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NAIC/Consumer Liaison Committee
Tampa, Florida
December 12, 2022

The NAIC/Consumer Liaison Committee met in Tampa, FL Dec. 12, 2022. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Lori K. Wing-Heier represented by Anna Latham (AK); Mark Fowler (AL); Alan McClain represented by Jennifer Bruce (AR); Evan G. Daniels represented by Maria Ailor (AZ); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by Chris Struk (FL); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt represented by LeAnn Crow (KS); Kathleen A. Birrane represented by Nour Benchaaboun (MD); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney represented by Ryan Blakeney (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by John Arnold (ND); Chris Nicolopoulos represented by David Bettencourt (NH); Barbara D. Richardson (NV); Anita G. Fox represented by Jana Jarrett (OH); Michael Humphreys (PA); Cassie Brown (TX); Jon Pike represented by Tanji Northrup (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).

1. <u>Adopted its Oct. 14 and Summer National Meeting Minutes</u>

The NAIC/Consumer Liaison Committee met Oct. 14 in joint session with the Innovation, Cybersecurity, and Technology (H) Committee and took the following action: 1) heard presentations on algorithmic bias and approaches insurance companies are or can implement to manage and mitigate the risk of unintended bias and illegal discrimination when developing and using artificial intelligence (AI)/machine learning (ML); 2) hear presentations on algorithmic bias and a holistic approach to confronting structural racism in insurance; and 3) received comments from interested parties.

Commissioner Richardson made a motion, seconded by Benchaaboun, to adopt the Committee's Oct. 14 (*see NAIC Proceedings – Fall 2022, Innovation, Cybersecurity, and Technology (H) Committee, Attachment One-b)* and Aug. 12 (*see NAIC Proceedings – Summer 2022, NAIC/Consumer Liaison Committee*) minutes. The motion passed unanimously.

2. <u>Heard Opening Remarks</u>

Commissioner Arnold said the NAIC Consumer Participation Board of Trustees met Aug. 12 to discuss the selection of the 2023 NAIC consumer representatives. Commissioner Arnold said the Liaison Committee has implemented many of the suggestions to enhance its meetings. These enhancements include having a smaller room for the meetings, holding the meetings earlier during the NAIC national meetings, distributing a summary of presentations prior to meetings, and holding interim meetings. Commissioner Arnold said the Liaison Committee affirmed the mission statement of the Committee on Oct. 21 through an e-vote.

3. <u>Heard a Presentation from UP on Insurance and Recovery in Hurricane Ian's Aftermath</u>

Amy Bach (United Policyholders—UP) said Florida experienced Hurricanes Ian and Nicole in short succession. There were 449,000 claims for Hurricane Ian, and 110,000 of these claims were closed without payment. Hurricane Nicole resulted in more than 30,000 claims, and approximately 25% of these claims have been closed without payment.

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Bach said there has been a housing shortage for adjusters and not enough local contractors and remediation professionals. She said the Florida insurance marketplace also has smaller, regional insurers. Bach said that this year, the Florida legislature overturned a building code requirement that specified a new roof should be provided if 25% of the roof is damaged. There is also consumer confusion regarding insurers offering lower premiums for actual cash value coverage for roofs and multiple deductibles.

Bach said the lost estimate from Hurricane Ian is $3.8 billion but that the catastrophe (CAT) bonds for Florida's Citizens Property Insurance Corporation should not be triggered. Bach said the National Flood Insurance Program (NFIP) has paid nearly $437 million to policyholders but that not enough Florida consumers have purchased flood insurance.

Bach said UP recommends consumers focus on avoiding further damage to their homes, obtain multiple estimates for repairs, and check the license of anyone who is hired during the claim process. She said UP recommends the following broader marketplace reforms: 1) restore fairness/integrity to the appraisal process; 2) let the legislative fixes work while not removing the deterrent and remedial value of civil litigation rights; 3) use market conduct exams to monitor insurer practices; 4) evaluate the impact of high and multiple deductibles, roof repair coverage limits and actual cash value (ACV)-only coverage, and the structural integrity of buildings.

4. <u>Heard a Presentation from the CFA on the Use of Auto Insurance Telematics</u>

Michael DeLong (Consumer Federation of America—CFA) said auto insurers are increasingly adopting telematics programs to collect data for insurance pricing. He said these programs show substantial promise for consumers but said regulatory oversight is needed to ensure that programs are not misused. DeLong said state insurance regulators have special responsibilities to ensure that auto insurance is affordable and that consumers are not subject to unfair discrimination because drivers are required to purchase auto insurance.

DeLong said telematics allows insurance companies to directly evaluate consumers' driving behavior and calculate rates based on that behavior. He said another goal of insurers is to encourage safer driving; however, insurers have generally withheld the full scope of these programs, and there is little transparency. This leads to consumer confusion. DeLong said telematics may measure breaking, time of day driving, distance traveled, acceleration, speed, and cornering. Telematics could replace currently used non-driving factors, such as credit history, education levels, job, rental status, and ZIP code.

DeLong said consumer concerns include data privacy issues, lack of transparency regarding algorithms and data models, unintended bias and unfair discrimination, continued use of non-driving factors, and insurer abuse of programs to raise costs. DeLong said insurers remain publicly vague about defining risk factors. For example, he said GEICO's DriveEasy rates customers on driving "smoothness" and "the speed at which [they] are cornering" but does not explain how fast is too fast or what constitutes an abrupt stop. Farmers told Consumer Reports that its Signal program determines discounts using information about the riskiest times and days to drive, but it would nt provide specific information. Farmers' website uses general descriptions like early morning, rush hour, and late at night.

DeLong said consumers remain skeptical about telematics. While insurers are promoting telematics as the default option, DeLong said a recent Policygenius study found that 68% of Americans would not install an application that collects driving behavior or location data for insurance discounts.

DeLong reviewed state laws. Florida does not have specific laws or regulations about telematics. New York requires insurers to have policyholder approval for the collection of data, and insurers cannot gather any data unrelated to discounts or rating insurance or use data to harm policyholders. California requires the use of

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telematics to be voluntary and premiums to be determined mostly by driving safety record and miles traveled. Additionally, insurers can only use factors related to risk of loss and adopted by insurance commissioner.

DeLong offered the following general recommendations: 1) data collection must be transparent and programs voluntary; 2) consumers and state insurance regulators need to know all the data points collected by insurers and third-party vendors; and 3) telematics must be completely voluntary for consumers. There must be no pressure or requirements.

Regarding standards for data collection, DeLong recommended the following: 1) state insurance regulators should only allow data demonstrably related to the risk of loss; 2) insurers must provide actuarial justification and causative explanation for each data point used. Each component must be related to risk; and 3) third-party vendors or developers should be subject to state insurance department oversight.

Regarding transparency, DeLong recommended the following: 1) state insurance regulators, elected officials, and consumers need to see how algorithms work (i.e., what goes into the calculations and what comes out); 2) all components and inputs should be identified and so should the weight given to them; and 3) algorithms should be presented to consumers in plain language, with weight percentages of each driving behavior.

Regarding privacy, DeLong recommended the following: 1) consumers should have control over their driving behavior data and determine what it is used for; 2) data should only be used for evaluating risk and not for other purposes; 3) data should not be sold or shared with other corporations for advertising; and 4) consumers should receive regular accounting of the data collected and how it has been used to rate their policy.

DeLong said telematics should be tested for disparate impact and unfair discrimination against protected classes. DeLong said biased data can perpetuate and reinforce structural racism. For example, DeLong said using time of day driven could lead to unfair bias against lower-income workers and people of color who may be driving earlier in the morning or late at night to work. Eric Ellsworth (Consumers' Checkbook/Center for the Study of Services—CSS) said telematics is a good example of where an algorithm could be incomplete.

5. Heard a Presentation from the AEPI and Consumers' Checkbook on the Lack of Consumer Understanding About Insurance.

Erica Eversman (Automotive Education & Policy Institute—AEPI) said auto insurers have promoted the posting of policies online for consumer access. She said this leads to several questions and concerns, such as whether consumers can access information on a mobile device, the ease of navigation to the policy, whether the policy includes all endorsements, and whether endorsements are posted as separate links. Eversman said insurers do not discuss all policy features with consumers, including uninsured/underinsured medical coverage, replacement cost for a new vehicle, gap coverage, coverage for vehicle customizations, rental car coverage, and the use of original equipment manufacturer (OEM) vs. non-OEM parts. Because of this, Eversman said consumers need easy access to the insurance policies purchased.

Ellsworth said one solution is for insurance companies to be required to make policies and endorsements available online and to provide standard policy numbers to all consumers. He said insurers could create QR codes to allow consumers to go directly to the consumer's own policy, endorsements, and declaration page. Ellsworth said providing consumers easy access to their individual policies allows others to use the data in new ways. This includes building applications to provide information tailored to consumers' specific situations, without them having to learn complex insurance language or concepts.

6. Heard a Presentation from the CAIF on the Ethical Use of Data to Investigate Insurance Fraud

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Matthew Smith (Coalition Against Insurance Fraud—CAIF) said the CAIF surveyed more than 2,000 individuals regarding the use of data to investigate insurance fraud. He said these included consumers, insurance professionals, legislators, and those working in the legal and data service industry.

Smith said 85% of the respondents said they are somewhat concerned or very concerned about the use of data to fight insurance fraud. Respondents indicated the highest level of trust with financial institutions and then insurance companies when asked what institutions they trust to handle their personal data. He said the survey indicates 60% of the respondents support insurers' use of data to fight fraud. Smith said survey respondents prefer a national standard for protection of data, but respondents put their highest level of trust in state insurance regulators to create guidelines about the ethical use of data to prevent insurance fraud.

Smith said 83% of the respondents support an insurance company using their data in an algorithm to help identify people who could be committing insurance fraud. At the same time, He said consumers want to be notified of an insurance company's data usage policy. Smith stressed that disclosure and clarity are key to consumer trust, and almost 90% of respondents want clear and concise policies regarding how insurers are using data.

Regarding specific feedback from respondents who are insurance professionals, 53% of insurance professionals said their companies have a policy regarding the use of data to identify potential insurance fraud but that the policies need to be updated.

Smith provided the following recommendations to state insurance regulators: 1) use the survey results for their work; 2) support the appropriate use of data to protect consumers from fraud; 3) require clear data usage policy language and disclosure; 4) support antifraud protections in data privacy laws; and 5) address bias and prejudice, whether intentional or unintended, including activities of third-party vendors and data aggregators.

7. Heard an Update from the LLs, the NHeLP, and the HIV+Hepatitis Policy Institute on Federal Actions Affecting State Regulation of the Health Insurance Market

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said the open enrollment period for 2023 is just past the halfway point. She said the family glitch has been fixed. Culp said the average benchmark premiums have increased but that consumer costs are aided by the continuation of federal American Rescue Plan Act subsidies. She said that relaxed eligibility rules and increased navigator funding should aid consumers in signing up for coverage. Culp said standard plans are available in most states and have the potential to help consumers by simplifying the shopping experience, stabilizing cost-sharing requirements, and addressing health disparities. Culp recommended state insurance regulators take further steps to aid consumers through consumer education and monitoring the marketplace.

Wayne Turner (National Health Law Program—NHeLP) said consumers are still waiting on the notice of benefit and payment parameters for 2024. Turner said consumer and patient advocacy groups have submitted letters to the U.S. Department of Health and Human Services (HHS) urging improvement of benefits in select essential health benefit (EHB) categories (e.g., Rx, pediatric services, maternity care), cost sharing, network adequacy, standardized plans, and broker standards.

Turner said the HHS and states should take action against insurers and pharmacy benefit managers (PBMs) that evade federal Affordable Care Act (ACA) cost-sharing protections by declaring certain benefits non-EHB. For example, classifying a particular drug as covered but non-EHB means that a patient will pay the full cost of the drug until the deductible is met, share costs with the plan (via copay or coinsurance) until the plan's annual or lifetime cap is hit, and pay out-of-pocket for all further costs for the drug. Turner said the ACA requires the HHS secretary to: 1) define EHBs; 2) periodically review and update EHBs to address the difficulty in accessing services and identification of coverage; and 3) update EHBs to address any gaps in access to coverage.

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Carl Schmid (HIV+Hepatitis Policy Institute) said consumers are awaiting the final, revised Section 1557 non-discrimination rule. He said the draft closed in October, and it restores many patient protections that were eliminated in 2020 and expands others. Schmid said the proposed rule expands the scope of the current rule to apply to all HHS health programs and activities, which includes all plans and operations by carriers—not just ACA plans. Schmid said the proposed rule restores inclusion of “Benefit Design” and “Marketing Practices,” including third-party contractors, such as PBMs. The rule also addresses network adequacy and prescription drugs. Schmid said states are responsible for implementation and enforcement.

Schmid provided a summary of key litigation. Schmid said there is copay accumulator litigation that alleges the HHS and the federal Centers for Medicare & Medicaid Services (CMS) 2021 Notice of Benefit and Payment Parameters violates the ACA, is contrary to ACA regulations, and is arbitrary and capricious. Schmid said the *Braidwood vs. Becerra* case challenges ACA requirements that most health plans cover certain preventive screenings and services without cost sharing. Schmid said these challenges will likely be appealed to the U.S. Supreme Court.

8. Heard a Presentation from the RIPIN and the HES on the Unwinding of the Public PHE

Shamus Durac (Rhode Island Parent Information Network—RIPIN) said the public health emergency (PHE) unwinding is not just a Medicaid issue with up to 15 million people expected to lose coverage. Durac said these consumers will no longer be eligible for Medicaid and will need to transition to other coverage. Durac said consumers who lose coverage may turn to state insurance departments for assistance, and many will not learn of their coverage termination until seeking care. Durac said state insurance departments should plan now to help prevent PHE coverage losses by helping consumers transition to new coverage and by providing assistance and resources to consumers who lose coverage.

Karen Siegel (Health Equity Solutions—HES) said the PHE unwinding will have a disproportionate impact on consumers who have less access to employer-sponsored plans, housing instability, and lack of accessibility to information. She said state insurance departments should standardize their messaging and take the following actions: 1) update websites and consumer-facing resources; 2) link to Medicaid, health marketplaces, navigators, and AIDS drug assistance programs; 3) prepare for an increase in consumer calls seeking assistance; and 4) educate consumers on steps they can take to avoid disruptions in care. Durac said state insurance regulators should also coordinate community engagement with Medicaid and leverage trusted messengers.

Durac said state insurance regulators can also prepare by: 1) considering automatic enrollment into qualified health plans (QHPs); 2) strategizing with Medicaid on the order in which redeterminations occur; 3) monitoring marketing to prevent adverse selection, unlicensed brokers, and misleading information; 4) enforcing nondiscrimination protections; and 5) reviewing network adequacy and plan capacity for an influx of new enrollees.

Durac said state insurance regulators can act through state continuity of care laws by issuing bulletins reminding issuers of their obligations under state continuity of care laws, using existing authority to expand health conditions protected and plans covered, issuing guidance encouraging plans to honor past prior authorization, and allowing consumers to access drugs already approved through an exceptions process. Duroc said long-term solutions beyond the unwinding of the PHE include automatic enrollment/renewal, community engagement, and uniform messaging and outreach.

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

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