birny Birnbaum
Center for Economic Justice

birny@cej-online.org

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 market regulation and 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 consulted with financial service regulators and public agencies in several states and internationally. 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 chairs the subcommittee on insurance availability.

Birny served as Associate Commissioner for Policy and Research and the Chief Economist at the Texas Department of Insurance. 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.

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.

Big Data, Artificial Intelligence and AI Systems Defined

Insurers' use of Big Data and AI have transformed the way they do product development, marketing, pricing, claims settlement, antifraud, consumer relations and their approach to risk management. For purposes of my talk, Big Data means:

- Massive databases of information about (millions) of individual consumers
- Associated data mining and predictive analytics applied to those data
- Scoring models produced from these analytics.

The scoring models generated by data mining and predictive analytics are algorithms. Algorithms are lines of computer code that rapidly execute decisions based on rules set by programmers or, in the case of machine learning, generated from statistical correlations in massive datasets.

Artificial Intelligence

With artificial intelligence (AI) or machine learning, the models can "learn" or change without human intervention based on new information. Examples:

- Chatbots that generate responses to consumer questions or requests for assistance;
- Claim settlement and anti-fraud models revised as new data are received during the claim settlement process individually or in aggregate;
- Product offerings and underwriting based on current and prior internet interactions – e.g., analyzing consumer keystrokes to identify propensity for fraud;

Any Information about / generated by a Consumer, Vehicle, Property, Built and Natural Environment is Raw Material for Insurance AI

- Telematics – Auto, Home, Wearable Devices
- Social Media
- Shopping Habits/Purchase History
- Hobbies and Interests
- Demographics/Household Data/Census Data
- Government Records/Property Records
- Web/Mobile Phone Tracking/GPS/Data Harvesting
- Vehicle Registration and Service Records
- Facial Analytics
- Mainstream Credit Files: Loans, Credit Cards
- Alternative Credit Data: Telecom, Utility, Rent Payment
- High Definition Aerial Photographs

Sources of Data include consumers (via telematics or wearable devices), government, social media platforms, web sites, mobile devices, e-mail/text, data brokers, online data aggregators, aircraft/satellite photos and many others.

What's So Big about Big Data and AI?

1. Insurers' use of Big Data has huge potential to benefit consumers and insurers by transforming the insurer-consumer relationship and by discovering new insights into and creating new tools for loss mitigation.

2. Insurers' use of Big Data has huge implications for fairness, access and affordability of insurance and for regulators' ability to keep up with the changes and protect consumers from unfair practices

3. The current insurance regulatory framework generally does not provide regulators with the tools to effectively respond to insurers' use of Big Data. Big Data has massively increased the market power of insurers versus consumers and versus regulators.

4. Market forces alone – "free-market competition" – cannot and will not protect consumers from unfair insurer practices. So-called "innovation" without some consumer protection and public policy guardrails will lead to unfair outcomes.

Insurers' Use of Big Data: Promise vs. Reality

Promise	Reality
Transparency	Opaque
Loss Mitigation/Behavioral Change	Black-Box Risk Segmentation/Pricing
Competitive Advantage via Policyholder Partnerships	Competitive Advantage via Proprietary Pricing/Segmentation
Transparent Risk-Based Pricing to Empower Consumers	Modeling Prices on Factors Unrelated to Risk to Optimize Revenue/Profit
Promote Greater Availability and Affordability	Increased Prices for Most Vulnerable Consumers; Discriminatory Algorithms
Cybersecurity Protections	Cybersecurity Vulnerabilities

Birny Birnbaum
Center for Economic Justice

Guidance for Insurers' Use of Big Data and AI

NAIC Consumer Liaison
August 12, 2023

Big Data Algorithms Can Reflect and Perpetuate Historical Inequities

Barocas and Selbst: *Big Data's Disparate Impact*[1]

Advocates of algorithmic techniques like data mining argue that they eliminate human biases from the decision-making process. But an algorithm is only as good as the data it works with. Data mining can inherit the prejudices of prior decision-makers or reflect the widespread biases that persist in society at large. Often, the "patterns" it discovers are simply preexisting societal patterns of inequality and exclusion. Unthinking reliance on data mining can deny members of vulnerable groups full participation in society.

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[1] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2477899

Virginia Eubanks, *Automating Inequality: How High-Tech Tools Profile, Police, and Punish the Poor*

America's poor and working-class people have long been subject to invasive surveillance, midnight raids, and punitive public policy that increase the stigma and hardship of poverty. During the nineteenth century, they were quarantined in county poorhouses. During the twentieth century, they were investigated by caseworkers, treated like criminals on trial. Today, we have forged what I call a digital poorhouse from databases, algorithms, and risk models. It promises to eclipse the reach and repercussions of everything that came before.

Amazon Created a Hiring Tool Using A.I.
It Immediately Started Discriminating Against Women.[2]

All of this is a remarkably clear-cut illustration of why many tech experts are worried that, rather than remove human biases from important decisions, artificial intelligence will simply automate them. An investigation by ProPublica, for instance, found that algorithms judges use in criminal sentencing may dole out harsher penalties to black defendants than white ones. Google Translate famously introduced gender biases into its translations. The issue is that these programs learn to spot patterns and make decisions by analyzing massive data sets, which themselves are often a reflection of social discrimination. Programmers can try to tweak the AI to avoid those undesirable results, but they may not think to, or be successful even if they try.

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[2] Jordan Wasserman at, https://slate.com/business/2018/10/amazon-artificial-intelligence-hiring-discrimination-women.html

Statutory Foundation:

Fair and Unfair Discrimination in Insurance

In the U.S., fair and unfair discrimination in is defined in two ways, typically found in rating and unfair trade practice statutes and regulations.

- Actuarial – there must be an actuarial basis for distinction among groups of consumers; and

- Protected Classes – distinctions among groups defined by certain characteristics – race, religion, national origin – prohibited regardless of actuarial basis.

NAIC Principles on Artificial Intelligence

https://content.naic.org/cipr-topics/artificial-intelligence

and

https://content.naic.org/sites/default/files/inline-files/AI%20principles%20as%20Adopted%20by%20the%20TF_0807.pdf

Insurance-specific AI applications should be:

- Fair and Ethical
- Accountable
- Compliant
- Transparent
- Secure, Safe and Robust

Consistent with the risk-based foundation of insurance, AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes.

Meaningful Regulatory Oversight of Insurers' Use of AI Systems

1. Focus on Consumer Outcomes, Not Process
2. AI Governance and Risk Management procedures and documentation necessary and important, but not sufficient. Do not prescribe the process or methods of AI Governance and Risk Management – establish required outcomes.
3. Require AI System Outcomes be Disputable – a broader requirement than Transparency.
4. Require Testing by insurers of their algorithms and actual consumer outcomes for unfair discrimination on both the actuarial and protected class bases in all phases of the insurance life cycle and in both model development and post-deployment.
5. New reporting by insurers to facilitate innovation in market regulation – greater use of analytics.
6. Regulatory guidance for bias thresholds and equity trade-offs.
7. Encourage Third Party Providers to become licensed as Advisory Organizations

Insurer Testing of Algorithms / Actual Consumer Outcomes

Some have suggested an algorithmic model governance approach to addressing structural racism in insurance similar to the approach used for ORSA and preventing cyber breaches.

Model governance is essential, but not sufficient. Testing of actual consumer outcomes is reasonable and necessary because there are literally millions of such outcomes in every phase of the insurance life cycle that be analyzed.

Insurers test these outcomes as they develop the algorithms for marketing, pricing, claims settlement and anti-fraud. Testing for spurious correlations (proxy discrimination) and disparate impact on the basis of protected class characteristics should simply be part of model development.

Uniform Methods of Testing and Evaluation across Insurers

A "principles-based approach" to address structural racism is not necessary or desirable, because uniform methods of testing and evaluation across insurers is possible because all insurers share the same types of consumer outcomes, regardless of business model or product:

- Did the insurer receive an application?
- Did the application result in a policy?
- If a policy was issued, what was the premium and coverage provided?
- Was a claim filed?
- Was the claim denied or paid?
- If the claim was paid, how much?

Why Test for Disparate Impact and Proxy Discrimination in All Aspects of Insurers' Operations?

While pricing / rating has gotten the most regulatory attention in terms of complex model scrutiny by regulators, it's imperative for insurers and regulators to test algorithms used in all aspects of the insurance life-cycle for racial bias.

Antifraud algorithms are particularly susceptible to reflecting and perpetuating historic racism because antifraud algorithms can identify suspicious claims. If the identification of suspicious claims is racially-biased, so will the identification of claims as fraudulent – a claim that's not investigated will not be identified as fraud.

Marketing algorithms also raise great concern – the new data sources and algorithms used to micro-target consumers have become the *de facto* gateway for access to insurance.

Focus on Holistic Testing, Not Individual Factors in Isolation

Over the last several decades, much of the focus on efforts to address racial bias in insurance has been on data sources that are highly correlated with race with calls to ban those factors.

While insurers should surely not be using data sources and factors that are proxies for race and not predictive of insurance outcomes, testing for racial bias must be of the entire algorithm and all the data sources used in the algorithm simultaneously.

- Eliminating one factor may simply shift the racial bias to another factor instead of eliminating the racial bias. Testing of the algorithm is designed to eliminate proxy discrimination and identify disparate impact of the entire algorithm.

- Multi-variate testing can remove eliminate correlations with race and reveal the factor's true contribution to explaining the insurance outcome and provide a statistical basis for addressing disparate impact.

Modernizing Data Reporting for Market Regulation is Essential

The current regulatory data collection is woefully outdated and doesn't serve the needs of regulators and policymakers generally. In particular, testing for protected class bias requires the reporting of granular consumer outcome data by insurers and analyses of those data by regulators. Absent this type of empirical analysis by regulators, we will not be able to move beyond the historical debates about race and insurance and not be able to ground our anti-racism efforts in the risk-based foundation of insurance.

The collection of granular consumer outcome data must include individual applications for insurance that don't end up in policy issuance. As mentioned, marketing algorithms have become the new gatekeeper for insurance access – analysis of application data is essential to see if those algorithms systematically deny communities of color such access.

Regulatory Standards for Bias Thresholds and Equity Trade-Offs

While there may be some data sources and factors that lie at the extremes – pure proxies for protected classes or pure predictors of risk-based insurance outcomes – the nature of structural racism means that the vast majority of data sources will likely result in some racial disparities.

Insurers need guidance on, for example, on

- What degree of proxy discrimination should lead to prohibiting the use of that data source or factor from the deployed algorithm?

- How can an insurer utilize alternate data sources to maintain the algorithm's efficiency while reducing disparate impact?

- What trade-off between reducing disparate impact and weakening the algorithm's efficiency is reasonable? If we could change an algorithm to eliminate 95% of disparate impact at a cost of 5% of statistical predictive strength, would that be a fair trade?

Testing for Disparate Impact and Proxy Discrimination:

A Natural Extension of Typical Insurer Practices

While proxy discrimination and disparate impact are different forms of unfair discrimination, there is a common methodology to test for both.

There is a long history of and many approaches to identifying and minimizing disparate impact in employment, credit and insurance. But, the general principle is to identify and remove the correlations between the protected class characteristic and the predictive variables by explicit consideration of the protected class characteristic.

The techniques to analyze proxy discrimination and disparate impact are the same techniques insurers use in developing predictive models for all aspects of the insurance life cycle. See below for more technical explanation.

Risk Segmentation is not the Purpose of Insurance

Insurer trades argue that anything that restricts their ability to segment the population for any aspect of the insurance life cycle will destroy the cost-based foundation of insurance, will lead to "good risks" subsidizing "bad risks" and lead to insurer financial ruin.

In fact, the existence of protected class characteristics demonstrates that risk segmentation – "predicting risk" – is not the goal of insurance but a tool to help achieve the real goal of insurance – a risk pooling mechanism providing financial security for as many as possible and particularly for those with modest resources. Insurers' arguments for unfettered risk classifications are inconsistent with the goal of insurance.

While some risk segmentation is necessary to avoid adverse selection, the logical extension of that argument is not unlimited risk segmentation. In fact, if unlimited risk segmentation was necessary, we would see all insurers using all risk characteristics – they don't – and collapsing markets in states where some limitations on risk characteristics exist – they aren't.

Disparate Impact Analysis Improves Cost-Based Pricing

With proxy discrimination, an insurer is using a factor – a characteristic of the consumer, vehicle, property or environment – that is predicting race and not the insurance outcome. Proxy discrimination is, therefore, a spurious correlation and eliminating such spurious correlation improves cost-based pricing. Since proxy discrimination is indirect racial discrimination, it is currently a prohibited practice. Testing would therefore both improve risk-based pricing and stop unintentional or intentional racial discrimination.

There is a long history and many approaches to identifying and minimizing disparate impact in employment, credit and insurance. But, the general principle is to identify and remove the correlations between the protected class characteristic and the predictive variables. Testing identifies true disparate impact that may require a public policy that recognizes equity – such as the prohibition against using race itself as a factor.

Why is it Reasonable and Necessary to Recognize Disparate Impact as Unfair Discrimination in Insurance?

1. It makes no sense to permit insurers to do indirectly what they are prohibited from doing directly. If we don't want insurers to discriminate on the basis of race, why would we ignore practices that have the same effect?

2. It improves risk-based and cost-based practices.

3. In an era of Big Data, systemic racism means that there are no "facially-neutral" factors.

Draft NAIC Model Bulletin: *Use of Algorithms, Predictive Models and Artificial Intelligence Systems by Insurers*

- Exposed for Public Comment on July 17, 2023

Not a "Principles-Based Approach"

Guidance has been described as "principles-based" and not prescriptive.

In fact, not principles-based, but laissez-faire.

Doesn't provide any additional guidance beyond the AI Principles

The guidance provide is prescriptive – directing insurers how to they should govern and manage AI systems.

No guidance on <u>how to</u> produce good and legally-compliant outcomes or what those outcomes should be. Telling insurers to comply with existing laws and regulations is not guidance.

No Actual Guidance – Governance in Place of Guidance, Expectations Relate to Process, Not Outcomes

The Department recognizes that Insurers may demonstrate their compliance with the laws that regulate their conduct in the state in their use of AI Systems through alternative means, including through practices that differ from those described in this bulletin. The goal of the bulletin is not to prescribe specific practices or to prescribe specific documentation requirements. Rather, the goal is to ensure that Insurers in the state are aware of the Department's expectations

. . .

Little of No Progression from 2020 AI Principles:

The Department recognizes the Principles of Artificial Intelligence that the NAIC adopted in 2020 as an appropriate source of guidance for Insurers as they develop and use AI systems. Those principles emphasize the importance of the fairness and ethical use of AI; accountability; compliance with state laws and regulations; transparency; and a safe, secure, fair, and robust system. These fundamental principles should guide Insurers in their development and use of AI Systems and underlie the expectations set forth in this bulletin.

No Guidance or Testing for Racial / Protected Class Unfair Discrimination.

"Current limitations on the availability of reliable demographic data on consumers make it challenging for Insurers and regulators to directly test these systems to determine whether the decisions made meet all applicable legal standards. Therefore, while the Department continues to encourage and emphasize the use of verification and testing methods for unfair bias that leads to unfair discrimination where possible, the Department recognizes that we must also rely upon robust governance, risk management controls, and internal audit functions to mitigate the risk that decisions driven by AI Systems will violate unfair trade practice laws and other applicable legal standards."

No Guidance or Testing for Racial / Protected Class Unfair Discrimination.

Beyond the lack of guidance for testing for unfair discrimination on the basis of race, the draft guidance falsely suggests such testing is not feasible and that governance processes can substitute for actual testing
– despite over 40 years of such testing under federal laws for credit, employment **and insurance!**

Three years after the murder of George Floyd and the recognition by insurers, NAIC leadership and the society at large that structural racism impacts all of institutions – including insurance – the NAIC's efforts to address structural racism have disappeared from the Special Committee on Race, were sent to the H Committee / Collaboration Forum and, based on the draft AI guidance, have now been abandoned.   The draft guidance not only equivocates on testing for racial bias, but doesn't even state that practices that have the effect of discriminating on the basis of protected class status – even if unintentional – are unfair discrimination.

Telling Insurers to Comply with the Law, but No Guidance on How to Measure or Ensure Appropriate Outcomes

Actions taken by Insurers in the state must not violate the Unfair Trade Practices Act or the Unfair Claims Settlement Practice Act or the UCSPA, regardless of the methods the Insurer used to determine or support its actions. As discussed below, Insurers are expected to adopt practices, including governance frameworks and risk management protocols, that are designed to assure that the use of AI Systems does not result in: 1) unfair trade practices, as defined in []; or 2) unfair claims settlement practices . . ..

Draft Guidance: Unhelpful Definitions / Missing Key Definitions

"Bias" – differential treatment that results in favored or unfavored treatment of a person, group or attribute.

Term is typically used in draft Guidance as "unfair bias that leads to unfair discrimination."

Unclear why "unfair bias" is used when fair and unfair discrimination are the statutory and long-standing terms used in insurance.

"Third Party" definition fails to distinguish between third party advisory organizations, whose activities are subject to regulatory oversight, and third parties not licensed as advisory organizations.

No definitions for the needed guidance for assessing fair and unfair discrimination – "on the basis of," proxy discrimination, disparate impact, data source, data type.

Draft Guidance Has No Realistic Path Forward for Market Regulation

The draft Guidance envisions an auditing approach by market conduct examiners regarding insurers' AI Systems processes. At best, the draft guidance suggests a check-the-box approach for documentation and procedures. Realistically, regulators lack the resources – both quantity and specific-skills – to examine every insurer's bespoke approach to avoiding unfair discrimination or entering into dialog with every insurer about each insurer's method of testing for unfair discrimination – if the insurer's governance even features such testing.

Our recommended Outcomes-Based guidance provides a path forward for meaningful oversight. Testing and reporting requirements provide common metrics across insurers that facilitate an analytic – as opposed to auditing – approach that permits evaluation of insurers' performance quickly and consistently. Our recommended guidance provides a path forward for specific and achievable regulatory resources and skill sets.

Draft Guidance – Insurers Assess What is High Risk for Consumers

"*An AIS Program that an Insurer adopts and implements* **should be reflective of, and commensurate with, the Insurer's assessment of the risk posed by its use of an AI System, considering the nature of the decisions being made, informed, or supported using the AI System; the nature and the degree of potential harm to consumers from errors or unfair bias resulting from the use of the AI System;**

Guidance should be that ALL of insurers' consumer facing AI applications are high risk

Whether the AI system is used for product development, marketing, underwriting, pricing, claims settlement, anti-fraud, consumer relations or consumer information, a flawed algorithm can unfairly deny coverage, charge unfair prices, unfairly settle claims or provide incorrect or misleading information that denies a consumer essential insurance coverage or the benefits of coverage purchased.

Guidance Should All Consumer-Facing AI Applications Have the Potential for Catastrophic Harm to Consumers. Which of These Harms are "Low Risk?

- A marketing algorithm that systematically denies product options on the basis of race;

- A policy form algorithm that generates policy language and provisions but produces misleading, deceptive, unfair or prohibited provisions;

- A pricing algorithm that systematically charges people based on race;

- A claims settlement algorithm that systematically offers lower claims settlements on the basis of race;

- An antifraud algorithm that reflects and perpetuates historic racial discrimination in policing and criminal justice;

- A chatbot that provides misleading or false information to consumers that causes consumers to not get the benefits of their purchase;

Agenda Item #3

3.   Hear a Presentation from United Policyholders (UP) and the Automotive Education & Policy Institute (AEPI) on the Appraisal Process for Automotive and Property Damage Claims–Amy Bach (UA) and Erica Eversman (AEPI) - 25 minutes

United Policyholders™
www.uphelp.org

Restoring time and cost efficiency, confidence and fairness to property insurance claim appraisals

NAIC Summer Meeting, Seattle WA, 8/12/23

UP is a 32+ year old insurance consumer non-profit whose website, programming, volunteers and guidance help over 500,000 people each year

CBS NEWS

JANUARY 11, 2023

Preschool and neighbors in San Francisco's Mission facing major storm damage repairs

One of the biggest impacts from the pouring rain is now showing up as damage to private property. For a preschool in a residential neighborhood in San Francisco's Mission District, damage to a retaining wall has left young

5 ON YOUR SIDE

JANUARY 9, 2023

Sneaky ways inflation affects your money in 2023

Here are a few of the less well-known changes this year — some that could hurt your wallet, and others that could help. By now, you're probably familiar with the more obvious ways inflation affects your finances. Your money doesn't go as far at the...

SCIENTIFIC AMERICAN

JANUARY 5, 2023

Are Home Insurers Abandoning Communities Vulnerable to Climate Change?

The U.S. Department of the Treasury makes an unprecedented move to find out if home insurers are abandoning communities vulnerable to climate change Dozens of environmental and consumer groups are rallying behind the Biden

The Washington Post

FEBRUARY 10, 2023

Gentrification by Fire

The West's new climate is exacerbating housing inequality in the quintessentially blue state of California Climate change and its most extreme consequences are pushing up the price of homes throughout much of the American West, as fires and flooding carve into existing housing stock and...

CLAIMS JOURNAL

FEBRUARY 6, 2023

Policyholders Counting on Calif. High Court for COVID Loss Claims

Courts around the nation have held that SARS-CoV-2 cannot cause direct physical damage or loss to property, but policyholder advocates are hoping the California Supreme Court will turn the tide. In a case that pits a concert organizer against its insurer, United Policyholders argues that...

GoodTimes

JANUARY 24, 2023

Businesses and Residents Hope for Post-Storm Relief

Costs continue to add up even with assistance from FEMA and flood insurance When Watsonville resident Amy Thomas reached out to the Federal Emergency Management Agency (FEMA) for help, she had already paid thousands of dollars to repair damages caused by a spate of recent...

Roadmap to Recovery® Program

SEP 28, 2022 – ACTIVE

2022 Hurricane Ian – Insurance Claim and Recovery Help Library

Hurricane Ian made landfall as a Category 4 Hurricane and caused extensive damage in late September, 2022 in regions throughout Florida and neighboring states.

Grant funded Recovery Efforts

- 2020 California Wildfires
- 2021 Colorado Marshall Fire
- 2022 California Wildfires

Donor/Sponsor supported recovery work

- 2023 CA Winter Storms
- 2022 Hurricane Ian, Tropical Storm Nicole
- 2022 Yellowstone Flooding (Montana)
- 2022 Southwestern Wildfires (NM)
- 2021 Louisiana Hurricane Ida

Find Help Directory and Ask an Expert Forum are extra critical in states where we're not funded to do recovery work

Roadmap to Preparedness Program

Helping people shop, avoid protection gaps/underinsurance

Rack cards, preparedness presentations, coordination with DOIs, realtors, financial institutions

Climate Change Adaptation assistance to property owners

Advancing mitigation support and insurance rewards

Advocacy and Action

Legislative and Regulatory Engagements:

CA: Mitigation Discounts, Annuity/Life Ins. Suitability Stds, CA Fair Plan, Post disaster claim improvements

CO: New wildfire survivor protections, Fair Plan creation

OR: New wildfire survivor protections, Mitigation discounts

Nat'l: Protection Gaps, Climate Change adaptation (NCOIL, NAIC, FACI) Consumer Disclosures re: rate increases, discounts, the Appraisal Process

Amicus Project: 32 Briefs filed in 2023 to date

Selected Issues:

- Water damage excluded as flooding
- Health Insurance Rates
- Scope of Cyber Coverage
- Choice of Law
- Occurrence
- Policy Interpretation

OREGON
Advocacy Win!

House Bill 2982 has been signed into law allowing Oregonians who experience a total loss in a major disaster to receive a **70% payout of personal property coverage without having to complete an itemized inventory.**

United Policyholders.   HB 2982

Why focus on restoring time and cost efficiency, confidence and fairness to property insurance claim appraisals? "Appraisal is Broken"

Disputes between insurers and insureds over the extent of damage, repair/rebuild costs are extremely common and technical (E.G. yards and grade of damaged carpeting, siding, roofing lumber, trades/subs, O&P)

It's waste of time, money and judicial resources to involve juries and judges in disputes over building materials

Appraisal can be done without attorneys or litigation

An appraisal can be done in weeks or months

The appraisal process has become "gamified," contentious, expensive, time-consuming, some insurers are reputedly removing the clauses from their policies

Insurance Appraisal Simplified

STEP 1 ➔ A dispute arises over the VALUE and/or EXTENT of an insured loss

★ Coverage disputes generally cannot be resolved through appraisal

STEP 2 ➔ Each side (insurer and insured) picks an appraiser, the appraisers pick the umpire/neutral

★ If parties can't agree on an umpire, court will appoint

Policyholder APPRAISER

Insurance APPRAISER
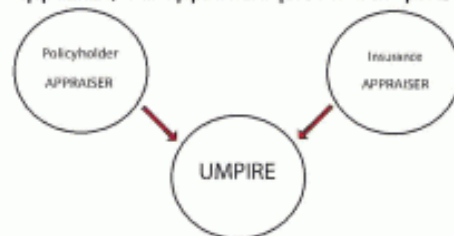
UMPIRE

★ Rules vary state by state on appraiser qualifications, selection, hearing process and costs

STEP 3 ➔ The two appraisers try to reach agreement on some or all items in dispute

STEP 4 ➔ As to remaining issues, the appraisers and umpire review documents, photos, evidence

STEP 5 ➔

Deliberations/Voting

STEP 6 ➔

2 out of 3 agree and write up and sign their decision

OR

3 out of 3 agree (unanimous)

STEP 7 ➔

DECISION/"AWARD"

★ Appraisal findings are generally called an "award"

STEP 8 ➔ Deliver Decision/Award to carrier and insured to trigger payment or enforcement of the award

★ Unconfirmed= Force/effect of a contract

Confirmed by a court =Enforceable judgment

Appraisal clause variations

Appraisal. If [Company] or [Policyholder] disagree on the value of the property or the amount of loss, either may make written demand for an appraisal of the loss. In this event, each party will select a competent and impartial appraiser. The two appraisers will select an umpire. If they cannot agree, either may request that selection be made by a judge of a court having jurisdiction. The appraisers will state separately the value of the property and amount of loss. If they fail to agree, they will submit their differences to the umpire. A decision agreed to by any two will be binding. Each party will:

a. Pay its chosen appraiser; and
b. Bear the other expenses of the appraisal and umpire equally.

If there is an appraisal, [Company] will still retain our right to deny the claim.

Appraisal clause variations

Appraisal. If you and we fail to agree on the actual cash value or amount of loss, either party may make a written demand that the amount of the loss be set by appraisal. Each party will select a competent and impartial appraiser and notify the other of the appraiser's identity within 20 days after the written demand is received. The appraisers will select a competent and impartial umpire. If the appraisers are unable to agree upon an umpire within 15 days, you or we can ask a judge of a court of record in the state where the residence premises is located to select an umpire.

The appraisers shall then appraise the loss, stating separately the actual cash value and loss to each item. If the appraisers submit a written report of an agreement to us, the amount agreed upon shall be the actual cash value or amount of loss. If they cannot agree, they will submit their differences to the umpire. A written award by two will determine the actual cash value or amount of loss. However, the amount of the award shall be subject to all applicable provisions of the policy, including Section I -- Property Protection Conditions 2. c. (4) and 2. c. (5). Each party will pay its own appraiser and bear the other expenses of the appraisal and umpire equally, except we will pay your appraiser's fee and the umpire's fee, if the following conditions exist:

a.   You demanded the appraisal; and
b.   The full amount of loss, as set by your appraiser, is agreed to by our appraiser or by the umpire.

Points of contention

Delays, expense, fairness, finality

Initiating Appraisal - Timely/untimely demand, stays litigation?

Appraiser Selection - Timing, neutrality, bias, court involvement

Umpire Selection - Timing, neutrality, bias, court involvement

The Appraisal Process – Formal/informal, discovery, hearing

Appraisal Award – Specificity, timing, enforceability, appealability, impact on pending litigation

Insider game/Good ol' boy network/Revolving cast/Repeat bias

Possible NAIC engagement:

C Committee charge/Catastrophe Working Group workstream

CIPR workstream

Thank you!

- Consumer Liaison Committee members and meeting attendees for your time and attention

- APCIA for dialoguing with UP on a reform concept pilot

- UP volunteers who serve as Appraisers and Umpires

- The Insurance Appraisal and Umpire Ass'n https://www.iaua.us/

- David Princeton, https://uphelp.org/wp-content/uploads/2023/06/230501-David-Princeton-Appraisal.pdf

- Jon Wilkofsky, Author: The Law and Procedure of Ins. Appraisal

USES AND RECOMMENDATIONS FOR P&C APPRAISAL CLAUSES:

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
SEATTLE, WA,   AUGUST, 2023

Erica. L. Eversman, J.D.

Automotive Education & Policy Institute

APPRAISAL CLAUSE: WHAT IS IT?

- Alternate dispute resolution mechanism
- Determine property loss claim value
- Permissive, not mandatory ("may" not "shall")
- Consumer or insurer can invoke
- Included in policy (first party only)
- Determination may be binding or non-binding

Typical Auto Appraisal Disputes:

- ❏ Partial Loss:
  - ➢ *Overall payment cost for repair*
    - ▪ **Parts**
      - ❖ *Repair or replace parts*
      - ❖ *Type of parts*
        - ▪ New auto maker (OEM)
        - ▪ New imitation (non-OEM)
        - ▪ Salvage (presumably OEM, but not assured)
    - ▪ **Procedures**
      - ❖ *Safety-related*
      - ❖ *Auto-maker recommended*
      - ❖ *Insurer alleged "cost of doing business"*
- ❏ Total Loss:
  - ➢ *Cost of replacement vehicle/value of lost vehicle*

USED AS SWORD AND SHIELD

❑ Shield: Wait until insured sues in court to demand appraisal

➤ *Then use appraisal to delay claim resolution*

❑ Sword: Use appraisal to try to resolve non-monetary issues

➤ *Liability*

➤ *RICO*

➤ *Fraud*

➤ See, e.g., *Travis v. American Manufacturers Mutual Insurance Co.*, 335 Ill. App. 3d 1171, 782 N.E.2d 322 (5th Dist. 2002) (court held appraisal requirements are enforced only when the subject matter of the claim clearly falls within the appraisal clause, and putative class action for fraud did not)

Recommendations

- Include:
  - *As mandatory in auto policies for full and partial property losses*

- Alert:
  - *Require insurers to notify consumers that right to appraisal exists if they disagree with offer*

- Require:
  - *Use of independent, evaluators and umpires*
  - *Establish timeframe for RTA completion and maximum consumer expense permitted*
  - *Inclusion of appraisal use, result, and $ value change as data elements for market conduct analysis*

APPRAISAL REQUIREMENTS MUST HAVE DETAILS AND **TEETH**

❑ Details: *e.g.*
  ➢ *Who may serve as "appraiser" or umpire (independent)*
  ➢ *Maximum allowable cost to consumer*
  ➢ *Maximum length for entire process*
  ➢ *Payment within 30 days of award, without fail*
❑ Penalties:
  ❑ *Substantial and exponentially increasing daily monetary fines for failure to comply*
  ❑ *Potential suspension from marketplace*

No Surprises Act Arbitration Payment Issues

- *Axios, August 3, 2023,* "Doctors say insurers are ignoring orders to pay surprise billing disputes"

    - *S*urvey by Americans for Fair Health Care of more than 48,000 physicians in 45 states across 12 specialties

    - 52% of all arbitration-determined payment amounts were not paid at all

    - 33% of all claims paid were paid in an incorrect amount

37 N.C. REG. 2122, MAY 15, 2023

❑ NC proposed regulation on auto appraisal

➢ *Detailed on availability for total and partial losses*

➢ *who may serve as "appraiser" or umpire (independent)*

# Persons Capable of Appraising Value

- Individuals who buy and sell vehicles at wholesale and retail best able to determine vehicle value
  - *Substantial restrictions and disclosures required to sell vehicles commercially*
  - *National Auto Auction Association (NAAA) arbitration rules, e.g.*
    - Must disclose if structural repair not performed to auto maker specifications
    - Must disclose any auto maker warranty impairment
    - Many others

REQUEST C COMMITTEE WORKSTREAM

QUESTIONS?

Erica. L. Eversman, J.D.
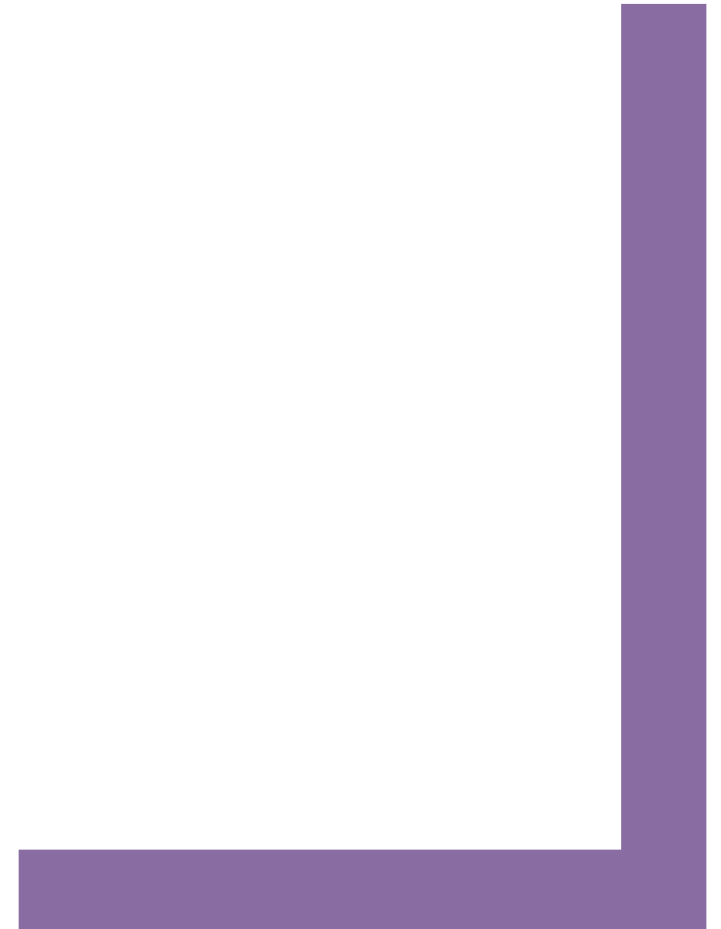
Agenda Item #4

4.   Hear a Presentation from the Disability Rights Education and Defense Fund (DREDF), the Whitman-Walker Institute, and the Leukemia & Lymphoma Society (LLS) on Federal Health Updates–Kellan Baker (Whitman-Walker Institute), Silvia Yee (DREDF), and Lucy Culp (LLS)

- 20 minutes

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

FEDERAL HEALTH DEVELOPMENTS AND RECOMMENDATIONS FOR STATES

Presented By:

Kellan Baker, Whitman-Walker Institute

Silvia Yee, Disability Rights Education & Defense Fund

Lucy Culp, The Leukemia & Lymphoma Society
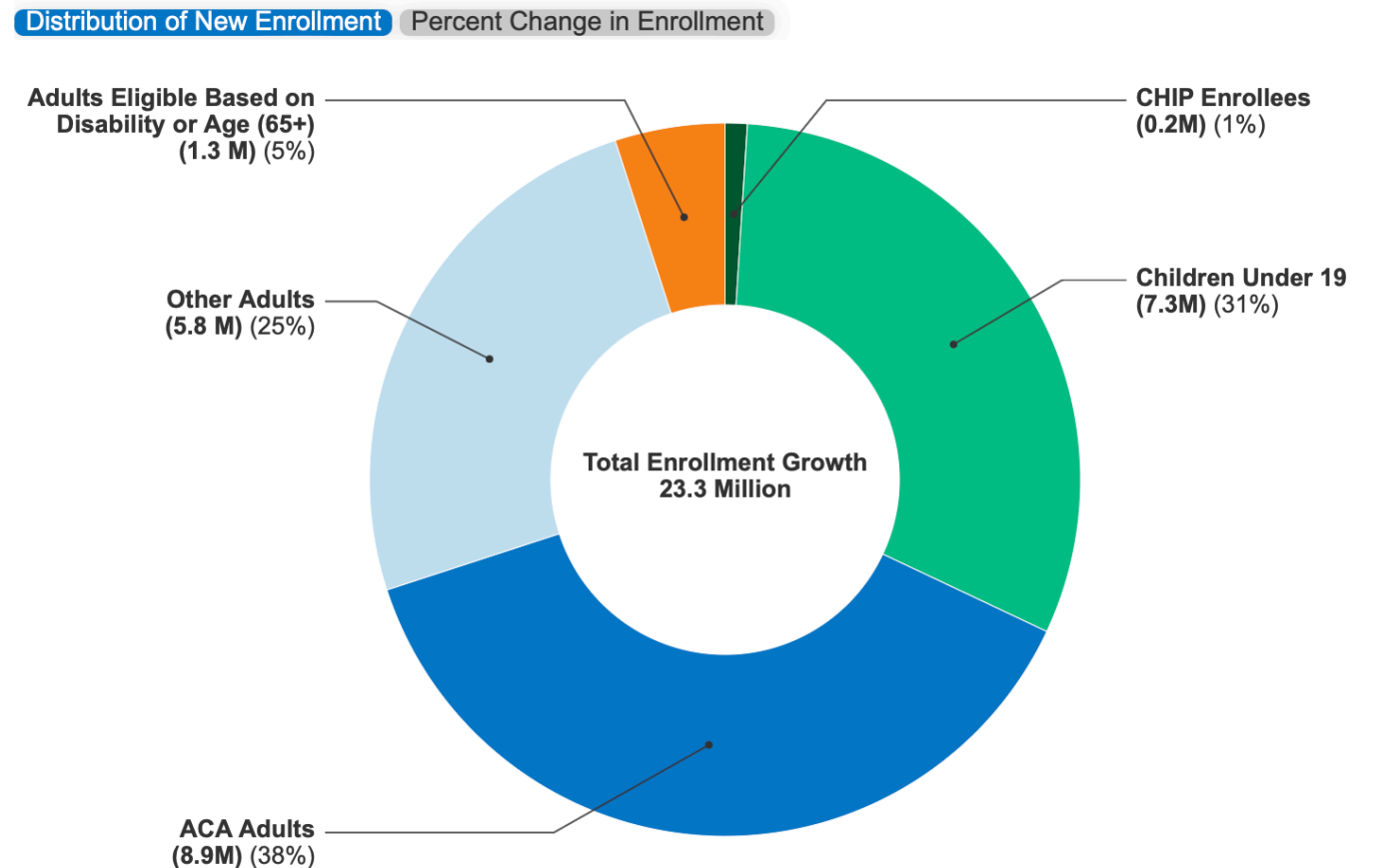
Medicaid During the PHE

- Families First Coronavirus Response Act (FFCRA) required states to implement continuous Medicaid enrollment through the end of the Public Health Emergency (PHE)

- Consolidated Appropriations Act, 2023 delinked continuous enrollment and the PHE, ending continuous enrollment on March 31, 2023

- Enhanced Medicaid match also phased out by December 2023

Change in Medicaid Enrollment During the PHE

- Between 2020 and 2023, Medicaid enrollment grew by an estimated 23 million (32%), to 95 million
- Continuous enrollment stopped "churn"

Medicaid Children, Adults Eligible through the ACA, and Other Adults Comprised the Vast Majority of Medicaid Enrollment Growth

Distribution of Total Medicaid Enrollment Growth From February 2020 to March 2023

Distribution of New Enrollment   Percent Change in Enrollment

Adults Eligible Based on Disability or Age (65+) (1.3 M) (5%)

CHIP Enrollees (0.2M) (1%)

Other Adults (5.8 M) (25%)

Children Under 19 (7.3M) (31%)

Total Enrollment Growth 23.3 Million

ACA Adults (8.9M) (38%)

Ramifications of PHE Unwinding on Medicaid

- An estimated 7.8-24.4 million people will lose Medicaid coverage during the PHE unwinding
- States are moving at different speeds to complete PHE unwinding and Medicaid eligibility redeterminations
- As of August 3, at least 3.8 million Medicaid beneficiaries (39% of those with completed renewals) have been disenrolled
- Disenrollment is an equity issue: it has differential impacts by race, ethnicity, income, type of eligibility, health conditions, etc.

Procedural Disenrollments

- Across all states with data, 74% of people dropped from Medicaid coverage were disenrolled for procedural reasons during the unwinding
- Many disenrolled beneficiaries are likely still eligible for Medicaid coverage:
  - States may not have correct contact information for enrollees
  - Enrollees unaware of needing to take action to stay enrolled
- Many others are eligible for Marketplace coverage or ESI

Strategies DOIs Can Take to Mitigate Impact

- Enhance outreach and in-person assistance
- Work with carriers and state Medicaid agencies to develop toolkits, simplified processes, and messages to help connect disenrolled Medicaid beneficiaries with Marketplace coverage or ESI
- Ensure that accurate information is available to consumers about inexpensive but potentially insufficient coverage alternatives (e.g., HCSMs, STLDI, catastrophic health plans) and about possible scams targeting vulnerable/confused consumers
- Monitor QHPs for marketing, enrollment, network adequacy, and coverage determination issues

Additional Strategies

- Consider an "unwinding" open enrollment period
- Expand continuity of care protections to preserve in-network cost-sharing rates for consumers in transition
- Require QHPs to honor prior authorizations, step therapy exemptions, formulary exemptions, and other protections for former Medicaid beneficiaries
- Pro-rate out-of-pocket costs for mid-year transitions
- Conduct auto-enrollment in coverage and premium assistance programs

MHPAEA – Brief Summary

- Applies to fully insured and self-ensured health plans, as well as non-federal governmental group health plans

- Enforcement authority held by DOL, CMS, & State Insurance Regulators

- In FY 2022, CMS enforced MHPAEA in Missouri, Texas, and Wyoming, and had collaborative enforcement agreements with Alabama, Florida, Louisiana, Montana, Oklahoma, and Wisconsin

- Most recent amendments to the 2008 Act made in CCA, 2021

Proposed Federal Rulemaking: MHPAEA

- July 25: DOL, HHS, & IRS proposed new MHPAEA rule to further ensure access to MH/SUD services
- Focus on NQTL parity from CCA maintained
- Further clarification of what MHPAEA compliance means
  - 13 factual examples of compliance or non-compliance
  - 3-part test for applicable group health plans and insurers to use when meeting their proactive obligation under CCA 2021 to provide an NQTL comparative analysis

MHPAEA – Technical Release

- July 25: Additional issuance by DOL, HHS, & IRS that provides concrete guidance on the data that plans and insurers must provide to show compliant that NQTL use consistent with network composition obligations
- "Safe Harbor" proposed for plans/issuers that meet certain independent professional medical or clinical standards for collecting and evaluating outcomes data for NQTLs
- Proposal to include TPAs for MH/SUD coverage
- State regulators can request plan/issuer analyses

Federal Rulemaking: Managed Care Rule

- Some consumer requirements and standards could apply across Medicaid and private managed care plans
- Secret Shopping: contract with an independent entity to carry out secret shopping that check for accuracy of provider directory information and meeting network adequacy standards (e.g., appointment wait times)
- Enrollee Experience Surveys: must meet interpretation, translation & tagline standards to achieve inclusive results
- Entities that offer both Medicaid and private health plans within a state can meet uniform standards across lines

Recommendations for Responses to MHPAEA & Managed Care Rulemaking

- Comments on MHPAEA proposed rule and on the Technical Provision (Safe Harbor) due October 2, 2023
- States - provide the federal agencies with information and additional examples on health plan/issuer use of NQTLs that do or do not comply with parity requirements
- NAIC comments – can provide insight on how state and federal cooperation can best be operationalized to ensure consumer access to MH/SUD treatment

Proposed Rule: Short-Term, Limited-Duration Insurance

- Defines STLDI
  - Short-term = no more than 3-month contract term
  - Limited duration = no more than 4 months w/ the same issuer (w/in a 12 month period)
  - Prohibits stacking by issuers
  - Applies to new policies
- Updates disclosure & additional information for consideration
- Seeking comments on additional ways to help consumers differentiate between products (i.e. sales during OE, associations)

Proposed Rule: Independent, Non-Coordinated Excepted Benefits

- Requires that individual market indemnity products are paid on a per-period basis
- Hospital and other fixed indemnity must be paid as a fixed dollar amount, regardless of expenses incurred
- Clarifies existing statute that excepted benefits must be independent from and not coordinated with other coverage
  - Group: products cannot be bundled by the employer
  - Individual: products cannot be bundled by the issuer
- Clarifies IRS tax treatment of excepted benefits (i.e. if plans are offered on a pre-tax basis, the benefits would be taxable income)
- Seeking comments on additional ways to help consumers (e.g. direct payments to providers, specified disease policies)
- Updates disclosure & additional information for consideration

New "Secret Shopper" Study

GEORGETOWN UNIVERSITY — McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

The Perfect Storm:
Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage

Consumer Profiles

Terri	Lorraine
22 years old with no pre-existing conditions	36 years old with a pre-existing condition (high cholesterol)

Both consumers:
- Are female;
- Live in Texas;
- Were informed that they will be losing Medicaid due to income ineligibility;
- Have an annual income of $25,000; and
- Have a household of two, including their 2-year-old daughter who is still eligible for Medicaid.

- The trend of misleading marketing continues as people lose their Medicaid coverage
- NONE of the 20 sales representatives offered the $0 marketplace plan
- Aggressive sales tactics that included false or misleading claims

https://georgetown.app.box.com/v/the-perfect-storm-august-2023

Recommendations for Regulators

Comment on the rule

- Support the definition of STLDI to be that of short-term and limited duration
- Support the proposals for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit
- Offer additional insights re: products sold across state lines through associations, level-funded plans

Further actions states can take

- Prohibit sales during open enrollment
  - ME, VA, WA
- Ban rescissions
  - CO, IL, ME, RI, WA
- Tighten restrictions on stacking
  - VT, WA
- Compliance with minimum standards
  - EHB (CO, CT)
  - Rating (CO, MN, MT)
  - MLR (CO, RI)
- Codify 3-month term for STLDI
  - DE, DC,HI, MD, NM, OR, VT, VA, WA
- Collect data and make publicly available

Congressional Activity That May Impact State-Regulated Plans

- **HR 824** – Telehealth Benefit Expansion for Workers Act
- **HR 2868** – Association Health Plans Act
- **HR 2813** – Self-Insurance Protection Act
- **HR 3799** – CHOICE Arrangement Act

Questions

Kellan Baker
Whitman-Walker Institute
KBaker@whitman-walker.org

Silvia Yee
Disability Rights Education & Defense Fund
syee@dredf.org

Lucy Culp
The Leukemia & Lymphoma Society
lucy.culp@lls.org

Agenda Item #5

5.   Hear a Presentation from Consumers' Checkbook, Georgians for a Healthy Future, and United States of Care on Preventative Health Services—Caitlin Westerson (United States of Care), Eric Ellsworth (Consumers' Checkbook), and Yosha Dotson (Georgians for a Healthy Future) – 25 minutes

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

IMPROVING ACCESS TO PREVENTIVE SERVICES: CONSUMER PROTECTIONS

NAIC National Meeting
Consumer Liaison Committee

August 12, 2023

Consumer Representative Presenters

❖ **Caitlin Westerson**
State Partnerships and External Affairs Director, United States of Care

❖ **Yosha Dotson**
Policy Consultant, Georgians for a Health Future

❖ **Eric Ellsworth**
Director of Health Data Strategy, Center for the Study of Services

Agenda

❖ **Introductions**

❖ **Overview of Preventive Services and update on Braidwood v. Becerra case**

❖ **Presentation of NAIC Consumer Representatives Report on Preventive Services**

❖ **Recommendations for Regulators**

❖ **Questions**

PREVENTIVE SERVICES OVERVIEW AND THE *BRAIDWOOD V. BECERRA* CASE

ACA Preventive Services Overview

- Under the Affordable Care Act's (ACA) preventive services mandate, most private health plans (non-grandfathered individual, group, and self-funded) are required to cover more than 100 preventive health services **without cost sharing**.

- This has led to improved health outcomes and reduced disparities in access to care for over 150 million people.

ACIP	**USPSTF**	**HRSA**
Advisory Committee on Immunization Practices	*US Preventive Services Task Force*	*Health Resources and Services Administration*
Vaccines & immunizations	General preventive services	Preventive services & screenings for women & children

Braidwood v. Becerra: Overview

- In September, 2022, Judge Reed O'Connor, a federal district judge in Texas, issued a ruling in the case *Braidwood Management v. Becerra*, a lawsuit that challenges the requirement that most health plans cover preventive services at no cost under the Affordable Care Act.

- In March, 2023, this same federal judge issued another ruling, clarifying that his decision applied nationwide and not just to the parties involved in this case. While the decision has been **temporarily stayed**, access to critical preventative care for more than 150 million people is now at risk – including approximately 37 million children.

- This decision is a sweeping ruling that will have **significant implications** for our health care system but, ***the ACA preventive services coverage requirements are still the law of the land*** and many states have adopted state laws and regulations that provide preventive services coverage and cost-sharing protections for **state-regulated plans**.

Braidwood v. Becerra: Implications

The *Braidwood* case threatens free access to approximately 100 covered preventive services for more than 150 million people with private health insurance coverage.

If access to free preventive services is eliminated:

- **2 in 5 adults would skip necessary preventive** care should these services and screenings not be covered cost-free.

- **Historically underserved communities will be disproportionately impacted**: for those with low-incomes, even a small copay could deter someone from receiving preventive care.

Important: While the current focus is on USPSTF services, the ultimate goal of the plaintiffs is to eliminate access to ALL free preventive services

Regardless of the outcome of the case, there are significant enforcement issues that must be addressed to ensure consumers can access preventive services without cost-sharing.

INCREASING ACCESS TO PREVENTIVE SERVICES HAS SIGNIFICANT HEALTH EQUITY IMPLICATIONS

Preventive Service	Communities Most Impacted	Benefits of the Intervention
Smoking cessation	Tobacco use is concentrated among low-income communities, including Native American and LGBTQ	Tobacco cessation interventions double the rate at which people who smoke quit smoking
Pre-exposure prophylaxis (PrEP) for the prevention of HIV	Black and African-American and Latino and Hispanic individuals comprise 40% and 29% of new HIV diagnoses, respectively	PrEP is 99% effective at preventing HIV from sex and 74% effective at preventing HIV from injection drug use
Colorectal cancer screening	Rates of late colorectal diagnosis are higher among rural populations, people with lower education and lower incomes, and people who are Black and African American, Latino and Hispanic, or Native American	When detected early, colorectal cancer can be treated with surgery, chemotherapy, radiation, and/or immunotherapy
Postpartum depression screening	Postpartum depression rates are higher based on low income, poor access to education/healthcare, adolescent age, Black and African-American race, and recent immigrant status	Depression treatment for parents with postpartum depression has health and economic benefits for the parent and children

NAIC CONSUMER REPRESENTATIVES PREVENTIVE SERVICES REPORT

THE REPORT METHODOLOGY

- Research included:

  - Review of policy analyses and studies on utilization, cost, and health outcomes

  - Informant interviews - patient groups; plan and issuer representatives; providers and provider associations; state regulators; and consumers

  - Analysis of Marketplace plan preventive services and payer guidance documents from insurers' websites, including:

    - Consumer-facing preventive services coverage descriptions (i.e., preventive services brochures or fact sheets) on publicly available plan websites

    - 2023 plan formulary

    - Most recent payer guidance for each of the four focus preventive services

1) DOCUMENTATION FOR CONSUMERS AND PROVIDERS IS EXTREMELY BURDENSOME TO SEARCH

- Each insurer puts this information different parts of the website, different documents, different format, different things mentioned and not mentioned

- Insurer websites lack clear, consistent paths to look up coverage for a particular preventive service like "colonoscopy" or "quitting smoking"

- Difficulty searching biases results and weakens confidence in answers about coverage:

    - Person searching is forced to conclude:
        "I couldn't find it so I guess the answer is no"
        rather than what they wanted:
        "yes/no/unclear because X,Y,Z exception"
    - Mixes of market segments puts consumer at risk of wrong answer and attendant financial risk

- **"Not Found vs No"** problem pervades insurer information sources (provider directories, formularies, etc.)

2) CONSUMER FACING DOCUMENTS ARE HARD TO FIND AND LACK COMPREHENSIVE PREVENTIVE SERVICES DESCRIPTIONS

- Most plans assessed did not describe every component of a preventive service, especially for services that involved both a medical and pharmacy benefit

- It's 2023: Your doc should be able to use her EHR system to automatically send you a text/email for your plan's coverage of preventive services

- Enabling that requires that every insurer:
    - Expose information about each service for each market segment via a direct link
    - List/names of services in a way that is standardized across all insurers
    - Use same website structure for this type of information
(that's in essence a standardized API)

3) PLAN FORMULARIES DID NOT ALWAYS DISTINGUISH PREVENTIVE VS NON-PREVENTIVE DRUG COVERAGE
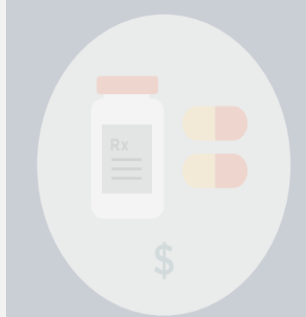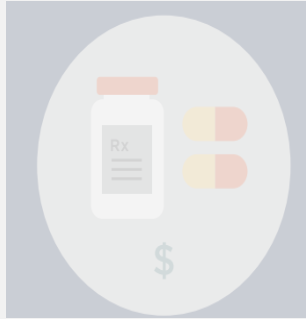
- Separate preventive services formularies made it easiest to find coverage details

- Especially useful was listing drugs by problem/intervention

- Very difficult to assess $0 coverage of preventive medications when they were listed in the main formulary by therapeutic class

4) PAYER GUIDANCE DOCUMENTS THAT INFORM CLAIMS ADJUDICATION POLICIES WERE OFTEN INCOMPLETE (CTD)
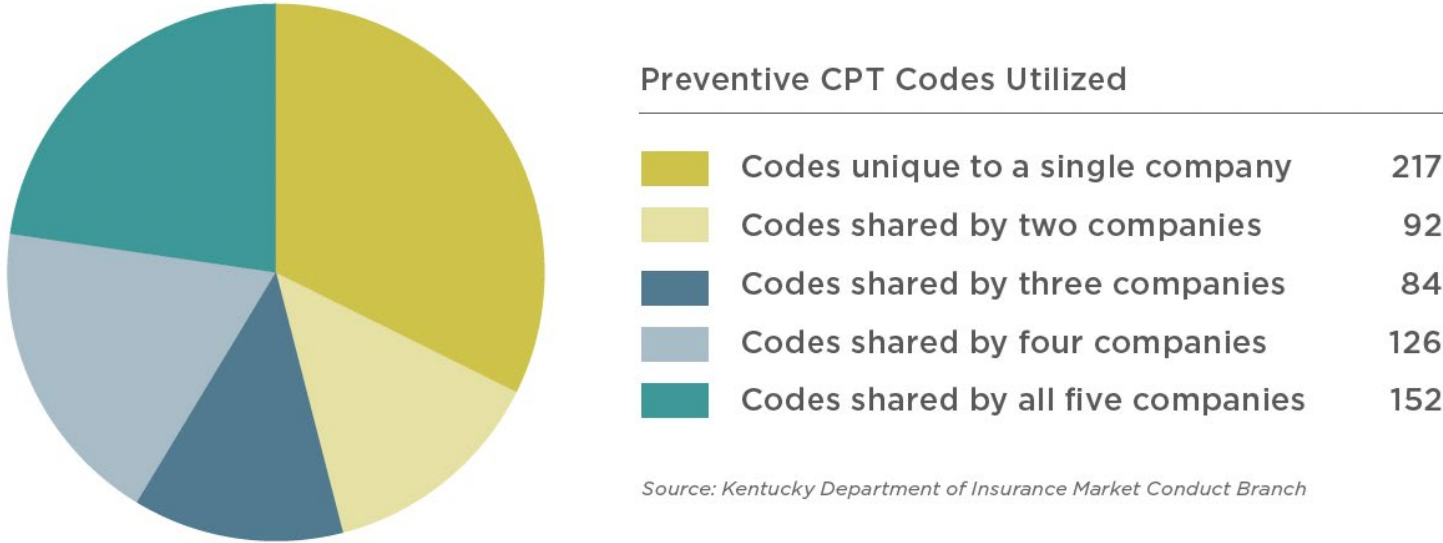
- Most plans did not have publicly available comprehensive payer guidance for each of the four services reviewed
- Common gaps in the payer guidance reviewed included:
  - No reference to nationally recognized clinical standards
  - Lack of specificity on what services will be covered and how often hampers effectively managing the patient
  - Especially hard to get complete info when the intervention included both a medical and pharmacy benefit
- Similar problems with payer guidance for most medical services, not just preventive
  - Big part of why prior auth/UM/denials so burdensome!

WHAT HAPPENS WHEN PROVIDERS BILL FOR PREVENTIVE SERVICES

Lack of specific coverage policies that are well articulated to providers leads to arbitrary coverage decisions

FIGURE 9

Kentucky CPT Code Variation for Preventive Services

Preventive CPT Codes Utilized

Codes unique to a single company	217
Codes shared by two companies	92
Codes shared by three companies	84
Codes shared by four companies	126
Codes shared by all five companies	152

Source: Kentucky Department of Insurance Market Conduct Branch

HOW BILLING OF PREVENTIVE SERVICES PLAYS OUT FOR CONSUMERS

The Role of Claims Adjudication in $0 Preventive Services
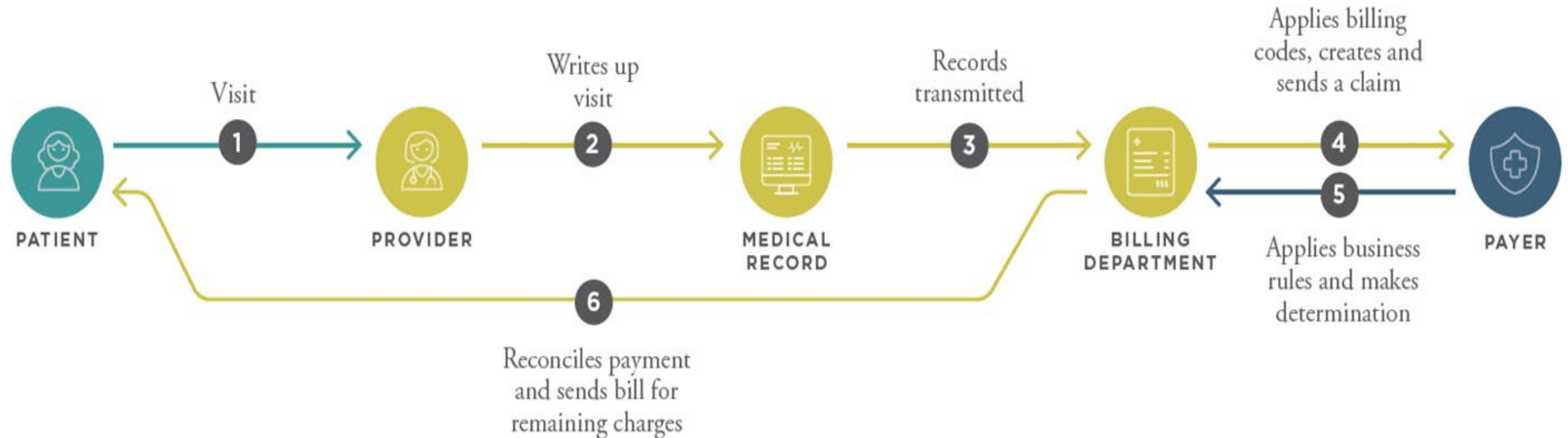
RECOMMENDATIONS FOR REGULATORS

1) UTILIZE DATA CALLS AND MARKET CONDUCT EXAMS TO ASSESS COMPLIANCE

2) ENSURE CONTINUED PREVENTIVE PROTECTIONS W/ STATE LEGISLATIVE AND REGULATORY ACTION

3) ENFORCE APPEALS PROTECTIONS FOR MIS-ADJUDICATED OR DENIED PREVENTIVE SERVICES CLAIMS

4) ENSURE THAT QUALIFIED HEALTH PLAN (QHP) CERTIFICATION ASSESSES FORMULARIES AND OTHER PLAN DOCUMENTS

5) HOLD PLANS ACCOUNTABLE FOR EDUCATING CONSUMERS AND PROVIDERS ON PREVENTIVE SERVICES REQUIREMENTS

6) ESTABLISH UNIFORM BILLING AND CODING STANDARDS

IN SUMMARY

- Preventive services mandate is a critical part of ACA
  - Brings much needed services to marginalized communities
  - States can use legislation and regulation to protect against legal threats

- Implementation is still shaky, specifically:
  - How consumers can figure out what why are entitled
  - How providers can figure out to bill such that consumers get what they are entitled for no cost

- Fixing this is not a legal problem, it's a process oversight problem

  - How insurer documents are exposed to consumers and providers

  - Billing codes and claims adjudication

CONTACT INFORMATION

❖ **Caitlin Westerson**, State Partnerships and External Affairs Director, United States of Care | cwesterson@usofcare.org

❖ **Yosha Dotson,** Policy Consultant, Georgians for a Health Future | yosha.dotson@gmail.com

❖ **Eric Ellsworth,** Director of Health Data Strategy, Center for the Study of Services | eellsworth@checkbook.org

Agenda Item #6

6.   Hear a Presentation from the American Kidney Fund (AKF) and the HIV+Hepatitis Policy Institute on Healthcare Appeals and Denials–Deb Darcy (AKF) and Carl Schmid (HIV+Hepatitis Policy Institute) – 15 minutes

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Claims Chaos:
Barriers to Health Insurance:
Prior Authorization, Denials & Appeals

Deborah Darcy
Carl Schmid

NAIC Consumer Liaison Meeting
August 12, 2023

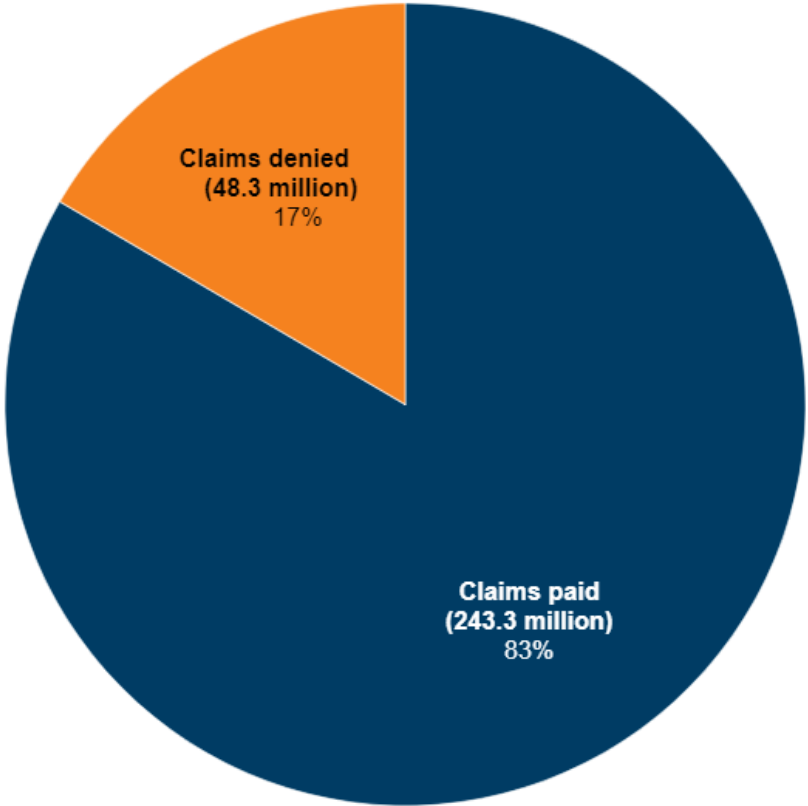# Claims Denials and Appeals in ACA Marketplace Plans in 2021

Karen Pollitz , **Justin Lo** , **Rayna Wallace** , and **Salem Mengistu**

Figure 1

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

Share of 291.6 million in-network denied claims

Claims denied
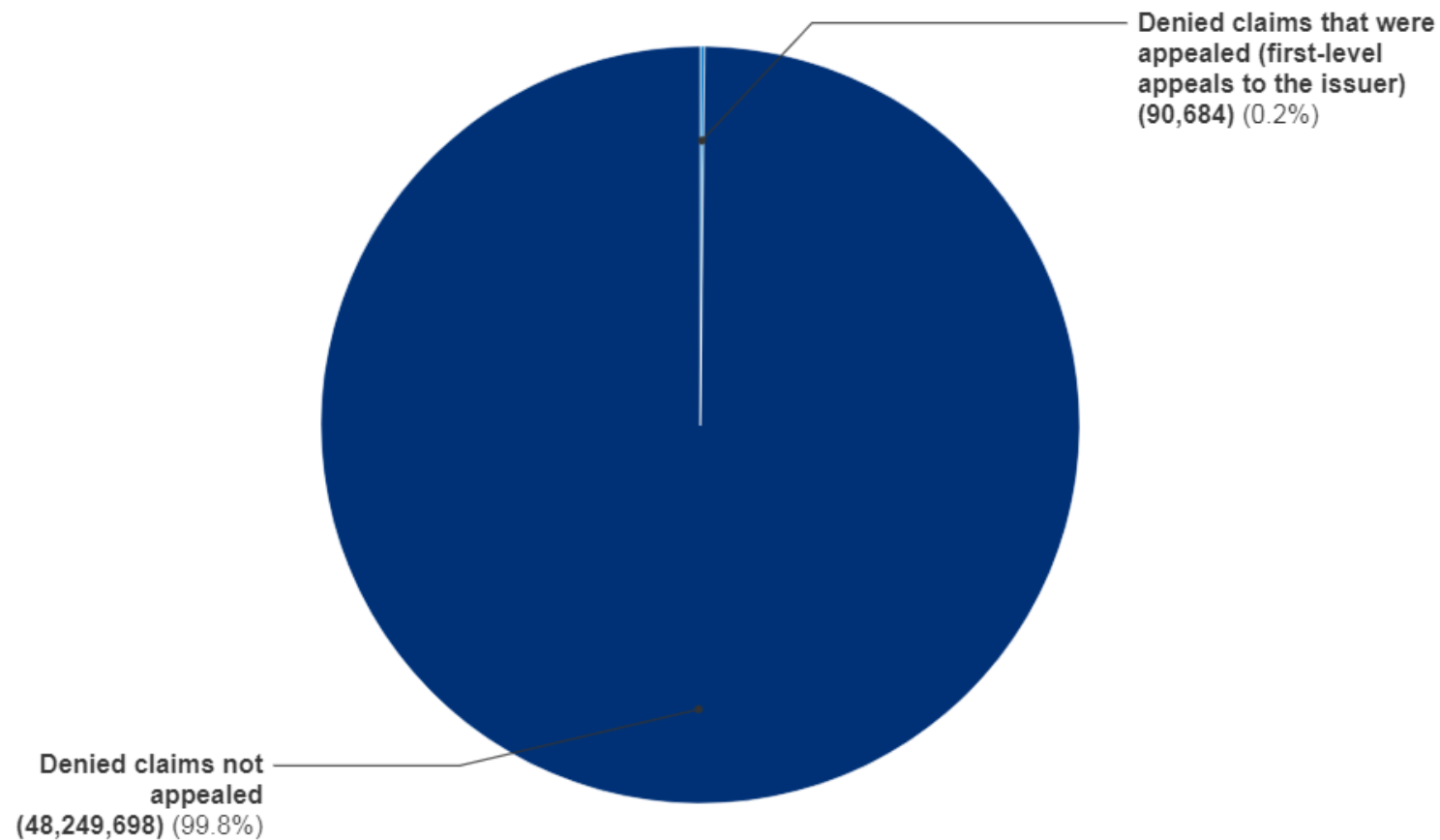(48.3 million)
17%

Claims paid
(243.3 million)
83%

SOURCE: CMS Transparency in coverage data for 2021 plan year • PNG

KFF

Figure 4

Consumers rarely appeal denied health insurance claims

Share of 48.3 million denied claims appealed by consumers in 2021 through internal issuer appeals process

Denied claims that were appealed (first-level appeals to the issuer) (90,684) (0.2%)

Denied claims not appealed (48,249,698) (99.8%)

NOTE: This figure only includes denied claims for issuers that show data on appealed claims.
SOURCE: CMS Transparency in coverage data for 2021 plan year. • PNG

KFF

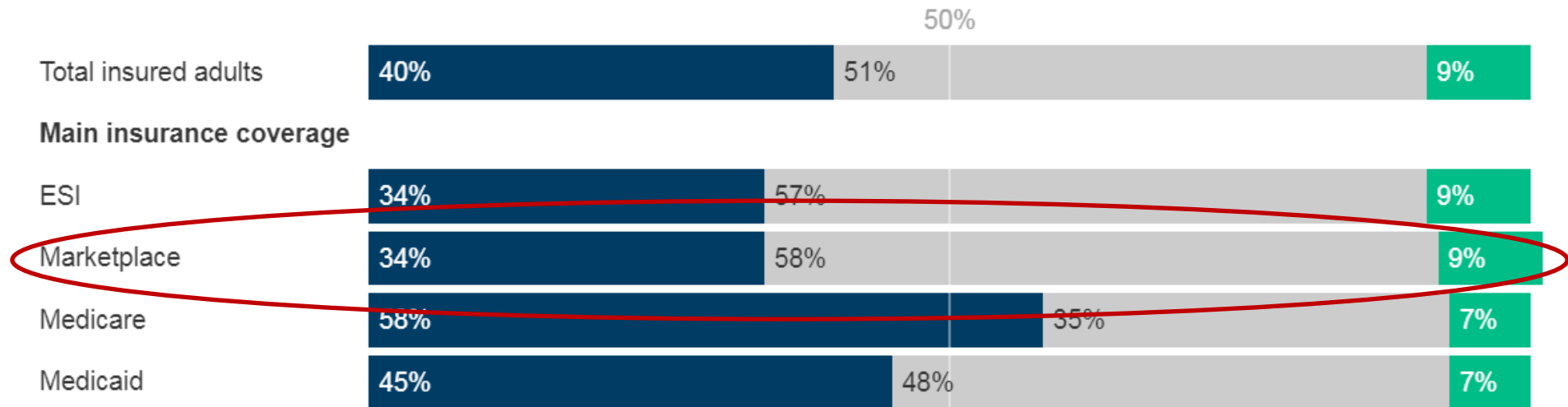# KFF Survey of Consumer Experiences with Health Insurance (June 2023)

- **"Pre-authorization issues** – About one in six insured adults (16%) say their health insurance denied or delayed prior approval for needed care in the past 12 months"

- **"Claims payment issues** – About a quarter (27%) of insured adults say there was a time in the past year when their health insurance paid less than they expected for a medical bill, and about one in six (18%) say there was a time when their insurance did not pay anything for care they received and thought would be covered. "

- **"Prescription drug problems** – About a quarter of insured adults (23%), including at least one in five across insurance types, say their insurance did not cover a needed prescription medication or charged a very high copay in the past 12 months."

- Source: https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/

Figure 9

Most Insured Adults Are Unaware They Have A Right To Appeal Insurance Decisions

As far as you know, if your health insurance refuses to cover medical services you think you need, do you have the legal right to appeal to a government agency or an independent medical expert?

Legend: ■ Yes, I have that right by law ■ Not sure ■ No, I do not have that right by law

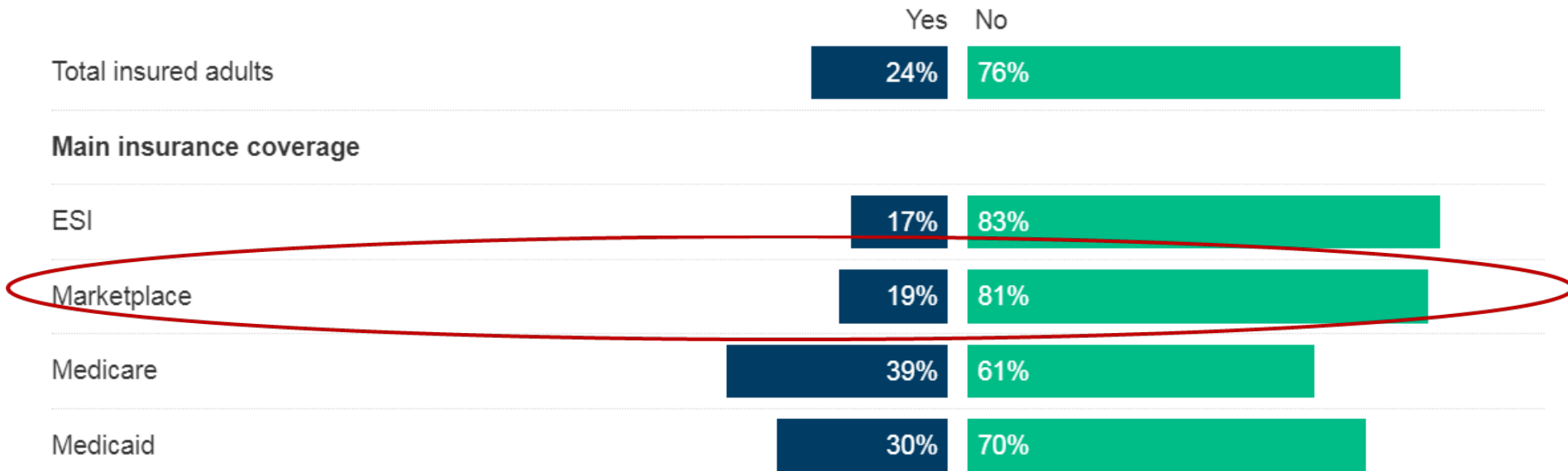|	Yes, I have that right by law	Not sure	No, I do not have that right by law
Total insured adults	40%	51%	9%
Main insurance coverage			
ESI	34%	57%	9%
Marketplace	34%	58%	9%
Medicare	58%	35%	7%
Medicaid	45%	48%	7%

NOTE: See topline for full question wording.
SOURCE: KFF Survey of Consumer Experiences with Health Insurance (Feb. 21-Mar. 14, 2023) • PNG

KFF

Figure 10

Just One In Four Insured Adults Say They Know Which Government Agency To Contact For Health Insurance Problems

If you wanted to contact a government agency for help dealing with your health insurance, do you know who you would call?

	Yes	No
Total insured adults	24%	76%
Main insurance coverage		
ESI	17%	83%
Marketplace	19%	81%
Medicare	39%	61%
Medicaid	30%	70%

NOTE: See topline for full question wording.
SOURCE: KFF Survey of Consumer Experiences with Health Insurance (Feb. 21-Mar. 14, 2023) • PNG

KFF

NAIC Consumer Representatives

Prior Authorizations, Appeals & Denials Work Group

Draft Suggestions for NAIC

Areas of Focus

▸ **Current Data & Reporting Requirements**

▸ **Prior Authorizations & Medical Necessity**

▸ **Appeals & Denials**

▸ **Consumer Information**

▸ **Use of Artificial Intelligence**

Current Data & Reporting Requirements

▶ **Goals:**

- Better understanding of:
  - existing data & reasons why behind the numbers
  - what is being collected and how
  - NAIC and ACA data requirements and who is not implementing
  - what is being publicly released
- Assess enforcement of data requirements
- Utilize data to inform consumer decisions
- Suggest changes/make recommendations on the above

Current Data & Reporting Requirements

▶ **Suggested Action Steps:**
- Meetings w/ & presentations by KFF
- Meetings w/ & presentations by CCIIO
- Examine MCAS (D Committee)
  - Presentations by states
    - including those that release results
- Other state presentations
  - Including state-based exchanges
- Meeting & Presentation by DOL
- Review and develop guidelines for data collection and release

Prior Authorizations, Other Utilization Management & Medical Necessity

▶ **Goals:**
- Better understanding of:
  - what states are doing relative to PA & other UM through laws and regulation, including gold carding
  - proposed Federal regulations, including interoperability proposals
- Prepare states for implementation of state and federal regulations

Prior Authorizations, Other Utilization Management & Medical Necessity

▶ **Suggested Action Steps:**
- State Presentations
- Federal presentations on proposed regulations and implementation
- Presentations by consumer groups, AMA & other impacted entities
- Review & Update Model Guidelines

Appeals & Denials

▸ **Goals:**

- Better understanding of:
  - reasons for denials and suggest system improvements
  - why consumers do not appeal denials
  - why low number of appeals are approved and suggest system improvements
  - shifts in provider behaviors around appeals (and role of insurers in those decisions)
  - appeals/denials for life sustaining devices and drugs

Appeals & Denials

▶ **Suggested Action Steps:**
- Invite states to present on their data, policies and plan reviews
- Invite insurers to present on their processes
- Invite consumers and outside experts to learn of consumer experiences and impact on health
- Update NAIC model guidelines/laws
- Review and update Explanation of Benefits (EOB) requirements

Consumer Information

▶ **Goals:**

- Increase consumer knowledge of their rights & government regulators
- Better utilize technology and social media
- Assess role and responsibility of insurers in these processes
- Regular assessment of state DOI websites for accessibility

Consumer Information

▶ **Suggested Action Steps:**

- Consumer Information Subgroup update materials-working with consumer reps and interested parties
- Investigate new and heightened resourced communication avenues
- Hear from states on their approaches, requirements and innovations
- Invite insurers to present on how they inform consumers of their rights

Role of Artificial Intelligence

▶ **Goals:**

- Better understanding of:
  - the use of AI in assessing medical necessity, PA & other UM, Denials and Appeals, including batch appeals and denial software use
  - the consumer impact, including on those with complex medical conditions
  - current regulations and laws
  - the role of third-party contractors and how they can/should fall under regulatory requirements
- Assess the need for model guidelines

Role of Artificial Intelligence

▶ **Suggested Action Steps:**
- Work in conjunction with H Committee
- Invite insurers to present on the use of AI
- Hear from outside experts
- Hear from regulators on how they are addressing AI
- Develop model guidelines/laws

Next Steps

▶ **Presented to B Committee Leadership**
  ▶ Awaiting Response

▶ **Ongoing Work with Committees**

▶ **Official Request Submitted for Action/Charges**

▶ **Consumer Rep. Work Group continues to meet**

▶ **Look forward to Addressing these issues with you**

Thank you!

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Agenda Item #7

7.   Discuss Any Other Matters Brought Before the Liaison Committee–Commissioner Andrew R. Stolfi (OR)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Agenda Item #8

8.   Adjournment

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