

Draft date: 11/21/23

*2023 Fall National Meeting  
Orlando, Florida*

### **NAIC/CONSUMER LIAISON COMMITTEE**

Thursday, November 30, 2023

12:00 – 2:00 p.m.

Bonnet Creek—Bonnet Creek IV-XII & Corridor I—Level 1

### **ROLL CALL**

Andrew R. Stolfi, Chair	Oregon	Anita G. Fox	Michigan
Grace Arnold, Vice Chair	Minnesota	Mike Chaney	Mississippi
Mark Fowler	Alabama	Chlora Lindley-Myers	Missouri
Lori K. Wing-Heier	Alaska	Francisco D. Cabrera	N. Mariana Islands
Peni Itula Sapini Teo	American Samoa	Eric Dunning	Nebraska
Alan McClain	Arkansas	Scott Kipper	Nevada
Ricardo Lara	California	D.J. Bettencourt	New Hampshire
Michael Conway	Colorado	Adrienne A. Harris	New York
Andrew N. Mais	Connecticut	Mike Causey	North Carolina
Trinidad Navarro	Delaware	Jon Godfread	North Dakota
Karima M. Woods	District of Columbia	Judith L. French	Ohio
Michael Yaworsky	Florida	Michael Humphreys	Pennsylvania
Gordon I. Ito	Hawaii	Alexander S. Adams Vega	Puerto Rico
Dean L. Cameron	Idaho	Cassie Brown	Texas
Dana Popish Severinghaus	Illinois	Jon Pike	Utah
Doug Ommen	Iowa	Scott A. White	Virginia
Vicki Schmidt	Kansas	Mike Kreidler	Washington
James J. Donelon	Louisiana	Allan L. McVey	West Virginia
Kathleen A. Birrane	Maryland	Nathan Houdek	Wisconsin

NAIC Support Staff: Lois E. Alexander

### **2023 NAIC Consumer Liaison Representatives**

David Arkush	Public Citizen's Climate Program	Janay Johnson	American Heart Association (AHA)
Amy Bach	United Policyholders (UP)	Karrol Kitt	The University of Texas at Austin
Kellan Baker	Whitman-Walker Institute	Kenneth S. Klein	California Western School of Law
Birny Birnbaum	Center for Economic Justice (CEJ)	Rachel K. Klein	The AIDS Institute



Ashley Blackburn	Health Care For All (HCFA)	Peter R. Kochenburger	Southern University Law School
Brendan M. Bridgeland	Center for Insurance Research (CIR)	Maanasa Kona	Georgetown University Center on Health Insurance Reforms (CHIR)
Bonnie Burns	Consultant to Consumer Groups		
Tasha Carter	Florida Office of the Insurance Consumer Advocate	Dorianne Mason	National Women’s Law Center (NWLC)
Symone N. Crawford	Massachusetts Affordable Housing Alliance (MAHA)	Colin Reusch Carl Schmid	Community Catalyst HIV+Hepatitis Policy Institute
Brenda J. Cude Lucy Culp	University of Georgia The Leukemia & Lymphoma Society (LLS)	Matthew J. Smith	Coalition Against Insurance Fraud (CAIF)
Deborah Darcy	American Kidney Fund (AKF)	Harold (Harry) M. Ting	Healthcare Consumer Advocate
Michael DeLong	Consumer Federation of America (CFA)	Wayne Turner	National Health Law Program (NHeLP)
Yosha P. Dotson	Georgians for a Healthy Future (GHF)	Richard Weber	Life Insurance Consumer Advocacy Center
Shamus Durac	Rhode Island Parent Information Network (RIPIN)	Caitlin Westerson Jackson Williams Silvia Yee	United States of Care Dialysis Patient Citizens Disability Rights Education and Defense Fund (DREDF)
Eric Ellsworth	Consumers’ Checkbook/Center for the Study of Services		
Erica L. Eversman	Automotive Education & Policy Institute (AEPI)		
Kelly Headrick Marguerite Herman Kara Hinkley	Autism Speaks Healthy Wyoming The Amyotrophic Lateral Sclerosis (ALS) Association		
Anna Schwamlein Howard	American Cancer Society (ACS) Cancer Action Network (CAN)		

**AGENDA**

1. Observe a Presentation of Consumer Representatives’ Excellence in Consumer Advocacy Award—*Bonnie Burns (Consultant to Consumer Groups) and Wayne Turner (NHeLP) —15 minutes*



2. Consider Adoption of its Summer National Meeting Minutes—  
*Commissioner Andrew R. Stolfi (OR)* Attachment One
3. Receive a Summary of the Consumer Board of Trustees Meeting—  
*Commissioner Andrew R. Stolfi (OR)*
4. Receive the E-Vote Results for the Reaffirmation of its 2023 Mission  
Statement for 2024—*Commissioner Andrew R. Stolfi (OR)* Attachment Two
5. Hear a Presentation on How Recent and Upcoming Federal Actions  
Impact State Regulation of the Health Insurance Market—*Carl Schmid  
(HIV+Hepatitis Policy Institute), Wayne Turner (NHELP) and Lucy Culp  
(LLS)—15 minutes*
6. Hear a Presentation on the Drivers of Medical Debt, Current State  
Protections, and Recent Federal Actions—*Ashley Blackburn (HCFA),  
Janay Johnson (AHA), and Maanasa Kona (CHIR)—15 minutes*
7. Hear a Presentation on Ways to Continue Expanding Access to Maternal  
Health Care Through Health Plan Networks and Essential Health Benefits  
(EHBs)—*Dorianne Mason (NWLC)—15 minutes*
8. Hear a Presentation on Addressing Property Insurance Market Failures  
with a Federal Catastrophe Reinsurance Program—*Amy Bach, (UP) and  
Birny Birnbaum (CEJ)—25 minutes*
9. Hear a Presentation on the Rapid Growth of Pet Insurance, Consumer  
Issues, and Concerns—*Brendan M. Bridgeland (CIR)—15 minutes* Handout One
10. Hear a Presentation on How Much of the Life Insurance Purchased in the  
U.S. Winds Up as a Death Claim—*Richard Weber (LICAC)—20 minutes* Handout Two
11. Discuss Any Other Matters Brought Before the Committee—  
*Commissioner Andrew R. Stolfi (OR)*
12. Adjournment

## Draft Pending Adoption

Draft: 8/28/23

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

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

### 1. Adopted its Spring National Meeting Minutes

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

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

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

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

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

## Draft Pending Adoption

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

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

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

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

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

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

Commissioner Lara asked about testing for unfair discrimination based on sexual orientation. Birnbaum suggested a phase-in approach and starting testing for unfair racial discrimination since data on race is available. Insurers, at some point, should be willing to ask policyholders for protective class characteristics on a voluntary basis.

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

## Draft Pending Adoption

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

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

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

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

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

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

Eversman requested that the Property and Casualty Insurance (C) Committee establish a workstream to address the appraisal process for auto losses. Crow asked what the recommended maximum a consumer should pay for an appraisal is. Bach said the cost is a deterrent for consumers, and she suggested that insurers should advance the cost of the appraisal and then deduct half the cost of the appraisal from the final settlement. Eversman suggested a maximum cost of between \$500 to \$800 for auto claim appraisals. She said states should mandate appraisal clauses in policies, and either the insurer or insured should have the right to request an appraisal.

## Draft Pending Adoption

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

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

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

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

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

Commissioner Stolfi said Oregon passed a law that required three free primary care visits, and consumers could pick whether the three free visits would be for medical or mental health purposes. Due to established federal methodology requiring insurers to estimate which costs would be for medical care versus mental health care, Oregon had to amend the law to require a \$5 copay for these visits. Commissioner Stolfi said Oregon would be submitting comments about this since the implementation of a \$5 copay is not something Oregon wanted to impose on consumers.

## Draft Pending Adoption

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

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

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

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

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

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

Darcy said the Kaiser Family Foundation (KFF) released a survey on consumer experience with health insurance and whether consumers understand what services will and will not be covered. She said the KFF survey reflects that 17% of health claims were denied for ACA plans, and less than 1% of denied claims were appeals. She said the survey reflected that 16% of consumers said their insurance company delayed or denied needed care and prior authorizations; 27% of consumers said their health insurance paid less than what they expected; 18% of consumers said insurance did not cover any of the care they received; and 23% said their insurance did not cover a needed prescription. She said the survey reflected that 40% of adults surveyed did not know they have the right to appeal a claim denial, and 24% of the consumers surveyed did not know who to contact when they have a problem with their health insurance.



## Draft Pending Adoption

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

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

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

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

Draft: 10/13/23

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

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

## **2024 Reaffirmed Mission Statement**

### **NAIC/CONSUMER LIAISON COMMITTEE**

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2024 will be closely aligned with the priorities of the NAIC Consumer Participation Board of Trustees.

NAIC Support Staff: Lois E. Alexander

# Federal Health Policy Update

NAIC National Meeting – Fall 2023

Consumer Liaison

November 30, 2023

[Lucy Culp](#) - The Leukemia & Lymphoma Society

[Wayne Turner](#) - National Health Law Program

[Carl Schmid](#) - HIV + Hepatitis Policy Institute



National Association of Insurance Commissioners

# Roadmap

- Association Health Plans (NPRM preview)
- Notice of Benefit and Payment Parameters 2025
  - SBM Minimum Standards
  - Essential Health Benefits
  - Standardized Plans
  - Prescription Drugs
- Transparency In Coverage Rule
- Pharmacy Benefit Managers
- Other issues

# AHP Proposed Rule - Background

- 1983: The Erlenborn-Burton Amendment
  - Provided states the authority to regulate MEWAs
- Success of state enforcement
  - State cease & desist orders enable quick closing of unauthorized entities
  - Across same time period, states shut down 41 illegal AHP-selling operations while DOL shut down 3
- Continued issues of fraud & insolvency
  - Between 2000 and 2002, AHP scams affected > 200,000 policyholders
  - Over \$252 million in unpaid medical bills

# AHP Proposed Rule – Previous Regulation

- “Look Through” doctrine
  - Long-standing regulation reiterated by CMS in 2011
  - The size of each employer in the association determines whether that employer’s coverage is subject to the small group market or the large group market rules
- **Bona fide associations**
  - “Rare” exception to the “look through” doctrine
  - Combine employees of all employers to attain ACA status as a large group plan, exempt from EHBs and community rating
  - Three criteria of bona fide associations: (1) Employers share organizational purposes; (2) Employers have commonalities unrelated to the provision of benefits; and (3) Employers exercise control over the program

# AHP Proposed Rule – 2018 Rule & NY Lawsuit

- **Executive Order 13813 & “Pathway 2” AHPs**
  - DOL rule modified the definition of “employer” to allow more employer groups and associations to form AHPs
  - Easier pathway to bona fide association status to be regulated as large group coverage
  - Permitted sole proprietors to be treated as small employers and join an AHP
- **State of New York v. United States Department of Labor**
  - Court ruled the DOL exceeded its rulemaking authority under the ERISA
  - Appeal held in abeyance, Biden admin to engage in notice-and-comment rulemaking to revisit the rule

# **NBPP Proposed Rule – SBM Minimum Standards**

- New steps to the process of moving from the federal platform to a state-based marketplace (SBM)
- Centralized eligibility and enrollment platform
- National standards for web brokers and direct enrollment
- Standard open enrollment periods
- Network adequacy minimum standards



# NBPP Proposed Rule – Essential Health Benefits

- Remove regulatory provision prohibiting non-pediatric health services as EHB (§156.115(d))
  - Would allow states to add adult dental to EHB benchmark
  - Also remove prohibition on adult vision, home health, and orthodontia?
  - Gives states new flexibility to address unmet health needs and advance health equity
  - See [NHeLP Letter to CCIIO on Legal Authorities and Regulatory Changes for Essential Health Benefits](#)

# **NBPP Proposed Rule – EHB Benchmarking**

- Consolidates options for state benchmarks
- Removes generosity standard and revises typicality standard
- Clarifies applicability of EHB benchmark to Basic Health Plans and Medicaid Alternative Benefit Plans

# NBPP Proposed Rule-Standard Plans

- Continued Requirement
  - Allowed to have 2 non-standardized for each standard plan
  - Proposes an exceptions process to benefit consumers with chronic and high-cost conditions
    - Patient cost-sharing must be 25% lower than the non-standard plan

# NBPP Proposed Rule-Prescription Drug Issues

- All covered drugs in excess of state benchmark are to be considered essential health benefits
- Add Patient Representative to P&T Committees
  - Beginning 2026
- Seek comment on new Drug Classification System
  - From US Pharmacopeia (USP) Medicare Model Guidelines to USP Drug Classification System
- Warn issuers against discriminatory plan design (Letter to Issuers)
  - Placing all or a majority of drugs to treat a condition is presumptive discrimination
  - Will conduct adverse tiering reviews
    - HIV, Hepatitis C, MS, Rheumatoid Arthritis

# Transparency In Coverage Rule

- Cost-sharing for services must be available on-line
- In network provider rates and out-of-network allowed amounts on website
- Negotiated rates and historical net prices for prescription drugs in three machine-readable files
  - Enforcement has been delayed
  - CMS announced in September 2023 general delay lifted
    - Will review enforcement on a case-by-case basis

# US Congress PBM Updates

- Ownership Disclosures
- Reporting of Compensation, Fees, Rebates
- Spread Pricing Bans
- Beneficiary Cost-sharing
- Rebate Pass Through
- Delink Price of Drug from PBM fees
- Reports to Congress

# Other Issues

- No Surprise Act Implementation
- Interoperability Rule- Final Rule
- 1557 Nondiscrimination Rule - Final Rule
- Section 504 Disability Protections Rule – Proposed Rule
- OTC Coverage of Preventive Services - RFI

# Questions?

Contact us:

- [Lucy Culp](mailto:lucy.culp@lls.org) - The Leukemia & Lymphoma Society - [lucy.culp@lls.org](mailto:lucy.culp@lls.org)
- [Wayne Turner](mailto:turner@healthlaw.org) - National Health Law Program - [turner@healthlaw.org](mailto:turner@healthlaw.org)
- [Carl Schmid](mailto:cschmid@hivhep.org) - HIV + Hepatitis Policy Institute - [cschmid@hivhep.org](mailto:cschmid@hivhep.org)



# Drivers of Medical Debt, Current State Protections, and Recent Federal Actions

Consumer Liaison Committee  
NAIC Fall National Meeting 2023  
November 30, 2023

Janay Johnson, American Heart Association  
Ashley Blackburn, Health Care For All  
Maanasa Kona, Georgetown University, Center on Health Insurance Reforms

# The Scale of Medical Debt

**40% of adults - about 100 million people - owe some form of health care debt.**

**23 million adults -**  
nearly 1 in 10 - owe  
at least **\$250** in  
medical debt.



**16 million adults**  
owe at least **\$1000**  
in medical debt.

**3 million adults** owe  
at least **\$10,000** in  
medical debt.

Total United States Medical Debt:

**\$195**  
**BILLION**

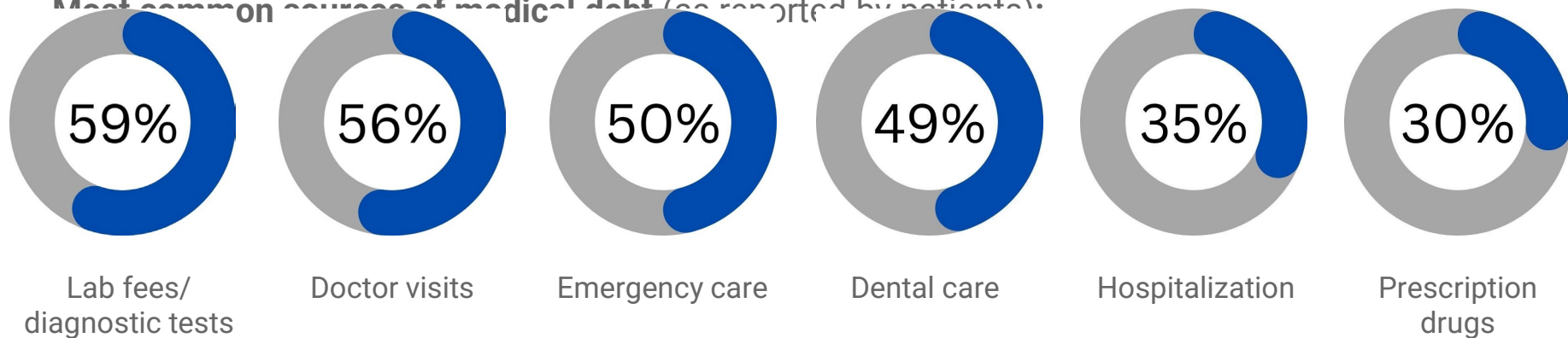
SOURCES: Noam N. Levey. 100 Million People in America are Saddled With Health Care Debt. KFF Health News. June 16, 2022. <https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/>

Matthew Rae, Gary Claxton, Krutika Amin, Emma Wager, Jared Ortaliza, and Cynthia Cox. The burden of medical debt in the United States. Peterson-KFF Health System Tracker. March 10, 2022. <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/>

# Drivers of Medical Debt

Uninsurance, rising out-of-pocket costs for the insured, the proliferation of substandard insurance products, and complex billing processes all contribute to the prevalence of medical debt.

Most common sources of medical debt (as reported by patients):



# Disparities in Medical Debt

**Racial disparities:** A larger share of Black adults (16%) report having medical debt compared to White (9%), Hispanic (9%), and Asian American (4%) adults.

**Gender disparities:** Nearly half of women (48%) report having medical debt, compared to about a third of men (34%).

**Age disparities:** People ages 30-64 are more likely than younger adults and adults over 65 to report medical debt.

**Disparities by health status:** Larger shares of people in poor health (21%) and living with a disability (15%) report medical debt.

**Disparities by health insurance status:** Adults who were uninsured for more than half of the year are more likely to report medical debt (13%) than those who were insured for all or most of the year (9%).

**Regional disparities:** People living in rural areas, in the South, and in Medicaid non-expansion states are more likely to have significant medical debt.

# Consequences of Medical Debt



# Federal Action on Medical Debt

# Recent Federal Action

No Surprise Act goes into effect protecting consumers from surprise billing

**April  
2022**

Voluntary reform by three nationwide credit bureaus

**August  
2022**

CFPB announces removal of medical debt from credit reports

**September  
2023**

**January  
2022**

Executive order directing federal agencies to examine pathways to reduce burden of medical debt

**July  
2022**

Executive order to federal agencies to reduce impact of medical debt on federal lending programs

# Recent CFPB Action



Consumer Financial  
Protection Bureau

## CFPB Kicks Off Rulemaking to Remove Medical Bills from Credit Reports

*Proposals under consideration would help end coercive debt collection tactics, clean up inaccurate data, and improve credit score predictiveness*

SEP 21, 2023

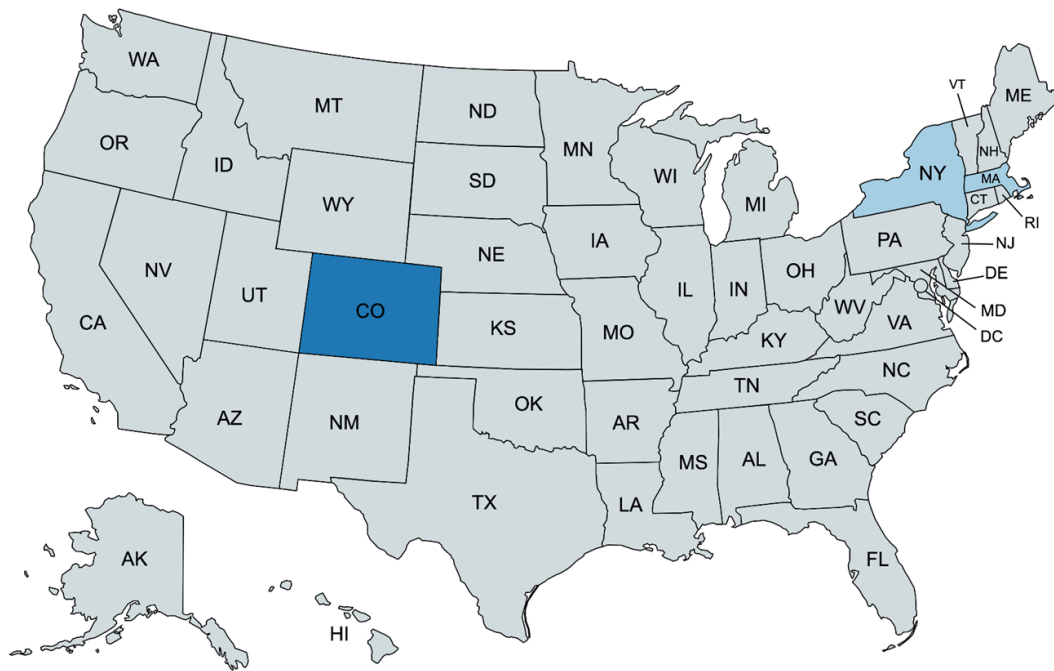
**KFF** Health News

DIAGNOSIS: DEBT

## Biden Administration to Ban Medical Debt From Americans' Credit Scores



# States Banning Medical Debt Credit Reporting



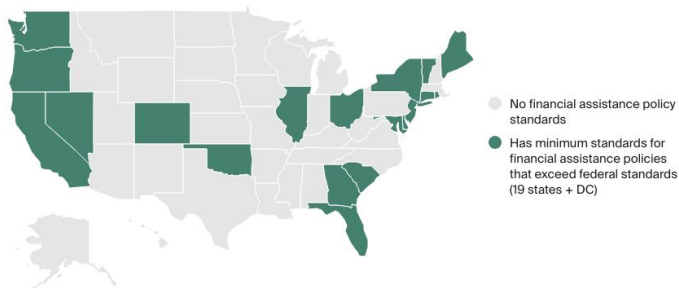
- Passed Legislation
- Proposed Legislation

# State Action on Medical Debt

# Financial Assistance or Charity Care Standards

## EXHIBIT 2

### State Adoption of Financial Assistance Policy Standards



Notes: Coding on this map identifies states that require hospitals to maintain a financial assistance policy and set certain minimum standards for these policies. The state can require hospitals to have these policies in place as a condition of licensure, as a legal mandate subject to penalties, or as a condition of receiving state funding. States that have less prescriptive requirements for their hospitals (like states that put the onus of providing financial assistance on individual counties, or states that generally require provision of financial assistance without setting minimum standards) have been excluded.

The MN attorney general has an agreement in place with almost every hospital in the state requiring them to adhere to certain patient protections, but it does not require hospitals to provide charity care.

Data: Center on Health Insurance Reforms, Georgetown University Health Policy Institute; Commonwealth Fund analysis.

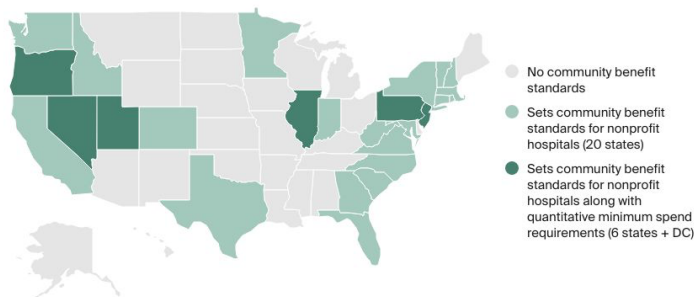
Source: Maanasa Kona and Vrudhi Raimugia, *State Protections Against Medical Debt: A Look at Policies Across the U.S.* (Commonwealth Fund, Sept. 2023). <https://doi.org/10.26099/7m6v-ve80>

- ACA requires non-profit hospitals to establish written FA policy; does not set minimum eligibility standards or standards on how much FA to provide
- 20 states require hospitals to provide financial assistance and set certain minimum standards that exceed the federal standard
- States vary in terms of enforcement mechanisms, setting eligibility requirements, how much FA must be provided, regulating the application process

# Community Benefit Standards

## EXHIBIT 4

### State Adoption of Community Benefit Standards



Notes: Coding on this map identifies states that require nonprofit hospitals to meet community benefit standards in exchange for an exemption from state taxes and states that also set certain minimum quantitative standards for how hospitals can fulfill their community benefit obligations.

ID, NV, and NH limit these requirements to hospitals of a certain size.

DC, MN, NV, RI, SC, and VA extend these requirements to for-profit hospitals as well.

TX requires nonprofit hospitals seeking certification as a "limited liability" entity to show that it spend 8% of its net patient revenue on charity care and provides 40% of the charity in its county.

GA state law requires destination cancer hospitals seeking a certificate of need to spend 3% of their adjusted gross income on indigent and charity care. While not in statute, the state might require this for all hospitals seeking a certificate of need, as a matter of practice.

Data: Center on Health Insurance Reforms, Georgetown University Health Policy Institute; Commonwealth Fund analysis.

Source: Maanasa Kona and Vrudhi Raimugia, *State Protections Against Medical Debt: A Look at Policies Across the U.S.* (Commonwealth Fund, Sept. 2023). <https://doi.org/10.26099/7m6v-ve80>

- ACA requires nonprofit hospitals to invest in community benefits in return for tax exemptions. Nonprofit hospitals have to produce a community health needs assessment every three years and have an implementation strategy
- 27 states impose community benefit requirements on nonprofit hospitals
  - At least 6 states extend requirements to for-profit hospitals
  - 7 states require hospitals to provide FA to satisfy their community benefit obligations
  - 7 states set minimum spending thresholds

# Billing and Collections Protections

- ACA imposes waiting periods and prior notification requirements for certain extraordinary collections actions (ECAs), such as garnishing wages or selling the debt to a third party
- State Protections:
  - Requiring hospitals to offer payment plans (8 states)
  - Prohibiting or limiting interest for medical debt (8 states)
  - Requiring hospitals to meet certain conditions before sending a bill to collections (14 states)
  - Prohibiting sale of medical debt (3 states)
  - Limiting/prohibiting credit reporting (10 states)

# Protections Against Legal Action

- ACA considers initiating legal action to collect on unpaid medical bills to be an extraordinary collections action. Federal law also limits how much of a debtor's paycheck can be garnished to pay a debt.
- State Protections:
  - Limiting when hospitals and/or collections agencies can initiate legal action (3 states)
  - Robust homestead exemptions (7 states with unlimited exemptions)
  - Prohibiting/setting limits on liens or foreclosures (11 states)
  - Exceeding the federal ceiling for wage garnishment (21 states)
  - Prohibiting wage garnishment in certain circumstances (15 states)

# Reporting Requirements

- ACA requires all nonprofit hospitals to submit an annual tax form including total dollar amounts spent on financial assistance and written off as bad debt. These reporting requirements do not extend to for-profit hospitals and lack granularity.
- State Can Collect:
  - financial data (15 states only collect this)
  - financial assistance program data (11 states additionally collect this)
  - demographic data (5 states additionally collect this)
  - ECA data (1 state additionally collects this)

What Can DOIs Do?



# What Can States Do?

- Study the impact of high deductibles and cost sharing on patients
- Require insurers to track and report on how many of their enrollees are experiencing medical debt, and what the causes are
- Educate enrollees about their rights under state law
- Require insurers to make information available to enrollees about their rights under state law

# What Can States Do?

- Leverage your role as banking regulators where applicable
- Depending on the state, the DOI commissioner might be responsible for overseeing:
  - Installment plans and interest rates
  - Licensing and regulating debt collectors
  - State-regulated entities' use of credit reporting information or when they report to CRAs

Questions?

A dark blue, solid-colored shape that starts as a thin line at the bottom left and expands diagonally upwards to the right, filling the bottom right portion of the slide.

# Resources

## Medical Debt Info

- [https://www.nclc.org/wp-content/uploads/2023/01/MedicalDebt\\_Rpt.pdf](https://www.nclc.org/wp-content/uploads/2023/01/MedicalDebt_Rpt.pdf)
- <https://www.ils.org/sites/default/files/2023-10/Medical%20Debt%20Report.pdf>
- <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/>
- <https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/>

## Federal Action

- <https://www.consumerfinance.gov/ask-cfpb/what-is-a-surprise-medical-bill-and-what-should-i-know-about-the-no-surprises-act-en-2123/>
- <https://www.nclc.org/biden-administration-issues-order-to-reduce-impact-of-medical-debt-on-federal-loan-programs/>
- <https://www.consumerfinance.gov/about-us/newsroom/cfpb-kicks-off-rulemaking-to-remove-medical-bills-from-credit-reports/>
- <https://kffhealthnews.org/news/article/medical-debt-credit-score-ban-biden-administration/>

## State Action

- <https://www.commonwealthfund.org/publications/maps-and-interactives/state-protections-against-medical-debt>
- <https://cclponline.org/news/medical-debt-credit-reporting-legislation-signed-co/>
- <https://www.cssny.org/news/entry/the-fair-medical-debt-reporting-act-removing-medical-debt-from-credit-repor>

# How Insurance Commissioners can Improve Maternal Health Outcomes

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DORIANNE MASON,  
NATIONAL WOMEN'S LAW CENTER



# Agenda

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- Brief background
- Federal landscape
- Recommendations

Woman in a hospital gown, who appears to be Black, holds a newborn and kisses the baby on the nose.

# Disparities in maternal and infant health

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Woman, who appears to be Black, holds baby who rests his head on her shoulder and the baby's eyes look off screen.

# Disparities in Health Care



In the forefront of the picture, a woman, who appears to be Black with shoulder length dreadlocks, smiles down at a baby laying on a table. The woman has on a gray, short-sleeved dress, and she is holding a striped small hat. The baby has on blue. Two women, who appear white, sit in the background of the picture.



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# Recent Federal Administrative Action



# Race and Data Collection

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- Reduction in Churn
- Tracking of utilization and expenditures
- Translating coverage to quality care



A woman, who appears to be Black, holds a baby in her right arm and smiles while she feeds the baby a bottle with her left hand. The woman has curly hair and has on a tan sweater. The baby has on a white onesie.

# Network adequacy standards

- Ensure access to quality providers
- Coverage for midwives and doulas
  - Including certified professional midwives (CPMs) and certified midwives (CMs)
- Culturally competent care
  - Encourage implicit bias and anti-racism training



Two women sit closely with the woman on the left's arm around the other's shoulder. A baby sits on one woman's lap staring up at her while both ladies look down at the baby with smiles. Both ladies wear hijabs, one purple and the other light green, and the baby has on a pink romper with a cartoon character on it.

# EHB benchmark selection

- Robust prenatal and postnatal services
- Coverage for birth centers & home births
- Ensure meet ACA requirements
  - Maternity coverage for dependent enrollees
  - No cost sharing for women's preventive services
  - No arbitrary limits on services
  - Coverage of breastfeeding education and breast pumps



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# Recommendations



# Addressing Property Insurance Market Failures with a Federal Catastrophe Reinsurance Program

NAIC Fall Meeting, Orlando, Florida, 11/30/23





# UP: A 32 year old 501(c)(3) insurance consumer non-profit

Our website, programming, volunteers and guidance help over 500,000 people each year

## The Press Democrat

NOVEMBER 8, 2023

### **‘Prompt action’ on fire insurance has yet to help California homeowners**

While state regulators craft new regulations and consult with the insurance industry, many Californians are paying extra-high premiums — or going without insurance entirely. In September, Gov. Gavin Newsom issued an executive order for “prompt regulatory action” to address the plight of California homeowners facing...



NOVEMBER 7, 2023



NOVEMBER 7, 2023

### **Climate change is impacting the home insurance industry and damaging the housing market**

When Michael Monaghan, a real estate agent with Coldwell Banker Sellers Realty in northern California, got an offer for a home in Bayside at the seller’s \$650,000 list price in September, he told the buyer’s agent that the buyer needed to start looking for insurance...



NOVEMBER 6, 2023



NOVEMBER 7, 2023

### **10th Circuit rules Black Hawk casino’s insurance policy did not cover COVID-19 closure**

The Colorado Supreme Court and the 10th Circuit have both found COVID-19 harms people, but does not damage property The federal appeals court based in Denver decided last week that a Black Hawk casino’s insurance policy, with limited exception, did not provide for hundreds of...

## The Press Democrat

NOVEMBER 5, 2023

# UP Goals:

**Contribute to solving market problems and protecting policyholders' reasonable expectations of coverage**

**Help consumers adapt to the changing P&C landscape/climate change**

**Restore affordable insurance options for home and business owners that provide essential asset protection and loss recovery financing.**

**Advance/increase mitigation support and insurance rewards (premium discounts, renewal assurances)**





# Growing alarm over the extent to which the private market is “failing”



NOVEMBER 1, 2023

## Insurance companies leaving California

A lot of people in the Bay Area are losing their homeowners insurance. Big companies, like State Farm and Allstate, and even some smaller companies, are either refusing to insure you, or simply closing up shop in California. NBC Bay Area's Rai Mathai spoke to



AUGUST 29, 2023

## More Americans are going without homeowners insurance. That could spell trouble.

Hurricane Idalia intensified Tuesday as it approached the Gulf Coast of Florida. Given that, recent reporting in The Wall Street Journal caught our eye. Its headline: “Americans Are Bailing on Their Home Insurance.” The Journal reported that some 12% of homeowners are choosing not to...

## THE WALL STREET JOURNAL.

OCTOBER 4, 2023

## Homeowners Flock to Last-Resort Insurance Policies

Robert Dubie was paying around \$1,100 a year to insure his Paradise, Calif., home before it burned down in a wildfire five years ago. He rebuilt it with a host of fire protections, but it costs 10 times as much to insure. He couldn't get...



## MONEY

## Farmers Insurance is the 4th major insurer to leave Florida, underlining insurance crisis



**Brandon Girod**

Pensacola News Journal

Published 3:04 p.m. CT July 12, 2023 | Updated 11:55 a.m. CT July 13, 2023



# Realism is in order

“

“Insurance coverage is no longer a one way street. In my opinion, the future won't support the current model” Jean Bonander, Joint Powers Authority/ Municipal Risk Pooling expert

“A publicly traded insurance company in the face of climate change is not a sustainable business model for the end user, the consumer.” Amy Bach, quoted in “This Changes Everything: Capitalism vs. the Climate”, Naomi Klein, Knopf Press, 2014

# Innovating is imperative

**Even if the reinsurance market softens in the spring as predicted...**

**Private reinsurers have an unsustainable degree of control over the P&C marketplace (and by reference, real estate, lending, homeownership, local, state and federal governments)**

**Reinsurance pricing and treaty conditions are dramatically reducing affordability and availability of essential property insurance**

**Reinsurers are directing underwriting, setting minimum risk scores**

**Gov't-sponsored insurers of last resort are in higher demand and experiencing significant reinsurance challenges**

# Gov't supported programs aimed at stabilizing property insurance markets, filling gaps/voids

**National:** National Flood Insurance Program, Terrorism Risk Insurance Program, Standards and programs related to Health, Workers Comp, Long Term Care, Crops, etc.

**State:** California Earthquake Authority, Citizens (Florida and Louisiana), California Fair Plan, Texas Windstorm Ins. Assn. Alabama Ins. Underwriting Assn., North Carolina Ins. Underwriting Assn., Georgia Underwriting Assn., Hawaii Property Ins. Assn., Florida Hurricane Catastrophe Fund

**HPIA**

Home

Welcome

Coverage Information

Forms for Download

General Info

## Welcome to the Hawaii Property Insurance Association

Providing stability to the Hawaii Property insurance market

North Carolina Joint Underwriting Association - FAIR Plan  
North Carolina Insurance Underwriting Association - Coastal Property Insurance Pool

HOME | WHAT'S NEW | CAREER OPPORTUNITIES | CONTACT US | OPERATIONAL DOCUMENTS | BOARD OF DIRECTORS | SCHEDULED BOARD MEETINGS

PAY ONLINE

PROUDLY PROVIDING COVERAGE FOR THE CITIZENS OF NORTH CAROLINA SINCE 1969

United  
Policyholders.

# Risk Pool History and Innovation

Through the 1970s, a majority of municipalities carried commercial insurance. Beginning in the mid-1970s and accelerating in the early-1980s, a crisis in the municipal insurance market led to a period of substantial insurance cost instability. Reinsurers were folding rapidly and rates paid by cities grew dramatically as the market contracted from the supply side. The causes of the market disruption are still debated today, but the result of municipalities shouldering the burden of untenable premiums for their insurance led many to seek out alternative sources of coverage.

Intergovernmental risk pools gained traction as commercial markets experienced their collapse in the early 1980s. In practice, they function much like commercial insurance companies. Cities, counties, or other government entities group together to pool their risk to diversify it and to control costs. By managing risk factors collaboratively, member entities reduce the overall cost of coverage for one another.

<https://riskandinsurance.com/considering-forming-an-insurance-pool-heres-what-the-public-sectors-found/>

# Risk Pool History and Innovation

Formed in 2007 by a group of Caribbean governments, the Caribbean Catastrophe Risk Insurance Facility (CCRIF) is a pooled catastrophe fund that helps limit the financial impact of natural disasters to member nations. The CCRIF provides liquidity and the means of recovery for various nations that, individually, would have found it impossible or cost-prohibitive to access such safeguards.... The CCRIF was among the first to develop parametric policies backed by traditional and capital markets. Impressively, the CCRIF was able to distribute \$29.6 million in payouts in less than 15 days to six countries in the wake of Hurricanes Irma and Maria in September 2017.

The Power of Community Risk Pooling, Raghuveer Vinukoilu, Climate Insights and Advocacy, Munich Re US

# Concepts to consider

- **A new national all-risks disaster insurance program offering limited essential benefits that would pair with existing Small Business**
- **Administration low-interest loans (already available up to \$500,000) and parametric products**
- **Community risk pools**
- **Federal and state loan guarantees for government sponsored insurers of last resort that would supplant a portion of the reinsurance**
- **Enhanced resources for State Insurance Regulators to be able to to evaluate CAT models, promptly review new rate filings, prevent excessive executive compensation and profits but allow pricing that's adequate to the risk to be assumed.**
- **Independently created public catastrophe models as a yardstick for commercially derived models**



# The fundamentals of a catastrophic property loss reinsurance program

- **Provide reinsurance for primary insurance companies offering residential and commercial property insurance that include coverage for the perils of flood, wind, hurricane, severe convective storms, wildfire, and earthquake.**
- **To be eligible insurers must offer an all-perils product and actively facilitate and reward loss mitigation activities**
- **Financial threshold at which an insurer may receive amounts from the fund shall be based on a percentage of no greater than 40% of the individual insurer's probable maximum loss as determined for the catastrophe perils included in the program**
- **Insurers will pay premiums for the reinsurance**
  - (A) **The expected average annual losses for the exposure of the participating insurer in the Program based on a (i) 100-year return; and (ii) pro-rata portion, based on the share of Program premium of the participating insurer.**
  - (B) **The administrative costs to administer and manage the Program.**



# Thank you!

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

[www.uphelp.org](http://www.uphelp.org)



## **Addressing Property Insurance Market Failures**

**Presentation to NAIC Consumer Liaison Committee**

**November 30, 2023**

Birny Birnbaum  
Center for Economic Justice

[birny@cej-online.org](mailto: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](http://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 studied insurance markets and competition for over 30 years. He performed the first insurance redlining studies in Texas in 1991 and since then has conducted numerous studies and analyses of competition in various insurance markets 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 in 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.

## **Solving a Problem Requires Accurate Assessment of the Problem and Its Causes**

**The Problem:** Private property insurance – a product required by lenders and/or government agencies and essential for individual, business, community and national resilience and security.

These markets are failing around the country. Insurers have cut coverage and otherwise shifted more risk onto consumers – when they have remained in the market.

Residual markets have grown and concentrated risk – while punishing consumers for whom the private market has failed with inadequate coverage and artificially-inflated rates in the name of reducing the size of the residual market.

## The Problem (con't)

The “experts” in risk assessment have failed to adequately assess risk. Insurers have assessed risk retroactively – after each major cat event, insurers “discover” risk they didn’t anticipate and cut coverage and leave markets.

The result is a hollowed-out policy that fails to meet consumer expectations and is more and more likely to fail to enable recovery from a cat event.

There is a profound mismatch between insurers’ again and again discovering their errors in assessing risk – “we didn’t know what we were doing when we agreed to insure your property, but trust us that now we do when we decline coverage or raise your premium astronomically” – and consumer / business long-term property investment horizon.

## Causes of Property Insurance Market Failures

One, state regulators and legislators have largely let insurers do whatever they want in terms of coverage. So, instead of investing in loss prevention partnerships and loss mitigation, insurers cut coverage and shift risk onto consumers to manage their profitability.

Two, insurers did not prepare for climate change and, in fact, fought efforts to recognize climate risk. So now insurers are using climate change to justify leaving markets -- we didn't know what we were doing when we originally wrote the policy, but, trust us, we know what we're doing now.

Third, unstable and volatile global reinsurance markets. Coupled with business models promoted by some states for thinly-capitalized insurers relying massively on reinsurance, global reinsurance capacity is dwarfed by the need for catastrophe reinsurance, leading to a sellers' market and price gouging with no regulatory oversight.



## Causes of Property Insurance Market Failures (con't)

Fourth, unaccountable catastrophe models. The promise of computer catastrophe models was rate stability. In place of the volatile 30 year historical average of cat losses – which could change dramatically as an old cat event left the 30 year period or a new cat even joined – the cat models promised rate stability through a forward-looking assessment of risk, such that the actual occurrence of a cat would not impact the assessment of risk – like the occurrence of a two heads in a row doesn't change the odds of the next coin flip being a heads or a tail.

Fifth, regulators have failed to meaningfully monitor markets and refused again and again to collect the data needed to inform public policy and assess insurer performance. The fact that state insurance regulators can't answer basic questions about the state of property insurance markets – while criticizing the federal government for trying to do so – is a contributing regulatory failure

## Causes of Property Insurance Market Failures (con't)

**The problem is not caused by regulation** -- when there is any meaningful regulatory oversight. It's clear that the insurer actions in CA are driven by an anti-regulatory political campaign -- the same problems with insurers leaving the market and overreliance on reinsurance is found in LA and FL, among other states.

The idea that further deregulation will bring insurers back into the market or lower premiums is as flawed as suggesting leaving health insurance to a deregulated private market will lead to better availability and affordability of insurance. More deregulation will further exclude the most vulnerable consumers as insurers utilize all manner of data and AI to hyper segment the market and exclude any property that doesn't meet the cat-model driven profit goal.

## How Do Our Nation Address Property Insurance Market Failures?

These are problems that affect the entire nation of consumers, businesses, taxpayers and state and local government. Failure to address property insurance market problems leaves everyone on the hook.

There is no insurance mechanism – public or private –that will be able to handle ever increasing frequency and severity of natural cat events

The short, medium and long-term solution requires massive investment in loss mitigation and prevention.

How do we get there?

## **How Do We Promote and Achieve the Massive Investment in Loss Mitigation and Resilience Needed to Address Climate and Cat Risk?**

We know these investments have a tremendous return, saving money for consumers, businesses and federal, state and local governments in the short, medium and long term.

We also know the private market, given the choice, will always opt for cutting coverage over loss mitigation investments, as a way to manage their risk.

## **How Can Our Nation Create a True Public-Private Partnership to Build Climate and Cat Risk Resilience and Property Insurance Markets That Function to Protect Consumers and Businesses?**

Insurers must provide a substantive product that meets consumer needs and focus on risk management through loss prevention partnerships with policyholders and communities instead of cutting coverage and shifting risk onto consumers.

Meaningful and effective property insurance is critical to reducing taxpayer burden for disaster relief and for ensuring financial stability -- particularly in the case of an event that destroys tens of thousands of homes and wreaks havoc on the mortgage finance and mortgage guaranty sectors.

## **Stable Reinsurance Needed**

Stable and reliable reinsurance for mega-catastrophe is needed. Consumers and businesses make long-term investments in their properties and the provision of stable property insurance requires stable reinsurance pricing and availability.

Private reinsurance markets alone cannot provide a stable source of reinsurance for mega-catastrophes as evidenced by the massive and sustained price increases in reinsurance over the past couple of years -- e.g., LA Citizens. The amount of reinsurance needed dwarfs the size of private reinsurance and related capital market products.

It's unreasonable for insurers to convey the message to consumers that the property is insurable only to eviscerate or withdraw coverage after a few years.

## The Strategy

1. A federal public catastrophe reinsurance program modeled after TRIA that kicks at a high level of catastrophe loss, leaving a reinsurance tranche for the private market below the Nat Cat Re threshold. In exchange for low-cost and stable cat reinsurance, insurers would offer an all-perils policy with achievable-for-consumers deductibles.

2. Although the federal government would provide stable and low cost cat reinsurance for the extreme portion of cat risk, property insurance oversight would remain with (or in the case of flood, return to) the states.

States would be encouraged to, one, promote all perils policy coverage and, two, loss prevention investment with massive matching federal funds. States would be encouraged to experiment with longer-term (5 years or more) policies to give consumers some confidence that the insurer has accurately assessed risk and invested in loss mitigation to be there for the consumer for a long time.

## The Strategy

3. Improved data collection on property insurance exposures and claims to assist the federal Nat Cat Re Fund in developing and adjusting nat cat re payout thresholds based on a percentage of a state's exposure AND provide data necessary for state and federal agencies to effectively monitor property insurance markets for availability, affordability and systemic financial risk.

4. The Nat Cat Re Fund would have some discretion in designing the program, but the thresholds would be based on calendar accident year cat losses. Nat Cat Re Fund would be directed to set the threshold at a level low enough to provide meaningful benefit to insurers, but high enough to encourage a competitive private reinsurance market for the tranche between insurer retention and Nat Cat Re.



## The Strategy

5. Means-tested financial assistance for low-income consumers provided in the following order, if possible:

- funding (in partnership with insurer and state/local funding) for loss prevention to reduce premium by reducing risk;
- relocation from an uninsurable property to an insurable property;
- cash assistance to pay premium.

Financial assistance would not be provided through compromising risk-based pricing.

6. Rethink state strategies permitting or encouraging the business model of thinly-capitalized insurers over-relying on reinsurance.

## Why Will This Strategy Work?

The strategy addresses the actual causes of property insurance market failures.

It creates a true public-private partnership in which both the public and private sectors bring something to the table and requires a product that meets the needs and expectations that consumers and businesses have of property insurance.

It focuses on promoting loss prevention and risk mitigation through resilience, not evisceration and improves the risk-based pricing and messaging needed to convey risk to consumers, businesses and government.

It creates a national solution to a national problem, while continuing to rely on state-based insurance regulation.

# How Does the Nat Cat Re Strategy Compare With Other Ideas?

1. Bond Financing
2. Parametric Insurance
3. Public Insurer / Competitive Residual Market
4. Public Subsidies to Insurers
5. Further Deregulation?

**Questions?**

**Thank you!**

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# Pet Insurance: No longer a Niche Product Line

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November 30, 2023

Brendan Bridgeland  
Center for Insurance Research  
[insuranceresearch@comcast.net](mailto:insuranceresearch@comcast.net)

# Center for Insurance Research

- The Center for Insurance Research (CIR) is a nonprofit, public policy and advocacy organization founded in 1991 that represents consumers on insurance matters nationally.
- CIR is based in Haverhill, Massachusetts.

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# Pet Insurance: No Longer a Niche Product Line

## Pet Insurance Statistics

- Premiums for pet insurance in the U.S. totaled \$3.2 billion in 2022.
- The total number of pets insured in the U.S. is 5.36 million, a 22 percent increase since 2021.
- The average premium for dogs was \$640 a year (or \$53 a month). The average premium for cats was \$387 a year (or \$32 a month).
- Dogs are 80% of insured pets, and cats 20%.
- 87 million (or approximately 66%) of households report owning a pet – including 65 million dogs and 46 million cats. Households with annual incomes of more than \$75,000 are most likely to own pets.

Sources: North American Pet Health Insurance Association (NAPHIA) State of the Industry Report and American Pet Products Association (APPA)

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## Pet Insurance Statistics

- The most common pet insurance claims for dogs: urinary tract infections, ear infections, gastroenteritis, diarrhea and skin conditions. For cats: urinary tract infections, diabetes, vomiting, kidney disease and hyperthyroidism.
- The average cost for swallowed foreign object surgery is \$3,500 for dogs and \$3,400 for cats.
- The top claims paid for dogs in 2022 included \$60,882 for a two-year old flat-coated retriever in New Hampshire (for pneumonia) and \$60,215 for a three-year old English bulldog in Texas (pneumonia).
- The top claim paid for a cat in 2022 was \$40,057 for a two-year old sphynx in New Jersey (for multiple conditions).

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# Pet Insurance: No Longer a Niche Product Line

## The History of Pet Insurance

- Pet insurance is over 130 years old. The first policy was written in 1890 (for horses and livestock) by a man named Claes Virgin in Sweden.
- Over 30 years later, a policy was issued for a dog in Sweden in 1920, which was then followed by similar coverage in Britain in 1947.
- In 1982, the first pet insurance policy was underwritten in the United States. This first policy was for the dog playing the title character on the TV show “Lassie.”
- This first policy was issued by Veterinary Pet Insurance (VPI). Throughout the 80s and 90s, VPI had a near monopoly over the U.S. market and owned 80% of the market through the early 2000s.



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# Pet Insurance: No Longer a Niche Product Line

## Pet Insurance Has Experienced Dramatic Growth in the last decade, particularly during the Pandemic

- Today, pets are often now regarded as family members rather than companions with many pet owners referring to themselves as pet parents.
- Veterinary care expenses have increased tremendously in recent years (as in other healthcare settings) and pet owners will sometimes incur large expenses in treating beloved pets.
- As the costs have increased, pet parents have turned toward pet insurance to protect their furry family members against unforeseen medical issues.
- Consumer prices for vet health services increased by 8.5% between July 2021 and July 2022. (<https://www.forbes.com/advisor/pet-insurance/pet-cost-inflation/>)

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- During the pandemic, nearly one in five households adopted a cat or dog - 23 million households. (per a survey by the American Society for the Prevention of Cruelty to Animals.) This includes 1 in 6 members of Gen Z.
- 36% of Gen X respondents had pets, second only to Millennials at 44%.
- Sales of pet insurance premiums have skyrocketed as a result of pet adoptions, and regulators should be prepared to handle new influxes of policy forms, data elements and consumer complaints.
- Pet insurance premiums have risen six-fold from 2013 to 2022, rising from \$500 million to \$3.2 billion.

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## Pet Insurance Has Experienced Dramatic Growth in the last decade, particularly during the Pandemic

- Pet insurance premiums increased:
  - 24.3% from 2018 to 2019
  - 27.5% from 2019 to 2020
  - 30.4% from 2020 to 2021.
  - 24.2% from 2021 to 2022.
- While millions of pets are insured, the vast majority of pets owned by U.S. households are still un-insured (about 4% of dogs are insured and about 1% of cats). This means the market for pet insurance is far from mature, leaving room for further exponential growth.

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# Pet Insurance: No Longer a Niche Product Line

## Pet Insurance Policy Basics

- Premiums are typically based on the animal's age, health profile and the level of coverage. Older animals cost more to cover and some plans have age limits.
- In many ways, pet insurance resembles health insurance (though it is a PC product and previously classified under "Inland Marine" for financial reporting purposes). Pet insurance policies may include exclusions, varying coverage options, deductibles, and payment limits. However, there are differences in some of these policy terms that may confuse consumers who are more familiar with health insurance policies.
- Providers have three main categories of products: 1) accident-only (less than 1% of plans); 2) accident and illness; and 3) wellness coverages (which are not insurance products).

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# Pet Insurance: No Longer a Niche Product Line

## Pet Insurance Policy Basics

- Premiums on a pet insurance policy may depend on many variables, including the species of animal, breed, gender, age, location, and the coverages and deductible. Pet insurance for French bulldogs, golden retrievers and German shepherds is more expensive than insurance for smaller breeds like chihuahuas, and shih tzus.
- Most policies operate on a reimbursement basis and methods can vary by insurer. Some use benefit schedules, which reimburses policyholders based on the illness or injury while others reimburse a percentage of the amount spent by the policyholder. Reimbursement requires a pet's owner to pay potentially large medical expenses up front, causing financial strain.
- Policies may have waiting periods ranging from five days to 12 months, depending on the illness, injury or condition.

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# Pet Insurance: No Longer a Niche Product Line

## Pet Insurance Policy Basics

- Accident coverage includes events such as vehicle strikes, broken bones, and snake bites while illness coverage includes conditions like arthritis, cancer and allergies.
- Pet insurance policies may be marketed online, or in veterinary clinics, pet stores, shelters and word of mouth referrals. Veterinary offices or hospitals may promote pet insurance products by carrying printed materials throughout their office.
- The fastest growing distribution source of pet insurance policies is via employee benefit packages.
- Market conduct issues identified by regulators have included unlicensed sales, illegal inducements, and unlawful claims practices.

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# Pet Insurance: No Longer a Niche Product Line

## Pet Insurance As an Employee Benefit

- Pet insurance is increasingly sold through employee benefit plans as employers use pet insurance to attract and retain employees. 15% of employers offer pet insurance plans as an employee benefit, including: Microsoft, Hewlett-Packard, Target and T-Mobile.
- Pet insurance has become an important employee benefit. In 2019, MetLife acquired a pet insurer in order to add pet insurance policies to group benefit programs offered to employers.
- One survey found that employees would be willing to give up employer provided snacks, meals or vacation days in exchange for receiving pet insurance as an employee benefit. (<https://people.com/pets/survey-employees-want-pet-perks/>) According to a survey by Nationwide, nearly one-third of pet owners said they would be more likely to stay at an employer that offered pet benefits.

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# Pet Insurance: No Longer a Niche Product Line

## NAIC Model 633 – Pet Insurance Model Act

- In the Summer of 2022, the NAIC adopted a new Pet Insurance Model Act which was drafted with the input of industry, veterinary providers and consumer representatives.
- Model 633 establishes consumer protections related to policy renewals, waiting period disclosures, policy limits and benefit schedules. The Act also limits preexisting condition denials and provides a 15-day free look period and prohibits waiting periods for accident coverage.
- The Act requires insurers to differentiate pet wellness programs from insurance policies and sets training standards for insurance producers.
- Three states have enacted a version of Model 633 to date: Maine, Washington and Mississippi. (California has a pet insurance law which predates the NAIC Model.)



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# Pet Insurance: No Longer a Niche Product Line

## Other Pet Insurance Regulatory Initiatives

- In the current NAIC P/C annual financial statement, pet insurance business is reported by companies in line 9 - inland marine. However, in 2024 pet insurance will be removed from inland marine and made a separate category. Pet insurance data will be added to the Underwriting and Investment Exhibits, Exhibit of Premiums and Losses (State Page), and Insurance Expense Exhibit and Schedule P. (Per 2023-01BWG)
- Policy forms and supporting materials are often filed by pet insurance providers on the SERFF system. In SERFF, most pet insurance falls into line 9.0004 of the product coding matrix.
- Pet Insurance data collection has also been added to the Market Conduct Annual Statement.

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# Pet Insurance: No Longer a Niche Product Line

## Common Consumer Issues in Pet Insurance

- Pre-existing conditions can be problematic for consumers if they let a pet insurance policy lapse. (Pre-existing condition waivers in pet insurance do not necessarily operate the same way they do in a health insurance policy, which may confuse consumers.) If a consumer lets a pet insurance policy lapse, when they later reinstate their, all their pet's previous ailments will now count as pre-existing conditions, even previously covered conditions.
- Broadly worded cancel clauses that afford insurers broad leeway to cancel or non-renew policies on short notice and without reason.  
(<https://thecaninereview.com/2022/05/25/pet-insurance-close-up-akc-pet-insurance/>)
- Lengthy waiting periods for certain conditions (up to 12 months in some policies – meaning coverage is only applicable to renewals) may mislead consumers about their coverage benefits.

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# Pet Insurance: No Longer a Niche Product Line

## Common Consumer Issues in Pet Insurance

- Waiting periods that encompass all coverages may lead to consumers to believe their pet is insured even though actual coverage may not begin until many days after the policy is signed. (The NAIC Model Pet Insurance Act fixes this by prohibiting waiting periods for accident coverage.)
- Consumers used to human health insurance may not understand the reimbursement method of pet insurance, and may lack the funds to pay for an expensive procedure without incurring debt.
- Large premium increases that exceed increases predicted by insurers may lead to complaints or lapses in coverage (which in turn potentially creates new pre-existing conditions). Recently, pet insurers have sought premium increases in New Jersey ranging from 33% to 56% (<https://tinyurl.com/263mkth6>).

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# Pet Insurance: No Longer a Niche Product Line

## Recommendations for Regulators

- Adopt the NAIC Pet Insurance Model Act in your jurisdiction.
- Prepare Consumer assistance staff to deal with an increase in pet insurance related complaints.
- Department staff should plan to begin analyzing new, state-specific pet insurance data that will be reported for the first time in the 2024 annual statement blanks and in MCAS reports.
- Develop a classification system for pet insurance complaints – including the State Based Systems (SBS) complaint tracking database. This would make it far easier for regulators, consumer groups and consumers to monitor developments in the pet insurance marketplace through the NAIC's Consumer Information Source.

**NAIC CONSUMER LIAISON  
REPRESENTATIVE RECOMMENDATION  
TO THE EXECUTIVE COMMITTEE**

(Please send completed form to Lois Alexander for processing)

**RECOMMENDED BY:** Brendan Bridgeland

**DATE:** November 20, 2023

**ISSUE:** Pet Insurance Complaint Collection and Classification

**COMMITTEE REFERRAL RECOMMENDATION:**

(A)\_\_\_\_\_ (B)\_\_\_\_\_ (C)\_\_\_\_\_ (D)  X  (E)\_\_\_\_\_ (F)\_\_\_\_\_ (G)\_\_\_\_\_

**ACTION REQUESTED/CHARGE RECOMMENDED:**

Adding pet insurance as a category in the NAIC's complaint database.

**NAIC ACTION:**

Develop a classification for pet insurance complaints in the State Based Systems (SBS) complaint tracking database. This would make it far easier for regulators, consumer groups and consumers to monitor developments in the pet insurance marketplace through the NAIC's Consumer Information Source. It would also support the NAIC's other pet insurance data collection initiatives – in the P/C financial statements and MCAS reports and provide states with the ability to evaluate this rapidly growing line of business.

RECOMMENDATION ACCEPTED: \_\_\_\_\_

RECOMMENDATION DECLINED: \_\_\_\_\_

# Not Much of the Life Insurance Purchased in the U.S. Winds Up As a Death Claim

Richard M. Weber, MBA, CLU

Consumer Representative



This presentation is based on a paper entitled

## **Lapse-Based Insurance**

**David Gottlieb** - London School of Economics and Wharton School, University of Pennsylvania

**Kent Smetters** - Wharton School, University of Pennsylvania

June 6, 2016, and updated in 2021

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# Why is this important?



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- Over 70 percent of US families own life insurance and annual premiums exceed \$110 billion

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- Annualized lapse rates lead to substantial lapsing over the multi-year life of the policies.

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1990 - 2010

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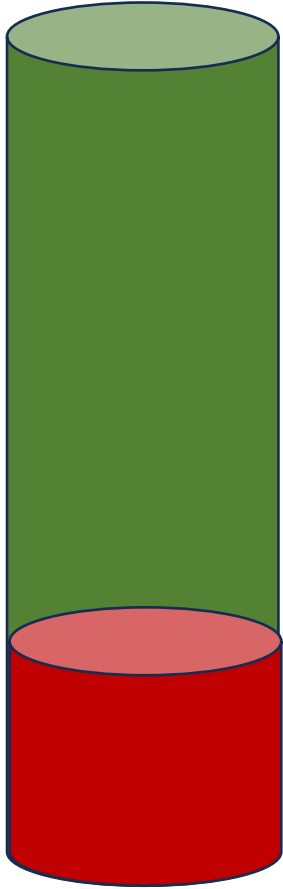


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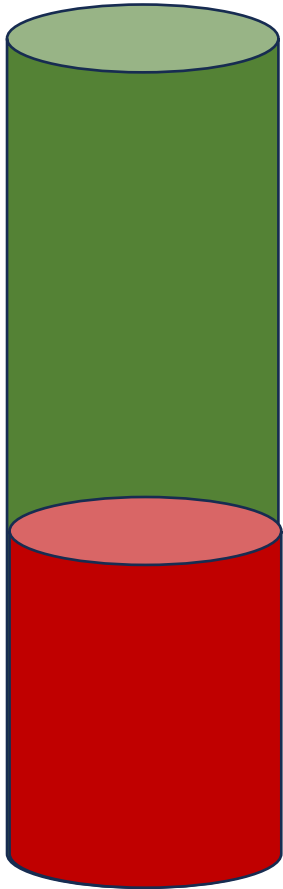
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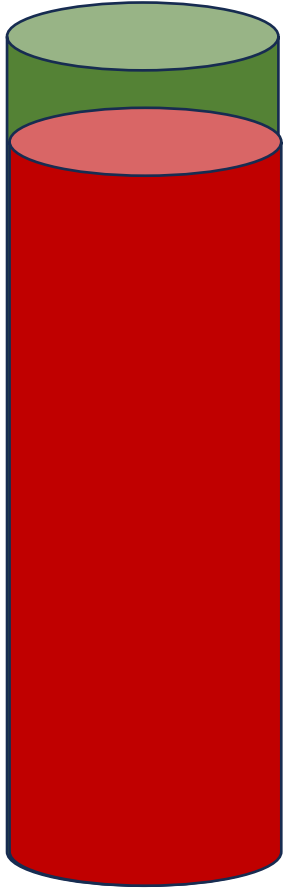
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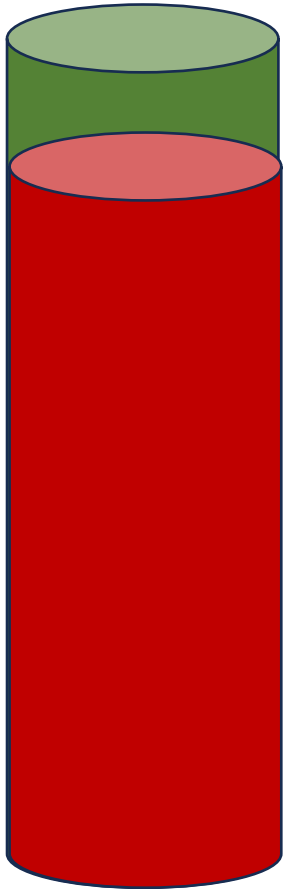
- Within 10 years, **40%** have lapsed.

# Why is this important?



- **Nearly 88% of universal life policies ultimately do not terminate with a death benefit claim.**

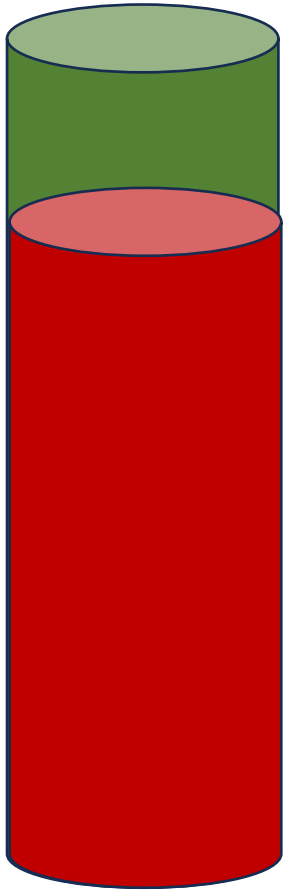
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- In fact, 74% of term policies and 76% of universal life policies sold to seniors at age 65 never pay a claim.

# Why people lapse - G&S

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## “Lapsers”

- “Lapses are more prevalent for smaller policies, and more exposed to ‘background’ shocks, including unemployment, medical expenses, new consumption opportunities, etc.”
- “Forgetting to pay.”

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## Insurers

- “There is substantial evidence that insurers take profits from lapses into account when setting their premiums.”
- Note: NAIC’s 1995 Life Insurance Illustration Model Regulation prohibits this activity, known as Lapse Supported Pricing (Section 6-B-9)

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## Insurers

- “What companies were doing to get a competitive advantage was taking into account these higher projected future lapses to essentially discount the premiums to arrive at a much more competitive premium initially because of all the profits that would occur later when people lapsed.”

(Society of Actuaries 1998, p. 12)

# Additional G&S Findings

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- Anecdotally, consumers are more likely to lapse their policies when they are not in contact with their sales agent.

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- Wealth managers typically earn fees based on the market value of accounts “...thereby encouraging the wealth manager to keep the relationship active.”
- The paper observes: “Our model suggests that front-loaded commissions may be used to incentivize insurance brokers to find clients without concern for whether they will hold their policies for very long.”



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Who is affected by these “**Best Interest**” and “**Suitability**” rules?

## **Legislated** fiduciary obligations of care

**360,000** Investment Advisor

Representatives (many of whom may also be regulated by FINRA as

Registered Representatives), and their

**14,800** Registered Investment Advisory firms.

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**624,000** Registered Representatives,  
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There are approximately **332,000** licensed insurance agents in the U.S, **20,500** of whom sell insurance products in New York.

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Most consumers are not keeping their life insurance until death. This has an adverse effect on families and is contrary to sensible public policy, and ...



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Not much of the life insurance purchased in the U.S. winds up as a death claim

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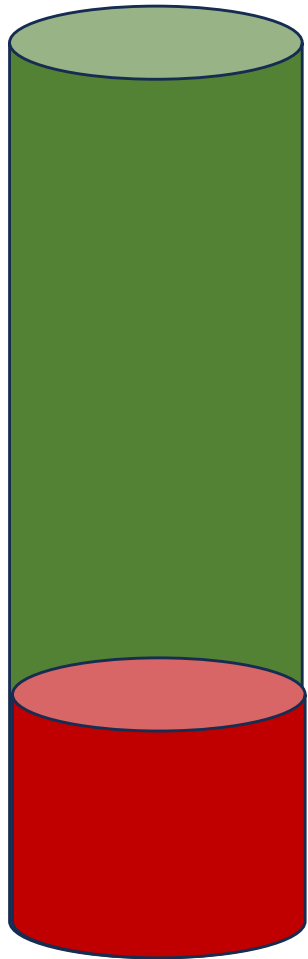
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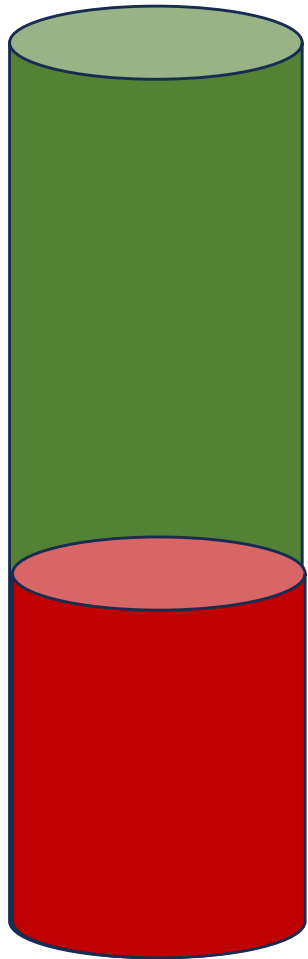


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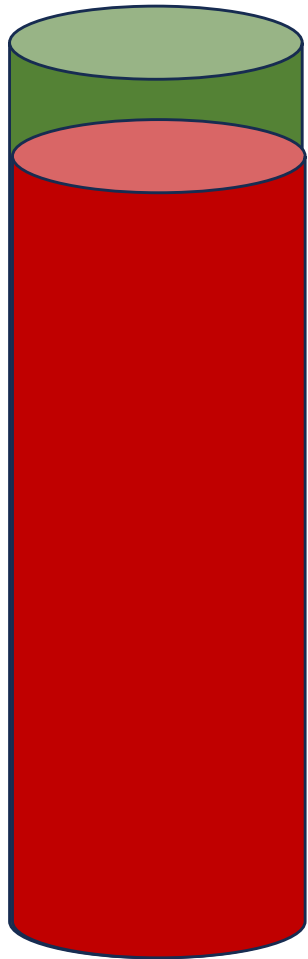
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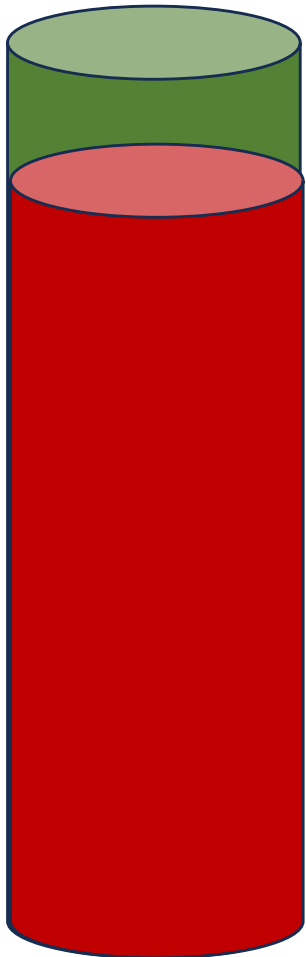
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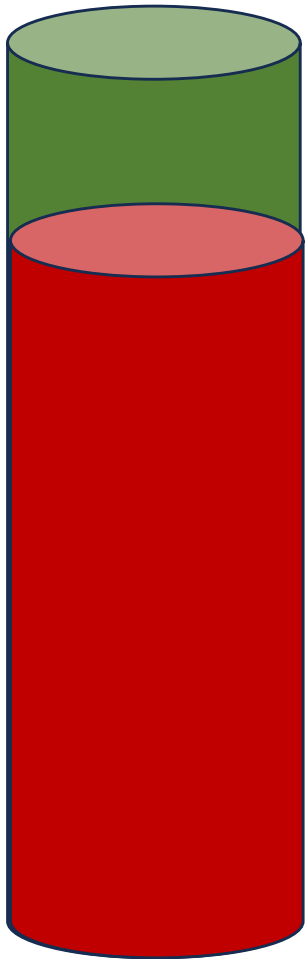
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