MARKET CONDUCT ANNUAL STATEMENT COMMENTS

JULY 14, 2017

Alaska—*Anna Latham*

America's Health Insurance Plans and Blue Cross Blue Shield Association
—*Marty Mitchell and David Korsh*

Center for Economic Justice
—*Birny Birnbaum*

NAIC Consumer Representatives
—*Tim Jost*

THE STATE
of ALASKA
GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development
DIVISION OF INSURANCE

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July 14, 2017

Randy Helder
Assistant Director of Market Regulation
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 61406-2197

Dear Mr. Helder,

Re: Request for Comments – Market Conduct Annual Statement

Thank you for the opportunity to provide comments on the proposed changes to the Health MCAS Data Call and Definitions and Blanks. The Alaska division of insurance recognizes the efforts in developing the Health MCAS data call and definitions and blanks documents and is looking forward to having such detailed information collected by the NAIC available for state use. The following comments are submitted for the Market Regulation and Consumer Affairs (D) Committee's consideration.

Explanation of Product Identifiers in the data call (page 3) and Interrogatories in the blanks include language carving out transitional, grandfathered, and student plans from the IEIH. This language is unnecessary as transitional, grandfathered, and student plans are not found "In-Exchange". It is recommended that the excess language be removed to improve understanding and flow of the documents.

The division recommends adding a new data element to Schedule 1 – Policy Administration (page 4) in the data call and In-exchange section of the blanks. Currently, a data element, "number of policy terminations and cancellations initiated by the consumer" is included. Another useful data element would be the "number of policy terminations and cancellations initiated by the Exchange". We would also like to see the number of lives impacted by these cancellations. The division has noted an increase in inquiries and complaints from consumers who are not notified by insurers that their policies are being cancelled on the direction of the Exchange. It would be expected that this information would only be provided for consumers with effectuated coverage.

General definitions on pages 9 and 10 of the data call reference the Code of Federal Regulations using the acronym CFD. It is believed that the usual acronym for the federal regulations is CFR. We recommend that this minor typo be corrected wherever it appears.

Transitional Plan in the General definitions (page 10) contains information that has been changed in updated guidance from CMS. Currently transitional plans are allowed to renew until October 1, 2018. The definition limits transitional plans to October 1, 2016. It is recommended that the language be updated to be consistent with current guidance to ensure accurate data submission.

As mentioned it is believed that these changes will result in improved understanding of the requested data elements required by MCAS as well as updated instructions for use by insurers.

Sincerely,

Anna Latham

Anna Latham
Deputy Director

By email

14 July 2017

Honorable Steven W. Robertson
Chair, Market Regulation and Consumer Affairs (D) Working Group
c/o National Association of Insurance Commissioners
Attention: Mr. Timothy B. Mullen/Mr. Randy Helder (NAIC)

Re: Comments on Health MCAS Expansion

Dear Commissioner Robertson:

We write on behalf of America's Health Insurance Plans (AHIP) and Blue Cross Blue Shield Association (BCBSA) regarding the proposed Health Market Conduct Annual Statement (Health MCAS) expansion. Thank you for this opportunity to comment.

As we have noted to the Market Analysis Procedures (D) Working Group (MAP), the NAIC is considering a significant expansion of the Health MCAS for its second-year reporting. This expansion is set to take place at the same time health insurers face an extremely volatile and uncertain political, regulatory, and business environment. The future of the Patient Protection and Affordable Care Act (Affordable Care Act) is unknown. Even if Congress does not pass major legislative changes this year, the Trump Administration may impose substantive regulatory changes. At a time when health insurers are facing such uncertainty, and are grappling with questions about offering products on the health insurance exchanges/marketplaces for 2018 and beyond, we question whether it is wise for MAP and the NAIC to require health insurers to make major changes to data collecting and reporting systems for a healthcare system that may not even exist in 2018.

We appreciate that MAP has previously approved limiting some of the originally-proposed first year reporting requirements. In fact, we acknowledge that the regulators serving on MAP have engaged with all interested parties on multiple occasions to address these issues. Still, health insurers would need to scour all claims records to identify, select, and report "denied, rejected or returned" claims at the service line or revenue code level of detail. Not only does the Health MCAS include many more data elements than any other MCAS product, but the sheer volume of health claims processed by health insurers dwarfs the number of claims in other lines of insurance by orders of magnitude.

Health insurers are beginning to implement data collection and reporting systems for what is the most complex MCAS project to date. The Health MCAS for 2017 consists of 18 interrogatories and nearly 1,800 possible separate data elements in 17 classifications of coverage, including detail arrayed by "metal level" for individual, small group, large group, and student insurance coverage on membership, premium, claims, total denials, prior authorization, and appeals by coverage types on all major medical and managed care health insurance, both on and off exchanges/marketplaces.

Yet, before health insurers file any reports with the NAIC, and before state insurance regulators will have even received this information let alone analyzed its meaning, this proposed Health MCAS expansion would require health insurers to reopen and reconstruct those same data

collection and reporting systems. We continue to question the timing of requiring substantial revisions to the first-year Health MCAS while it is still in the initial phase of implementation and before the users of that system can validate that the Health MCAS will produce the intended information desired by state regulators.

Considering the current problems facing the Affordable Care Act exchanges/marketplace, the uncertain business outlook for health insurers, and the attendant operational and reporting burdens being placed on health insurers which includes the initial implementation of the NAIC's Health MCAS, we continue to urge the NAIC not to revise the Health MCAS at this time.

Sincerely yours,

Martin L. Mitchell, Jr.	David I. Korsh
Executive Director, State Policy	Director, State Affairs
AHIP	BCBSA

cc: Mr. John Haworth (Wash.)/Mr. Mark Hooker (W.Va.)

CENTER for ECONOMIC JUSTICE | FAIR ACCESS FAIR TREATMENT

Comments of the Center for Economic Justice

to the NAIC Market Regulation (D) Committee
Urging Adoption of the Proposed Lender-Placed Insurance MCAS

July 12, 2017

The Center for Economic Justice writes to urge the adoption of the proposed Lender-Placed Insurance Market Conduct Annual Statement (LPI MCAS) data elements, definitions and related reporting instructions. The LPI MCAS was the result of numerous open meetings with interested stakeholders. The various issues raised by industry and consumer stakeholders were thoroughly discussed and deliberated, resulting in unanimous adoption by both the Market Conduct Annual Statement Blanks Working Group and the Market Analysis Procedures Working Group. CEJ urges the Market Regulation (D) Committee to adopt the proposals from the working groups for initial reporting in 2019 of 2018 experience.

Background

Although the NAIC has been slow to respond to systemic problems with lender-placed insurance (LPI), the LPI MCAS represents an important step. It is useful to review the abuses in LPI markets in recent years:

- Investigative journalism by Jeff Horwitz exposed the financial interests of lenders and servicers in LPI;[1]
- Provisions in the National Mortgage Servicing Settlement to address unnecessary force-placement of insurance, inadequate and untimely disclosures to consumers and untimely refunds;
- Provisions in the Consumer Financial Protection Bureau's mortgage servicing rule to address content and timing of disclosures before a borrower can be charged for LPI and unnecessary force-placement;
- Investigations by the New York and Florida insurance departments revealing a "kickback" culture following by consent orders prohibiting the kickbacks;
- Changes in servicing guidelines by Fannie Mae and Freddie Mac to stop LPI insurer kickbacks to servicers
- Investigation and consent orders by the Minnesota Department of Commerce
- State insurance departments compelling LPI insurers to dramatically lower excessive rates; and
- A multi-state examination and settlement agreement

[1] "Ties to Insurers Could Land Mortgage Servicers in More Trouble," *American Banker*, November 10, 2010

The work to address problems in LPI markets is not done. As the attached charts show, LPI loss ratios – both LPI auto and LPI home – remain very low and far below voluntary personal auto physical damage and homeowners loss ratios, respectively. The LPI MCAS is a critical piece of effective regulation of LPI markets because it will provide regulators with baseline data on the performance of LPI insurers.

The Proposed LPI MCAS Blank and Definitions

Generally, the LPI MCAS tracks the data elements in the Private Passenger Auto and Homeowners MCAS blanks with a few key changes relevant and necessary for the LPI business. However, the LPI MCAS adds no new categories of data. Like the auto and homeowners MCASs, the LPI MCAS asks about insurance issued and cancelled, premium written, claims and lawsuits.

In support of the proposed LPI MCAS, we offer the following points.

<u>A single data element may be useful in and of itself or in combination with other data elements.</u>

A common refrain from industry during any MCAS drafting session in opposition to particular data elements is that "that data element won't be useful to regulators." As a general proposition, more data is more useful for both data quality review and market analysis. As data reporting becomes more granular, there are more opportunities for examining data quality and more opportunities for analyzing data. Such opportunity is more efficient for regulators and insurers because more time is spent on refined market analysis and less time interacting with reporting companies over data issues. We ask regulators to look at the overall usefulness of particular data elements in concert with other data elements. With this approach, the proposed LPI MCAS is a strong effort for the initial reporting of LPI experience for market analysis.

We urge the D Committee to reject industry calls to eliminate any of the proposed data elements. We also note that each of these issues was discussed and deliberated by the LPI MCAS drafting group, the MCAS Working Group and MAP Working Group with no significant differences of opinion among the regulators.

<u>The proposal to require reporting of all experience for which there is a separate charge to the borrower is reasonable and appropriate.</u>

With most LPI, the LPI insurer issues a policy to the lender/servicer and charges a premium to the lender/servicer only when coverage under that master policy is issued based on the specific coverage issued (e.g. specific auto or property insured). The lender/servicer then typically assesses a charge of the same amount to the borrower to recoup the premium the lender/servicer has paid to the LPI insurer.

There is another type of LPI – called blanket coverage – which also involves the issuance of a master policy to the lender/servicer providing coverage for all vehicles or properties serving as collateral for loans in the lender/servicer's portfolio. However, the premium charge for blanket coverage is based on the total amount of exposure – say, number of vehicles or total outstanding principal amount or total aggregate coverage – on a periodic (e.g., monthly) basis. In some cases, the lender/servicer does not assess a separate charge to the borrower, while, in other cases, the lender/servicer does assess a separate charge. This separate charge for blanket LPI coverage may be a one-time charge at loan origination or a periodic charge throughout the life of the loan.

The proposed LPI MCAS excludes reporting of experience which is a true commercial policy, paid for by the business (lender/servicer) with no subsequent charge to the borrower. But, the proposal does require reporting of blanket LPI for which there is a separate charge to the borrower because such policies now involve the borrower in the same manner as the traditional LPI.

Finally, industry may argue that they sell a blanket policy and don't know if the lender/servicer imposes a charge on borrowers. This concern is easily addressed. The reporting insurer should include all experience other than coverage the reporting company knows / is certain that there is no separate charge to the borrower.

The <u>reporting threshold using gross written premium at the aggregate LPI Home and aggregate LPI Auto categories is appropriate and reasonable.</u>

While we do not believe there should be a reporting threshold, the proposed reporting threshold using gross written premium at the aggregate LPI Home and aggregate LPI auto category levels is reasonable and necessary.

If there is a reporting threshold, the proposal for using gross written premium is appropriate since the net written premium (gross written less refunds) is much less than gross written premium due to the high rate of cancellations in LPI. Consequently, gross written premium is the relevant metric for measuring actual LPI activity.

The proposal for applying the threshold to all LPI Home and to all LPI Auto is also appropriate and necessary and should not be applied at the Single Interest or Dual Interest level or at the LPI Home Hazard, LPI Home Flood and LPI Home Wind thresholds. Application of a threshold at the sub-coverage level will make reconciliation with CIEE totals impossible in some instances because, for example, LPI Home Hazard experience might be reported, but LPI Home Flood and LPI Home Wind Only might not reach $50,000 with the result that the reported data are not available for reconciliation with the CIEE values for LPI Home.

The collection of data on lawsuits, generally, and the inclusion of a data element for lawsuits settled with consideration for the consumer, specifically is reasonable and appropriate.

The proposed LPI MCAS adopts the most current data elements and definitions for suits from the long-term care MCAS blanks. In addition to tightening up the definitions from the earlier auto and homeowners MCAS blanks, one additional data element is added – suit settled with consideration for the consumer.

Some commenters suggested that the data elements/definitions might not be appropriate because they are taken from the LTC blanks and LTC is a different line than LPI. The data elements and definitions for Suits in the LTC blanks are not content-specific to LTCI. Rather, the data elements and definitions are generic for any line of insurance. Indeed, four of the five data elements match those in other MCAS lines with the additional fifth data element included for further clarification and information about suits.

Assurant repeated its objection to the data element Suit Closed During the Period with Consideration for the Consumer, arguing that such reporting could violate confidential agreements and that such reporting would be difficult due to assessment of consideration for the consumer. The first concern is not an issue because no confidential information is released to the public or to the regulator. The data to be reported is a count of suits closed during the period with consideration for the consumer. This count does not reveal which suits were settled versus otherwise closed nor which suits were subject to a confidential settlement. Consequently, reporting of this data element cannot breach a confidentiality order or agreement.

The definition of the data element squarely addresses the issue about how to assess consideration for the consumer:

> **Suits Closed During the Period with Consideration for the Consumer**—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment , benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought

This data element allows market analysts to analyze Suit data more efficiently and effectively by, for example and not limited to, identify situations in which a reporting company experiences a high number of suits with a high number dismissals with no consideration for the consumer (which might indicate frivolous lawsuits or unclear or ambiguous policy language) or situations in which a reporting company experiences a high number of suits with most closed with consideration for the consumer (which might indicate problems with claim settlement procedures).

The collection of data on master policies and individual certificates/policies is reasonable and appropriate.

In the vast majority of states, LPI is sold as a master policy to the lender or servicer. (A servicer is an entity that manages the loan after loan origination on behalf of the owner of the loan. The vast majority of mortgage loans are serviced by mortgage servicers, as opposed to the lender or broker who originated the loan. Since the servicer is responsible for managing the loan, the LPI master policy is issued to the servicer and not the owner of the loan.) These master policies provide coverage for all loans in the lender's or servicer's portfolio – as needed. That is, coverage is issued under the LPI master policy whenever a borrower's voluntary coverage lapses at the time of lapse.

The proposed LPI MCAS includes underwriting data elements for master policies and individual certificates/policies. The reporting of master policy information is useful to regulators for market analysis, since the number of master policies is a general indicator of the number of lenders/servicers for whom the LPI insurer is providing coverage. The number of master policies will not exactly equal the number of LPI clients, but will be close. Consequently, information on master policy counts, as presented in the four data elements, would provide a very good indicator of changes in business beyond the information provided by changes in the number of individual policies/certificates.

The data elements for Flat Cancellations are critically important, reasonable and necessary LPI-specific data elements.

Lenders/servicers force-place LPI when they believe that the borrower's required voluntary insurance has lapsed in order to ensure continuous insurance coverage of the vehicle or property serving as collateral for the loan. A relatively high percentage of LPI coverages are falsely placed, meaning that coverage is force-placed even though voluntary coverage is, in fact, in-force. This false placement can occur for a variety of reasons, including failure of the borrower, her insurer or her agent to provide the lender/servicer with evidence of insurance in a timely manner or an error on the part of the lender/servicer or the lender/servicer's insurance tracking vendor. When LPI coverage is issued falsely and subsequently cancelled because voluntary coverage had been in-force, the LPI insurer cancels the LPI coverage as of the effective date of the coverage and provides a full refund to the lender/servicer. This type of cancellation is called a flat cancellation.

The data elements on flat cancellation are very important for market analysis of LPI. The proposed data elements indicate not only the volume of flat cancellations (which might indicate general problems with insurance tracking if flat cancellation rates are high) but more granular insight by reporting of the timing of flat cancellations. Information on the number and timing of flat cancellations is relevant and important for market analysis for at least two reasons. First, a flat cancellation is not harmless to the borrower. Some LPI coverage charges are far greater than voluntary coverage premium so the impact on a borrower's escrow account and monthly payment amount can be significant and put borrowers in financial distress. Clearly, flat cancellations occurring 25 days after placement pose far less potential harm to borrowers than flat cancellations occurring, say, 105 days after placement.

Second, significant differences in timing of flat cancellations or lengthy industry-average times for flat cancellations may be indicators of poor tracking processes and procedures by a particular insurer and/or the industry. Consequently, it is useful and important to get information on the amount of time between false placements and the flat cancellation.

At this point, it is useful to explain that while lenders/servicers are responsible for insurance tracking (because it is the loan contract that requires the borrower to maintain insurance), the vast majority of loans are tracked by the same LPI vendors providing the LPI. Most LPI vendors provide LPI and a variety of outsourced services to lenders/services and the most common outsourced service is insurance tracking. The point is that LPI insurers are the ones who perform the tracking and the ones who have the flat cancellation information. The fact that CEJ and industry disagree over whether insurance tracking is a reasonable expense to include in LPI rates is not relevant to the issues before MCAS.

<u>The additional data element for complaints received from the department of insurance is important and necessary until such time that NAIC and state complaint coding allows identification of LPI-specific complaints.</u>

The drafting group proposed adding a data element for complaints received from the DOI in addition to the data element found in all other MCAS blanks for complaints received directly by the reporting company. Unlike complaints for all other MCAS lines, current complaint coding does not include an option for LPI or specific LPI coverages. Consequently, there is no automated mechanism for identifying LPI claims. If and when LPI codes are added to the complaint codes, these complaints-from-the-DOI data elements can be eliminated.

<u>The proposal for initial reporting of 2018 experience by June 30, 2019 and subsequent reporting by April 30 of the year following the experience year is reasonable and appropriate.</u>

CEJ does not object to a June 30 reporting date for first year experience, but urges the normal reporting date of April 30 for second and future year experience. While an argument can be made that first year reporting requires new programming and testing by the reporting companies, second year reporting does not require reinventing the wheel and use of the normal April 30 due date is reasonable and necessary for regulators to obtain MCAS data in a timely fashion.

As a placeholder, CEJ requests that a data element for Placement Rate/Penetration Rate be considered for 2019 experience reporting.

The LPI MCAS drafting group considered and declined to include a data element on placement/penetration rate for 2018 experience year reporting, but to consider this data element for 2019 or later experience year reporting. We include this in our comments as a placeholder for discussion later in 2017 or early in 2018.

CEJ strongly urges inclusion of the Gross Placement rate data element. This data element indicates whether LPI is placed on 1% or 20% of borrowers and is a fundamental metric for monitoring the LPI markets as well as consumer outcomes for individual insurers.

Placement rates will vary based on the type of loan, delinquency rate of the portfolio, state and type of coverage, among other things. Placement rates can also vary based on lender/servicer/tracking vendor policies, procedures and competence.

In addition to being basic information about LPI markets, the placement rate – and changes and differences in the placement rates over time and across states and across insurers – is important information for monitoring the consumer outcomes of individual insurers.

We note that in the 2012 NAIC LPI public hearing, the placement rate was discussed by John Frobose of Assurant.[2] At page 3 of the presentation, Mr. Frobose discusses the historic and current placement rates, thereby demonstrating that data on placement rates are an important metric for monitoring LPI markets.

Placement rate is a common metric used by LPI insurers with the data and calculation routinely performed by LPI insurers in the normal course of business. Consequently, the reporting of placement rates will not be burdensome for reporting companies.

Data Element: Average Gross Placement Rate During Period

Data Element Definition: **Average Gross Placement Rate** means the total number of coverages placed before cancellations during the reporting period divided by the average number exposures during the reporting period. Average number of exposures means the average number of vehicles covered by Lender Placed Auto policies or average number of properties covered by Lender Placed Home policies during the reporting period.

[2] http://www.naic.org/documents/committees_c_120809_public_hearing_lender_placed_insurance_presentation_frobose.pdf

LPI Auto, LPI Home Loss Ratios vs
PPA Physical Damage and Homeowners Loss Ratios
2012 - 2016
Compiled by the Center for Economic Justice

Year	LPI Auto	PPA Phys Dam	LPI Auto LR / PPA Phys Dam LR
2012	27.1%	64.5%	42.0%
2013	31.3%	62.4%	50.2%
2014	35.4%	64.1%	55.1%
2015	40.3%	64.6%	62.4%
2016	41.5%	68.4%	60.7%
2012-16	**36.4%**	**64.9%**	**56.1%**

Year	LPI Home	Homeowners	LPI Home LR / HO LR
2012	30.8%	59.1%	52.0%
2013	28.3%	46.7%	60.7%
2014	28.1%	49.8%	56.5%
2015	28.5%	49.9%	57.1%
2016	38.4%	52.6%	73.0%
2012-16	**30.5%**	**51.5%**	**59.2%**

LPI Loss Ratios compiled from CIEE
Auto and HO Loss Ratios compiled from Annual Statement State Pages

LPI Home vs Homeowners Loss Ratios by State

State	LPI Home 2012-16	Homeowners 2012-16	Difference
AK	33.2%	44.7%	11.6%
AL	36.3%	45.9%	9.6%
AR	48.5%	54.3%	5.8%
AZ	26.6%	49.1%	22.5%
CA	25.6%	50.0%	24.4%
CO	32.1%	86.7%	54.6%
CT	34.3%	44.1%	9.8%
DC	32.6%	41.8%	9.2%
DE	63.2%	48.0%	-15.2%
FL	15.2%	28.3%	13.1%
GA	37.4%	59.2%	21.8%
HI	11.4%	26.8%	15.3%
IA	32.0%	48.4%	16.4%
ID	16.9%	58.4%	41.5%
IL	36.0%	65.1%	29.1%
IN	46.3%	60.0%	13.7%
KS	48.2%	47.3%	-0.9%
KY	42.9%	61.1%	18.2%
LA	62.1%	34.9%	-27.2%
MA	31.3%	50.4%	19.1%
MD	27.8%	54.0%	26.2%
ME	29.5%	40.9%	11.4%
MI	46.4%	56.9%	10.5%
MN	30.0%	49.1%	19.1%
MO	52.5%	57.3%	4.8%
MS	43.5%	51.5%	8.0%
MT	31.2%	87.7%	56.6%
NC	27.1%	48.6%	21.5%
ND	33.3%	49.7%	16.4%
NE	50.5%	93.4%	42.9%
NH	28.8%	45.5%	16.6%
NJ	39.5%	57.5%	17.9%
NM	33.1%	58.7%	25.6%
NV	21.6%	49.0%	27.4%
NY	40.2%	49.3%	9.1%
OH	35.0%	51.2%	16.2%
OK	59.3%	66.9%	7.6%
OR	20.1%	48.0%	27.9%
PA	30.4%	51.1%	20.7%
RI	39.4%	50.2%	10.8%
SC	38.1%	44.5%	6.4%
SD	43.3%	80.9%	37.7%
TN	45.8%	58.2%	12.4%
TX	35.0%	58.1%	23.1%
UT	17.0%	49.5%	32.5%
VA	23.4%	45.9%	22.5%
WA	27.3%	53.0%	25.7%
WI	87.6%	46.3%	-41.2%
WV	33.1%	58.0%	25.0%
WY	29.7%	58.5%	28.8%

LPI Auto vs PPA Physical Damage Loss Ratios by State

State	LPI Auto 2012-16	PPA Phys Dam 2012-16	Difference
AK	52.5%	54.7%	2.2%
AL	30.9%	64.0%	33.1%
AR	30.0%	64.3%	34.3%
AZ	41.5%	62.9%	21.5%
CA	52.0%	62.2%	10.2%
CO	39.0%	80.3%	41.3%
CT	50.1%	58.5%	8.4%
DC	33.8%	56.7%	22.9%
DE	29.9%	66.0%	36.2%
FL	32.8%	67.3%	34.5%
GA	12.7%	60.1%	47.4%
HI	34.2%	56.4%	22.3%
IA	48.3%	61.3%	13.0%
ID	35.9%	62.5%	26.5%
IL	27.2%	63.1%	35.9%
IN	38.1%	65.5%	27.3%
KS	45.2%	62.0%	16.8%
KY	41.6%	69.5%	27.9%
LA	40.7%	74.8%	34.1%
MA	34.8%	60.8%	26.0%
MD	29.2%	64.5%	35.2%
ME	46.9%	56.6%	9.6%
MI	47.5%	66.9%	19.4%
MN	37.5%	61.7%	24.2%
MO	40.6%	66.8%	26.2%
MS	31.2%	68.5%	37.2%
MT	44.3%	72.3%	28.0%
NC	29.2%	59.5%	30.3%
ND	35.4%	58.9%	23.4%
NE	41.6%	69.3%	27.7%
NH	35.2%	56.5%	21.4%
NJ	36.6%	61.3%	24.7%
NM	48.9%	63.4%	14.5%
NV	28.2%	62.3%	34.1%
NY	39.7%	71.6%	31.8%
OH	40.2%	60.2%	20.0%
OK	61.9%	66.3%	4.4%
OR	37.3%	64.2%	26.9%
PA	37.9%	66.6%	28.7%
RI	28.1%	64.7%	36.6%
SC	44.7%	66.9%	22.2%
SD	26.7%	80.3%	53.6%
TN	29.6%	63.1%	33.4%
TX	40.0%	70.2%	30.2%
UT	31.4%	63.1%	31.7%
VA	35.9%	62.4%	26.5%
VT	40.5%	60.2%	19.7%
WA	39.6%	60.2%	20.6%
WI	34.5%	62.4%	27.9%
WV	33.1%	59.8%	26.7%
WY	43.2%	68.5%	25.3%

To: Stephen Robertson, Chair;
Allen W. Kerr, Vice Chair;
Laura Cali Robison, Vice Chair,
Market Regulation and Consumer Affairs (D) Committee

From: The undersigned NAIC consumer representatives

Re: 2018 Improvements to the Health Market Conduct Annual Statement

Date: July 14, 2017

The undersigned NAIC consumer representatives write to support the 2018 changes to the Market Conduct Annual Statement for Health endorsed unanimously by the Market Analysis Procedures (D) Working Group on May 23, 2017. The 2018 Health MCAS modifications proposed by the MAPWG fall short of the changes recommended by a stakeholder drafting group that has been working on health MCAS updates for 2018, which we had preferred. Instead, the MAPWG adopted more modest changes proposed by AHIP and the Blue Cross Blue Shield Association. Although we believe that the changes currently being considered by the D Committee should have gone further, we offer our support for them as improvements to the 2017 Health MCAS. We ask you, however, to not further weaken or delay these changes, but rather to allow the process of improving the Health MCAS to continue.

The changes to the Health MCAS approved by the MAPWG would require carriers to report the number of claims they denied in each market in which they participate for five categories of claims denials. Carriers would be required to report medical necessity denials for mental health and for non-mental health services (two of the five new categories) as well as data on prior authorizations requested and denied for mental health and for medical services. These data would facilitate mental health parity compliance oversight by state regulators.

The recommended changes to the Health MCAS were developed by a drafting group chaired by John Haworth, chair of the MAPWG. The drafting group included regulators, a market analyst, and representatives of insurers, trade groups, and consumers. The deliberations of the group were actively monitored by representatives from the Department of Labor and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services. The drafting group met numerous times by conference call during 2016 and 2017 and thoroughly discussed proposed changes to the Health MCAS.

The drafting group originally recommended that the Health MCAS be updated to require the reporting of twelve categories of denial codes, including an "other" category, which would together capture all reasons given by insurers for claims denials not captured by the other eleven. Preliminary analysis indicated that the "other" category would include relatively few claims denials, but the drafting group recommended an interrogatory to gather more information regarding the claims denials that fell into this category.

While we are willing to accept the AHIP and BCBSA proposal for collecting data on five categories for 2018, we still believe that collecting data on the twelve initial categories is

preferable. Although the original MCAS health blank collected data on the total number of denials, that information is of less value for market analysis than more granular information on the reasons why insurers have denied particular claims. The lack of specific denial information was recognized as a major gap in the 2017 blank in MAPWG discussion of the Health MCAS proposal in 2016, but the pressure of time to get the blank in place made it impossible to develop a classification system for the 2017 blank version. The recommended 2018 changes would have provided the needed denial code granularity. We continue to believe that the dozen categories of denied, rejected, and returned claims identified by the Working Group are appropriate and would give regulators a comprehensive overview of the claims denial practices of particular carriers. Data on denials would provide a sound basis for market analysis, and in particular for identification of outliers.

The drafting group discussed the twelve proposed denial code classifications with Maryland. Maryland has collected denial code information for many years using a very similar classification. Maryland reported that carriers have not had significant problems reporting codes.

The Departments of Labor and Treasury have proposed revisions to the form 5500, which collects information from group health plans, to begin collecting claims denial information from ERISA plans beginning with 2019. The Centers for Medicare and Medicaid Services have also been considering the collection of denial code information from qualified health plans. By adopting the proposed coding classifications for 2018, the NAIC could have gotten out of the gate first on denial code classification, with the federal government likely to follow. This would have preserved the primacy of state regulation and reduced the burden imposed on carriers of having to report denial codes using multiple classification schemes. By focusing only on a subset of denial codes, the NAIC may be forfeiting its opportunity to establish state leadership on this issue, but the revision proposed by the MAPWG will at least show that the NAIC is aware of the issue of denial code classification and beginning to work on it.

As already noted, the 2018 Health MCAS changes would also begin the collection of data on medical necessity denials and prior authorization requests, approvals, and denials for mental health, behavioral health, and substance use disorder services. They prohibit carriers from imposing qualitative or quantitative limits on mental or behavioral health or substance use disorder services that are not imposed on medical services.

The mental health parity laws are independent of and predate the Affordable Care Act, and Congress is not considering their repeal. Indeed, the current administration recently released a FAQ with a draft form that could be used by health plan applicants, enrollees, and state regulators for requesting information on health plan non-quantitative limits on mental and behavioral health services. Many states have also adopted mental health parity requirements into state law. Given the current opioid epidemic sweeping much of the country, coverage of these services is more important than ever.

The additional Health MCAS questions on mental health, behavioral health, and substance use disorder services would give market analysts the necessary information to determine whether plans are complying with federal and state requirements. We assume that carriers are already tracking this information to ensure their compliance with federal and state law and will not be unduly burdened in providing the information to the MCAS.

We urge you to adopt the changes unanimously approved by the MAPWG.

Signed

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