Draft Pending Adoption

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NAIC/Consumer Liaison Committee
Phoenix, Arizona
March 15, 2024

The NAIC/Consumer Liaison Committee met in Phoenix, AZ, March 15, 2024. The following Liaison Committee members participated: Grace Arnold, Chair (MN); D.J. Bettencourt, Vice Chair (NH); Mark Fowler (AL); Lori K. Wing-Heier represented by Heather Carpenter (AK); Alan McClain (AR); Ricardo Lara represented by Lucy Jabourian (CA); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods represented by Michael Ross (DC); Trinidad Navarro (DE); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt (KS); Kathleen A. Birrane (MD); Anita G. Fox represented by Renee Campbell (MI); Mike Chaney represented by Ryan Blakeney (MS); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Martin Swanson (NE); Justin Zimmerman (NJ); Scott Kipper represented by David Cassetty (NV); Andrew R. Stolfi (OR); Michael Humphreys represented by David Buono (PA); Jon Pike (UT); Scott A. White represented by Zuhairah Tillinghast (VA); Mike Kreidler represented by Todd Dixon (WA); and Nathan Houdek represented by Sarah Smith (WI). Also participating was Gary D. Anderson (MA).

1. Adopted its 2023 Fall National Meeting Minutes

Commissioner Stolfi made a motion, seconded by Commissioner Kipper, to adopt the Liaison Committee's Nov. 30, 2023, minutes (*see NAIC Proceedings – Fall 2023NAIC/Consumer Liaison Committee*). The motion passed unanimously.

2. Received a Report on the Consumer Participation Board of Trustees

Commissioner Arnold said the Consumer Participation Board of Trustees, which consists of six regulator members and six consumer representative members, met earlier today in closed session. This is because it administers the NAIC Consumer Participation Program, which may require discussions of a confidential nature concerning personal information. The Board discussed its budget, suggested changes to the plan of operation and application, and automation of the application this year.

3. Heard a Presentation from the CFA on its Report on Uninsured American Homes

Michael DeLong (Consumer Federation of America—CFA) said that CFA's report, *Exposed: A Report on $1.6 Trillion of Uninsured American Homes,* is a statistical analysis of data from the 2021 American Housing Survey and American Community Survey that he, Sharon Cornelissen, Ph.D., and Douglas Heller published. He said the analysis of the data began with research questions asking how many households lacked homeowners' insurance; the type of household, the market value of the homes, and locations are more likely to lack homeowners' insurance; and what portion of uninsured homes belong to Black and Hispanic homeowners. The results showed 6.1 million homeowners or one in 13 (7.4%) representing $1.6 trillion in property value that is not covered by insurance. It also showed homeowners of color, rural homeowners, and homeowners in metropolitan Miami, FL, and Houston, TX, are disproportionately without insurance. DeLong said lower-valued homes are the most likely to not have insurance, with 19% of homes under $150,000 not being insured compared to 4% to 5% of homes over $150,000 not being insured. Homes built before 2000 are more likely to be uninsured than homes built after 2000. Owners of manufactured homes are the most likely not to have homeowners' insurance. Most uninsured homes have no mortgage. Homeowners with lower incomes are more likely to be uninsured. Additionally, homeowners who are people of color, along with older adults who are not white, are more prone to not having homeowners' insurance. This tendency is evident in the national averages: 7.4% of homeowners lack homeowners' insurance, with rates

for different racial groups varying—6% for white homeowners, 10.6% for Black homeowners, 13.6% for Hispanic homeowners, and 22.3% for Native American homeowners.
DeLong said homeowners' insurance is vital for protecting consumers' homes and ensuring they can recover from disasters. He said rising premiums due to climate change and reinsurance costs could force many homeowners to "go bare" and do without homeowners insurance coverage. He said the average annual insured catastrophe losses have increased 300% in the last 25 years. The U.S. property/catastrophe (P/C) reinsurance rate-on-line has increased 100% in the last 10 years. Homeowners' insurance premiums have increased 50% in the last five years. DeLong said he appreciated the NAIC data call that was spurred on by the Federal Insurance Office (FIO) and the Incorporating National Support for Unprecedented Risks and Emergencies (INSURE) Act being proposed by Rep. Adam Schiff (D-CA). He recommended that states: 1) collect more data to track preexisting and emerging inequalities in homeowners' insurance markets and promote data transparency; 2) invest in risk reduction through mitigation measures; 3) create a public reinsurance mechanism to reduce insurers' overreliance on unregulated reinsurance; and 4) conduct additional research on racial equity and the homeownership insurance gap.

Commissioner Lara asked if the data call was missing any information. Delong said it looks comprehensive and suggested it be collected regularly, constantly, and translated into action items quickly. Commissioner Lara said climate has had an effect on the Latino/Hispanic community and that he has a working group looking into homeowners getting pushed out of the urban core because they cannot find coverage in areas that burn. Carpenter asked that American Indians and Alaska Natives be included in the next report. Commissioner Stolfi asked if the research looked into why homeowners did not have insurance or was it based solely on cost. He also asked if the research looked at higher risk areas. DeLong said this was outside the scope of the report but that areas like Florida did show that to some degree.

4. Heard a Presentation from the AEPI on How Insurers Exploit State Consumer Protection Acts to Harm Consumers

Erica Eversman (Automotive Education and Policy Institute—AEPI) said P/C insurers are using consumer protection laws to encourage providers to not pay claims. Eversman said these laws are based on consumer issues like the individual consumer use of services rather than commercial use. The laws only apply to service providers such as roofers, dealerships, carpet layers, and auto repair shops. However, Eversman said insurers are using these laws to sue these providers. Consumer protection laws require consumers to sign repair service contracts to prevent service providers from forcing expensive repairs on to consumers. The laws set out all consent, signatures, and authorizations for those entitled to recover minimum standard expenses.

Penalties for noncompliance can include actual damages incurred or minimum dollar recovery of $200, double or treble actual damages, payment of the consumer's attorney fees, and precluding the seller/service provider from obtaining payment for goods/services performed but not authorized. The attorney's fees provide incentive for lawyers to take unprofitable cases. Eversman said the crucial issue is the express payments of legal fees. Consumer protection laws were supposed to give this power to the consumer. However, insurers go through this paperwork to find errors or any technical violation of the consumer protection law to avoid paying claims, recover payment made, and seek attorney fees in litigation. In a current court case, one insurer is suing one provider to recover or avoid payment on 1,700 claims where there is not one consumer complaint. This is business-to-business litigation. It is not for the consumer. It is insurer vs. provider lawsuits over technical issues. Eversman said the use of consumer protection laws by insurers to sue providers destroys the very purpose of the law. By doing so, service providers will no longer serve consumers' interests due to fear of lawsuits from insurers that create a service class obeying only insurance companies.

Eversman recommended that state insurance regulators issue a bulletin or statement that insurers cannot use consumer protection law claims or legal avenues, even in subrogation. She recommended that legislators be notified that insurers are not considered eligible to use consumer protection law and to codify this position. She

further recommended that insurers be required to notify the insurance department of any currently pending or considered litigation involving a consumer protection law to determine if consumer interests are at risk.

Buono asked what insurers are doing. Eversman said one example is that an auto body shop neglected to put the date that the car came into the shop on the document, which is a technical issue. The insurance company said it does not have to pay the claim due to that technical issue. Commissioner Arnold asked how often this is happening. Eversman said it is becoming more and more prevalent, with many insurance companies jumping on the bandwagon. She said if the consumer is satisfied, the insurance company should not penalize the repair shop for technical issues.

5. Heard a Presentation from UP on Providing Consumers with Updated Tips on Buying Property Insurance

Amy Bach, (United Policyholders—UP), said her standard tips to consumers buying homeowners insurance have always been to: 1) comparison shop based on coverage, not just price; 2) use the shopping tools the state offers; 3) request a list of all discounts the insurer offers and ask for those applicable; 4) bundle your home, auto, and/or umbrella policies with one insurance company; 5) insure one's dwelling for replacement cost value; 6) increase the deductible, and avoid filing small claims; and 7) if feasible, buy gap filler products (including peril-specific policies for flood and earthquake damage). Bach said her updated tips for guiding consumers through current home insurance affordability and availability challenges are to: 1) start shopping right away; 2) get help from a professional agent or broker; 3) reduce risk/mitigate; 4) understand the deductible options; 5) find out one's risk score and correct any errors; 6) consider all types of insurer options; 7) supplement as feasible; and 8) trim coverage.

Bach said a consumer should start shopping immediately upon receiving a non-renewal notice because the average non-renewal notice is 30 days if the consumer is not offered another policy. She recommends states change the notice to 60 days. Seeking out an experienced, proactive insurance agent or broker will help with timing. However, if an agent or broker tells a consumer their only option is the residual market or FAIR plan, then find a second agent. Bach said consumers should seek out programs in the community that offer mitigation help and/or grants. They should also do as much mitigation as possible to reduce the risk of a severe weather event damaging or destroying their home. Additionally, consumers should provide the insurer with documentation of completed mitigation steps and/or the community's risk reduction activities. Bach advised to cautiously look into raising the deductible by getting quotes for different deductible levels in order to make an informed decision and to understand how a policy with a wind and/or roof deductible affects available benefits. She said a higher deductible reduces premium. However, too high of a deductible means insurance will not cover even a moderate-sized claim.

Bach said consumers should ask their carrier for their risk score and appeal it if it is based on inaccurate information. The carrier has to tell the consumers and can help them correct any errors. Bach said to consider all types of coverage, even surplus lines, which is riskier, but desperate times call for desperate measures. If a last resort insurance plan is the only option available, consider adding supplemental policies to fill any gaps (fire, wind, water, earthquake, flood, etc.). Trim coverage by reducing or eliminating any coverage consumers can live without, such as high dollar limits on contents and other structures. Bach said not to trim Coverage A, though. She recommended regulators: 1) increase grant funding for mitigation; 2) work on advanced programs with the Insurance Institute for Business & Home Safety (IBHS); 3) require rating plans to include mitigation; 4) encourage multiple layers of deductibles; 5) step up the appeals process and regulation on surplus lines; and 6) create a FIO plan.

Commissioner Lara said federal dollars need to be released now outside of legislation to help with mitigation to bring down the risk in uninsured areas; help low-income and retired persons; or build up to current building codes. Additionally, he said a national strategy is needed to request release of funding now. Commissioner Stolfi said he

loved the new ideas, especially publicizing discounts and incentives that are and are not included, such as metal roofs as companies that say there is no discount for it even though one is allowed. Commissioner Arnold said places where programs touch homes (such as insulation in homes) need to be emphasized.

6. Heard a Presentation from NHeLP, the HIV+Hepatitis Policy Institute, Whitman-Walker Institute, and NWLC on What the New Section 1557 Means for Health Insurance Nondiscrimination Protections and Considerations for Regulators

Wayne Turner (National Health Law Program—NHeLP) said state insurance regulators need to be prepared to implement the nondiscrimination protections under the new Section 1557, which will be released by the U.S. Department of Health and Human Services (HHS) soon as it is self-implementing. Turner said the federal Affordable Care Act (ACA) addressed many nondiscrimination and civil rights issues. However, Section 1557 is the key. Changes in the 2020 Final Rule: 1) narrowed applicability by exempting a broad array of federal health care programs and activities; 2) declared an entity "principally engaged in providing health insurance shall not be considered to be principally engage in providing health care"; 3) removed provisions against discriminatory health plan benefit design; 4) eliminated regulatory protections against sex determination that included gender identity, sexual orientation, sex stereotyping, and pregnancy status; 5) sanctioned discrimination by religiously affiliated hospitals, providers, and health plans; and 6) limited enforcement for restricting the ability to file court actions. Turner said the new 2022 proposed rule clarifies that Section 1557: 1) applies to all federal programs and activities (not just the ACA); 2) provides or administers health insurance as a health program/activity; 3) applies to short-term, limited-duration plans (STLD) and limited benefit plans; and 4) applies to third-party administrators (TPAs) and pharmacy benefit managers (PBMs). Turner said the new rule builds on a presumptive discriminatory benefit design of cost sharing, medical necessity definitions, narrow networks, drug formularies, adverse tiering, exclusions, visit limits, waiting periods, service areas, utilization management, and coercive wellness programs.

Carl Schmid (HIV+Hepatitis Policy Institute) said the 2022 proposed changes in prescription drug access: 1) includes PBMs and prescription drug formularies; 2) places all or almost all drugs to treat a condition on the highest tier; 3) includes step therapy, prior authorization, and durational and quantity limits; and 4) acknowledges utilization management as a standard industry practice applied in a neutral, nondiscriminatory manner. Schmid said there was a need for enforcement of prescription drugs so state insurance regulators, the federal Centers for Medicare & Medicaid Services (CMS), and the Office of Civil Rights (OCR) must ensure compliance with Section 1557 and essential health benefits (EHBs) through plan reviews, the approval process, and complaint handling. He said that North Carolina Blue Cross Blue Shield had placed almost all HIV prescription drugs, including generics, on the highest tiers, and all had quantity limits. A complaint was filed and a review by the OCR after plan correction indicated the issuer reasoned that the plan was based on clinical practices. No action has been taken by state insurance regulators. Community Health Choice of Texas places drugs on the highest tier and does not meet treatment guideline because it excludes many antiretrovirals, breaks up single tablet regimens, and covers old, discontinued drugs. A complaint filed with CMS yielded inadequate response and actions.

Kellan Baker (Whitman-Walker Institute) said the 2016 rule included gender identity, sex stereotypes, and pregnancy under the definition of sex and gave specific examples of nondiscrimination in coverage and care. Baker said the 2020 rule eliminated regulatory protections for these and sexual orientation from various CMS rules. Based on the 2020 Supreme Court decision in *Bostock v. Clayton County*, the new rule: 1) re-establishes protections on the basis of sex stereotypes; 2) clarifies that sex-base distinctions are allowed, but only if they cause de minimis harm to beneficiaries or patients; 3) clarifies that religious/conscience exemptions will be considered on a case-by-case basis by OCR under existing federal laws; and 4) does not require providers to perform services outside of their scope of practice or area of specialty.

Dorianne Mason (National Women's Law Center—NWLC) said the new rule would remedy the 2020 rule by reinstating women's reproductive rights, including pregnancy or related conditions such as abortion. Mason said

when Indian Health Services (IHS) denied abortion information to patients, such denials included inequitable outcomes affecting patients' future help. Turner said proposals for health care refusals should be: 1) that there are no blanket exemptions from Section 1557 for religious or other covered entities; 2) that procedures for submitting requests for exemptions to the OCR should be established on a fact-sensitive, case-by-case basis; and 3) that should rescind 45 C.F.R. Section 92.6 (b), where the final rule incorporated the Danforth Amendment, Title IX's exemption for abortion-related services.

Turner recommended that state insurance regulators: 1) ensure that insurers are aware of the new protections by releasing bulletins and guidance; 2) review plans for discriminatory benefit design as part of the certification process; 3) revise the state's EHBs benchmark to eliminate exemptions that contravene Section 1557; 4) monitor and enforce compliance through the complaint process, data calls, and market conduct exams; and 5) make such data and reports public. Turner said practical tips for benefit design review include: 1) prior authorization criteria that is not clinically-based; 2) overuse of co-insurance for certain medical conditions; 3) narrow provider networks that prevent access to specialists; 4) visit limitations that cap coverage without regard for medical necessity; 5) racial bias underlying prescribing practices and automated decision-making; and 6) coverage exclusions that disproportionately affect certain populations with regard to gender-affirming care and durable medical equipment.

Commissioner Lara asked how states can further protect consumers with individual states doing artificial intelligence (AI) and big data regulations. Turner said states could require access to the insurers' black box for more information and that advance testing is important.

7. Heard a Presentation from Consumers' Checkbook/CSS, a Health Care Consumer Advocate, and the LLS on CMS Interoperability, the Prior Authorization Rule, and Federal Updates

Eric Ellsworth (Consumers' Checkbook/Center for the Study of Services—CSS) said prior authorization has the fundamental problems of having a burdensome provider submission process and an unclear or inappropriate review criteria, which delays treatment and harms consumers. Ellsworth said questionable denials occur when generally accepted criteria are not used, when proprietary criteria lacks appropriate transparency, and when reviewers are not clinically qualified. Such denials increase provider expenses, translating into higher costs. The level of difficulty in appealing denials also harms consumers, especially those in underrepresented and underserved communities.

Ellsworth said CMS' Interoperability & Prior Authorization Rule process requires: 1) electronic data exchange tools by 2027; 2) tools to convey if prior authorization is required, its requirements, status, and reasons if denied by 2027; 3) initial prior authorization decisions: expedited in 72 hours and others in seven calendar days, with qualified health plans (QHPs) being the exception at 15 days by 2026; 4) that denials must be reviewed by qualified clinicians; 5) that payers must post annual prior authorization statistics by 2026; and 6) a financial incentive for providers to use the tools by 2027.

The rule's criteria has requirements only for Medicare Advantage plans that are consistent with Medicare statutes and follow local and national coverage determinations, with some improvements in transparency by specifying the information needed for specific prior authorization decisions and the reasons for the denial. Ellsworth cited several shortcomings of the rule: 1) it excludes prescription drug prior authorization, even those covered under medical benefits; 2) the review process allows for proprietary criteria with no transparency, no decision timeline mandates for Federally-facilitated Exchange (FFE) QHPs, and no mention of "gold carding"; 3) the criteria is inconsistent across plans, which is confusing to providers and patients; 4) state-based QHPs, insured commercial plans, and federal Employee Retirement Income Security Act of 1974 (ERISA) plans are excluded; 5) the annual reporting of prior authorization statistics is too aggregated; and 6) compliance is not well defined as to state vs. federal enforcement.

Harry Ting (Health Care Consumer Advocate) recommended that states: 1) make state and CMS regulations as consistent as possible regarding prior authorization decision timelines, transparency rules, reviewer qualifications, and data reporting; 2) collect data to identify outlier plans by comparing prior authorization turnaround times and approval rates by category, as well as reversal rates of adverse determinations; and 3) establish the states' role in enforcing compliance with CMS rules. Dr. Ting said other steps might be to: 1) adopt elements of the CMS rule, such as public reporting of statistics, process transparency, clinically recognized standards, and decision timelines; 2) include prescription drugs using National Council for Prescription Drug Programs (NCPDP); and 3) add gold carding to providers with high approval rates. Dr. Ting said the steps the NAIC can take are to: 1) maintain an inventory of state prior authorization regulations; 2) have the National Insurance Producer Registry (NIPR) compare outcomes under different state regulations; and 3) collaborate to promote consistency of requirements across states.

Lucy Culp (The Leukemia and Lymphoma Society—LLS), filling in for Caitlin Westerson, (United States of Care—USofCare) said other federal updates include the Association Health Plan (AHP) proposed rule, which would rescind the 2018 rule and return to pre-2018 guidance that included a more comprehensive review process. This rule is on the regulatory agenda for April and is subject to change. Culp said the short-term, limited-duration insurance (STLDI) proposed rule is currently at the Office of Management and Budget (OMB) and on the agenda for April as well. It would limit these plans to three months and only allow them to be renewed for one month beyond that. It also has implications for the ongoing deliberations on the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standard Model Act* (#171). Culp said the Notice of Benefit and Payment Parameters (NBPP) proposed rule is also at the OMB and on the agenda for April. Culp said this annual rule would allow states to add required benefits without triggering EHB cost defrayal and removed the prohibition on including adult dental benefits as EHB. Culp said the *Braidwood Management v. Becerra* (Preventive Services) case is in the Fifth Circuit, which could affirm or reverse the lower ruling that the ACA's no-cost preventive mandate was unconstitutional later this year. However, the losing party is expected to appeal any decision to the Supreme Court for consideration.
8.

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

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