

Draft Pending Adoption

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NAIC/Consumer Liaison Committee
Louisville, Kentucky
March 21, 2023

The NAIC/Consumer Liaison Committee met in Louisville, KY, March 21, 2023. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); Lori K. Wing-Heier represented by Sharon Comstock (AK); Mark Fowler (AL); Alan McClain (AR); Andrew N. Mais represented by Kurt Swan (CT); Michael Conway (CO); Trinidad Navarro (DE); Michael Yaworsky (FL); Doug Ommen represented by Sonya Sellmeyer (IA); Dean L. Cameron represented by Shannon Hohl (ID); Vicki Schmidt (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 Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by David Bettencourt (NH); Scott Kipper represented by Dave Cassetty (NV); Adrienne A. Harris represented by John Finston (NY); Judith L. French represented by Jana Jarrett (OH); Michael Humphreys (PA); Jon Pike represented by Shelley Wiseman (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); and Allan L. McVey (WV).

1. Adopted its 2022 Fall National Meeting Minutes

Commissioner Arnold made a motion, seconded by Beatty, to adopt the Committee's Dec. 12, 2022, minutes (see *NAIC Proceedings – Fall 2022, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

2. Heard Opening Remarks

Commissioner Stolfi said the NAIC Consumer Participation Board of Trustees met March 21 to discuss Michael Delong's (Consumer Federation of America—CFA) request that the NAIC review the use of telematics in auto insurance. The Property and Casualty Insurance (C) Committee is reviewing this request under its existing charges. The Board reviewed the 2023 budget for the Consumer Participation Program and discussed potential changes to the Consumer Representative applications for 2024.

3. Heard a Presentation from RIPIN, ACS CAN, and CHIR on Barriers to Enrollment

Shamus Durac (Rhode Island Parent Information Network—RIPIN) said Medicaid eligibility is determined at the time of application, during regulator redeterminations, and when a Medicaid agency receives new eligibility information. At the beginning of the COVID-19 public health emergency (PHE), redeterminations were paused, and Medicaid terminations were prohibited. Durac said these protections end on March 31, 2023, and states have 12 months to initiate Redeterminations for all current Medicaid enrollees.

Durac said redeterminations are expected to result in as many as 15 million Americans losing Medicaid coverage. Medicaid renewals can take place *ex parte* when Medicaid can verify income and all other eligibility information. If Medicaid does not have all necessary information, consumers must go through the full renewal process, which requires consumers to provide information and documentation to demonstrate continuing eligibility for Medicaid.

Anna Schwamlein Howard (American Cancer Society Cancer Action Network—ACS CAN) said state insurance regulators should work with their Medicaid counterparts to coordinate the notices Medicaid will be sending to consumers. Schwamlein Howard encouraged state insurance regulators to reach out to health plans so they are prepared for an influx of enrollees and remind health insurers of the requirement to comply with network adequacy requirements. Schwamlein Howard said state insurance regulators should reach out to consumers to

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explain changes to Medicaid provisions, provide consumer notices in multiple languages, and be vigilantly watching for fraudulent activity, which may occur during the Medicaid unwinding. For states with state-based exchanges, Schwamlein Howard said states can extend open enrollment past 60 days.

Maanasa Kona (Georgetown University Center on Health Insurance Reforms—CHIR) said federal continuity of care protections apply to patients with serious conditions, including consumers undergoing treatment, such as those who are pregnant or terminally ill. Kona said the protections are available for up to 90 days for the duration of the patient’s treatment and that 29 states offer similar protections to enrollees who lose access to an in-network provider. These protections are limited since they are triggered when a provider leaves a network. Only 13 jurisdictions extend their continuity of care protections when consumers transition from Medicaid to a new plan. At the same time, the protections vary by state. Kona said that state insurance regulators should extend continuity of care protections to consumers transitioning to new plans, require pro-rating of deductibles and out-of-pocket maximums, and require insurance companies to honor prior authorizations for care.

Bettencourt asked how to engage with provider groups to encourage enrollment in Medicaid. Kona said state insurance regulators are encouraged to reach out to providers to ensure they have the necessary information to communicate with consumers.

3. Heard a Presentation from the HCFA, LLS, Consumers’ Checkbook, and the HIV+Hepatitis Policy Institute on “Obstacles to Medically Necessary Care – Part 1: Delays and Red Tape Due to Prior Authorization”

Carl Schmid (HIV+Hepatitis Policy Institute) referenced multiple situations in which consumers had problems accessing necessary prescription drugs due to a lack of authorization by health insurers. Schmid said 17%, or 48 million consumers, experience denied prescription coverages, and very few consumers appeal a denial. Schmid said African Americans and Hispanic Americans were much more affected by the privatization of step therapy. Schmid said prescription drugs that prevent HIV should not require preauthorization by an insurer and that some companies’ preauthorization requirements for long-term HIV treatment are very difficult to meet.

Lucy Culp (Leukemia & Lymphoma Society—LLS) said her organization has seen blood cancer patients struggling with accessing medically necessary care prescribed by their providers. Culp said LLS partnered with Manatt to identify barriers to care and solutions.

Eric Ellsworth (Consumers’ Checkbook/Center for the Study of Services—Consumers’ Checkbook) said the claims adjudication system, with most claims being adjudicated automatically, contributes to the access to care problem. Ellsworth said the medical necessity rules and coding rules are all different between insurance carriers, and it is almost impossible for a health provider or patient to determine what the rules and codes mean. This leads to confusion on why claims and charges are denied. In addition to code-based claims, the utilization management system is unclear and disjointed. Ellsworth said the appeals rate is very low because consumers are not aware of their options for appeal.

Ellsworth said state insurance regulators should work to standardize the different rules and codes across all insurers. Ellsworth said the federal Centers for Medicare & Medicaid Services (CMS) has a rule on interoperability in prior authorization, which addresses patient access, provider access to claims for patients, payer-to-payer guidance, prior authorization rules, and reporting requirements regarding prior authorizations. Ellsworth said the proposed effective date is Jan. 1, 2026, and does not supersede more stringent state laws.

Ashley Blackburn (Health Care for All—HCFA) talked about a proposal in Massachusetts, which is facing an extreme workforce shortage. Blackburn said there is a prior authorization work group that has been developing standardized pre-authorization forms. The current proposal is focused on improving access to and continuity to care by prohibiting prior authorization for generic medications and medications and treatment with low denial

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rates, low variation in utilization, or an evidence base to treat chronic illness. The second goal of the Massachusetts bill is to promote transparency and fairness by requiring public data from insurers related to approvals, denials, appeals, and wait times. The third goal of the Massachusetts bill is to improve timely access to care and administrative efficiency, which requires a 24-hour response time for urgent care.

Culp outlined the following recommendations for state insurance regulators: 1) monitor implementation and compliance with the federal interoperability rule; 2) utilize existing authority to monitor carrier conduct; 3) support efforts to improve access and continuity of care; 4) increase public transparency around utilization management; 5) require the use of standard forms and electronic processing; and 6) require standardization in documentation and publication of medical necessity criteria.

4. Heard a Presentation from the NWLC and the NHeLP on “Obstacles to Medically Necessary Care – Refusal of Care and Network Adequacy”

Dorianne Mason (National Women’s Law Center—NWLC) said health care refusals are when consumers are denied medically necessary care. Wayne Turner (National Health Law Program—NHeLP) said individual providers may deny care due to personal or religious objections, and religiously affiliated health care systems may deny care as a matter of policy. Turner said providers may also fail to inform patients of the full array of services and treatment options.

Mason said standards of care are made up of a patchwork of state and federal laws, and through this patchwork, a consumer’s care may be driven by a hospital or individual health care provider’s beliefs rather than what is best for the patient’s health. Mason said refusals of care force patients to delay or forgo necessary care. This is particularly true and dangerous for patients who have limited options for care. Mason said the refusals of care cause the most harm to people of color, people with limited financial resources, young people, LGBTQ individuals, and people seeking gender-affirming care.

Turner said the Center for American Progress (CAP) said 15% of transgender individuals were refused gender-affirming care, and 20% of transgender people of color reported that a provider refused to see them due to the provider’s religious beliefs or the state religious tenets of the healthcare facility. Turner said people who are turned away from care suffer pain and humiliation. Turner said some of the refusals of care violate federal non-discrimination laws. Turner said end-of-life care directives may not be followed due to ethical and religious directives of religiously affiliated healthcare systems. Turner said religiously affiliated providers also dominate some healthcare markets.

Mason said the expansion of Catholic health care has had a disproportionate effect on the sexual and reproductive health care available to women of color, especially with regard to miscarriage management.

Mason and Turner provided the following recommendations for state insurance regulators: 1) prioritize patient access in federal and state rulemaking; 2) conduct state assessments on access to service to identify coverage gaps; 3) include healthcare refusal as part of network adequacy reviews; 4) require transparency for exclusions from coverage; and 5) consider refusals when reviewing health plan/provider mergers and acquisitions.

5. Heard a Presentation Calling Attention to the Dilemma of Current Assumption Policy Illustrations

Richard Weber (Life Insurance Consumer Advocacy Center—LICAC) said current policy illustrations cannot reflect the long-term likelihood of a policy sustaining its ultimate use as a needed death benefit. Weber said the NAIC *Life Insurance Illustrations Model Regulation* (#582) has a stated purpose to protect consumers and foster consumer education. The goal of Model #582 is to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable.

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Weber said the total death benefits in the U.S. is \$21 trillion, with \$14 trillion being term/group life insurance policies. Weber said all universal life insurance policies are designed to combine term life insurance and cash value. Over time, the cash value replaces the term life insurance element, which makes the policy affordable over time. Weber said the cash accumulation will fluctuate over time, and this is not apparent through the use of a current policy illustration. Weber said policy illustrations are not projections. Weber said the main difference in universal life insurance policies is how universal life credits its cash value. Weber said the original universal life insurance policy was a cash accumulation policy with a minimum guaranteed crediting rate (general account). Weber said the variable universal life insurance policy is a cash accumulation policy in a brokerage account with market-driven ups and downs (security). Weber said there is also an indexed universal life insurance policy where cash accumulation is based on an external index.

Weber provided some simple graphic views of variable universal life policies and said an illustration showing a \$5,900 annual premium with an illustrated rate of return of 10% had only an 8% probability of success of actually covering a policyholder until age 100. Weber said consumers should buy policies based on the probability of success rather than the lowest premium. Weber said a policy with a constant illustrated rate of return of 4.4% would need an annual premium of \$16,500 to reach a 99% probability of success.

Weber suggested insurance companies and agents should discuss the probability of success based on annual premiums and the implied constant illustration rate. Weber said this would provide consumers with a better understanding of what they are purchasing. Weber recommended the NAIC reopen Model #582 to address indexed universal life products, no-lapse guarantees, and variable universal life insurance products.

6. Heard a Presentation from the CEJ on “Dark Patterns in Digital Communications: Addressing the Perils of Moving from Paper to Digital Consumer Interactions”

Birny Birnbaum (Center for Economic Justice—CEJ) said dark patterns are user interface techniques that benefit an online service by leading consumers into making decisions they might not otherwise make. Some dark patterns deceive consumers, while others exploit cognitive biases or shortcuts to manipulate or coerce them into choices that are not in their best interests. Birnbaum said dark patterns are a specific type of choice architecture in website and app design that interfere with user autonomy and choice. Dark patterns modify the presentation of choices available to users or manipulate the flow of information so that users make selections that they would not otherwise have chosen—to their own detriment and to the benefit of the website or app provider. Dark patterns include imposing asymmetric burdens to achieve competing choices, restricting the choices available at the same time (or at all), and hiding information or presenting information deceptively.

From Jamie Liguri published in “Shining a Light on Dark Patterns,” Birnbaum listed the following types of dark patterns:

- Nagging: Repeated requests to do something the firm prefers.
- Confirm shaming: Choice framed in a way that makes it seem dishonorable or stupid.
- Forced Action: Requiring opt-out of optional services, manipulative extraction of personal information and information about other users.
- Social Proof: False/misleading notices that others are purchasing or offering testimonials.
- Roach Motel: Asymmetry between signing up and canceling.
- Price Comparison Prevention: Difficulty in understanding and comparing prices.
- Hidden Information/Aesthetic Manipulation: Important information visually obscured.

From the European Consumer Organization’s (BEUC’s) “Fast Track to Surveillance,” Birnbaum quoted the following: “During this signup process, which involves consumers taking important decisions about how Google will process their personal data, the tech giant uses a combination of deceptive design, unclear language,

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misleading choices, and missing information. With only one step ('express personalization'), the consumer activates all the account settings that feed Google's surveillance activities. Google does not provide consumers with the option to turn all settings 'off' in one step. If consumers want to try to protect their privacy, it requires 'manual personalization': five steps with ten clicks and grappling with information that is unclear, incomplete, and misleading. Consider the consent for use of cookies on most websites. In almost every case, one click is required to accept all cookies. If you want to avoid sharing your personal information, it requires many clicks."

Birnbaum provided some examples of state regulation of dark patterns in California, Connecticut, Colorado, the Federal Trade Commission (FTC), and the Consumer Financial Protection Bureau (CFPB). Birnbaum said it is critical for state insurance regulators to understand and address dark patterns. Insurance regulatory disclosures are based on and designed for paper, not digital interfaces. Paper disclosures are static. Digital disclosures are dynamic and change based on the consumer, the method of consumer interaction, and the choices of the consumer during the process. There has been a massive and rapid increase in digital interactions in place of paper or face-to-face interactions between consumers and insurers.

Birnbaum provided the following recommendations for the Market Regulation and Consumer Affairs (D) Committee:

- Train analysts and examiners to recognize dark patterns and manipulative digital design.
- Compile resources on manipulative digital design.
- Review existing disclosure requirements. Do they make sense for a digital interface and protect against dark patterns?
- Update guidance in regulations as needed—not just revisions in disclosures and disclosure requirements but articulating dark patterns as an unfair and deceptive trade practice.
- Develop relevant methods of regulatory review and update the *Market Regulation Handbook*.

In response to Commissioner Stolfi's question of when a website design becomes a dark pattern, Birnbaum said a website design becomes a dark pattern when the website obscures a choice for a consumer. For example, Birnbaum said a person can purchase travel insurance with one click but cannot revoke a purchase with one click. This is an example of an asymmetric approach.

7. Heard a Presentation from the AEPI on "Aftermarket Parts: Imitation Often is Not Equal"

Erica Eversman (Automotive Education & Policy Institute—AEPI) said an aftermarket part is any part that is not factory-installed. An imitation or generic part is any part that was made for use in the repair of a vehicle that is not sanctioned or authorized by the automobile manufacturer. Eversman said the NAIC's *After Market Parts Model Regulation* (#891) applies to only external sheet metal and plastic parts. Eversman said the evolution of arguments in favor of the use of imitation parts include the following: 1) the parts are purely cosmetic; 2) the parts are identical to the automaker parts; and 3) the parts are made by the same manufacturer as the automaker parts. Because of these arguments, Ford Motor Company successfully sued parts makers and distributors for design patent infringement.

Eversman said the claims that aftermarket parts and imitation parts are of the same likeness, kind, and quality as factory-installed parts are not accurate. Eversman said aftermarket parts and imitation parts are not made of the same steel type, weight, and specifications. Eversman said automakers routinely void and restrict auto warranties for any portion of a vehicle on which an insurance claim is paid. In addition, Eversman said an automobile conditions report will note the use of imitation parts if a vehicle repair has been made, which reduces the value of the vehicle.

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Eversman said the Certified Automotive Parts Association (CAPA) was funded by the insurance industry. However, Eversman said CAPA routinely decertifies parts. At the same time, Eversman said there is no entity responsible for providing consumer notifications about decertification, and the National Highway Traffic Safety Administration (NHTSA) does not have the authority to recall parts.

Eversman provided the following recommendations:

- Establish a charge under the Property and Casualty Insurance (C) Committee to revisit what an aftermarket part is.
- Establish a concrete definition and criteria for determining proper use in insured/consumer repairs.
- Require auto insurers to establish and publish recall methodology for decertified or defective imitation parts.
- Establish a mechanism for insureds/consumers to obtain replacement parts and installation.
- Mandate payment for replacement parts and installation.

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

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