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John Haworth, Chair (WA)
Market Analysis Procedures (D) Working Group
c/o Randy Helder, NAIC
Via RHelder@naic.org

RE: Consider Adoption of Disability Insurance MCAS Proposed Scorecard Ratios

Dear Chairman Haworth & Members of the Working Group:

Thank you for the opportunity to review revisions and updates recently made to the proposed ratios for a new Disability Income Market Conduct Annual Statement.

Disability Income Insurance Data Call and Definitions Adoption

To better understand recent history related to the drafting of the disability income MCAS Ratios, the ACLI reviewed the minutes adopted 7 August 2018 and reported to the NAIC Executive/Plenary meeting that occurred during the 2018 Summer National Meeting. The minutes reflect that the Data Call and the Definitions for Disability Income were adopted at that meeting.

Pages 171 through 185 of the minutes contain the adopted Data Call and Definitions. This content also appears on the Working Group's webpage (within the Related Documents tab). Accordingly, ACLI better understands that the Working Group's current effort to draft related disability income Ratios must be done in a manner that aligns with the approved Data Call and Definitions components.

However, as the ACLI seeks to understand the NAIC process for the development and vetting of new MCAS lines, we question why Ratios are not constructed in conjunction with the development of the source Data Call and Definitions. Insight regarding the NAIC process in this area is welcomed.

Disability Income MCAS Ratios

To supplement the general observations noted above, the ACLI offers the following additional, specific comments and questions regarding certain ratios. The ACLI also encourages the working group to further define what "paid" means and what "denied" means and it requests the Working Group include specific examples or scenarios. For example:

- If an insured seeks payment for a disability that began in January and ended in November and the carrier denied payment for January through March (consistent with a waiting period within the contract) but paid a benefit for the period of April through

November, has the claim been paid or denied? For a given disability, some insurers may utilize one claim number for the duration of the disability. In other words, if an insured seeks payment for a disability that began in January and ended in November and the period of January through March is excluded (consistent with a waiting period within the policy) but the remainder of the disability period (April through November) is covered and the benefit is paid, the industry contends that this claim is paid pursuant to the policy. Does the Working Group agree that the claim has been paid?

- What about claims that are paid for a period of time and are then no longer covered under the policy due to the claim status changing from short term to long term due to the time that has elapsed? It is not uncommon for an insured with individual coverage to qualify for short term benefits but then later fail to continue to meet eligibility for continued, long term benefits if the claimant can return to work in another occupation. The industry contends that this claim is paid pursuant to the policy. Does the Working Group agree?

- What about a claimant/insured who met the contact's definition of 'disabled' and who received benefits for a period of time (for example, benefits were paid for January through November) before the claimant's physician cleared the claimant to return to work and, accordingly, no further benefits were paid. Would that be considered a paid claim or denied claim? Benefits were paid for part of the year but they were also denied for part of the year.

Regarding select ratios, the ACLI offers the following additional comments and questions:

- Ratio #1: Percentage of claims denied. The denominator includes "paid" and "closed" claims. Based on the "Market Conduct Annual Statement Disability Income Insurance Data Call & Definitions" document approved during the NAIC summer 2018 meeting, a more appropriate denominator would perhaps be: "Claim denials during reporting period" + "New paid claim determinations during reporting period."

- Ratio #6: The number of complaints relating to group policies to average number of group policies in force during the reporting period. More insight regarding this ratio is desired. What will this ratio measure and what value or insight will be derived from its use given the fact that complaints are at the individual, not group, level? One policy can have 20,000 members and 10 policies can have 80 members. Measuring at the policyholder level without regard to the number of insured members does not appear to have statistical value and is likely to result in incorrect or misleading conclusions. It would seem more appropriate to measure the number of complaints related to group policies to the total number of individuals insured under group policies, not the number of group policies.

- Ratio #7: The percentage of lawsuits closed with consideration for the consumer. More insight regarding this ratio is desired. What will this ratio measure and what value or insight will be derived? The "number of lawsuits closed with consideration for consumer" is not a measure of wrong-doing or fault on the part of insurer. On the contrary, some litigation efforts result in a good-will settlement to limit a company's exposure to negative publicity even when the carrier had no wrong-doing. Other litigation matters may be settled due to economic interests—a balancing of the cost of continued litigation with the cost of settling the claim (with payment in whole or in part). Litigation that results in consideration for the consumer does not equate to, nor correlate with, carrier malfeasance. For this reason, any data obtained from such a ratio would be both misleading and irrelevant in ascertaining a carrier's level of compliance with insurance regulations or its adherence to contract provisions. Such erroneous information could lead to increased frivolous litigation. This ratio should be omitted.

- Ratio #8: Non-renewal and cancellations to average policies in force. Does this ratio pertain to individual coverage only? If yes, that should be noted within the ratio. With regard to group insurance, in many cases, there are limited reasons for termination of such coverage. Such reasons may include: failure to pay premium, falling below the minimum number of lives, or the group's election to not renew the coverage.

- Ratio #9: Covered lives affected by non-renewals to average policies in force. The construct of ratio #9 is problematic. With group coverage, a non-renewal or a cancellation occurs at the group policy level, not at the individual insured level. Additionally, the ratio becomes even more skewed if the insurer's groups are disparate in size. For example, the nonrenewal of an exceptionally large group may result in a ratio that does not accurately reflect the true experience of the carrier's overall group business. Similar to the comments offered above, there are limited reasons for termination of such coverage. Such reasons may include: failure to pay premium, falling below the minimum number of lives, or the group's election to not renew the coverage. For these reasons, an alternative ratio should be considered. If this ratio is needed, the focus should be on nonrenewals resulting from actions taken by the insurer, not the group, though we struggle to understand what scenarios would fall into that category.

- Ratio #10: Average pending benefit determinations to claims received. The usefulness or purpose of this ratio is unclear. If claims are managed appropriately (meaning, they are processed within state standards for timely claim processing) of what significance is the average pending determination?

Recommendation of the ACLI

The ACLI appreciates the sense of duty the members of the NAIC working group may have to decide Disability Income Ratio factors this month in order to proceed with data gathering and analyses next year. We support MCAS ratios for use as one of the tools state regulators may consider when evaluating insurers. It is important that these tools use appropriate indicators so as to allow regulators to identify potential concerns and risks with proper focus to achieve clarity about insurance company activities. The ACLI respectfully observes that proceeding in a manner where evaluation of the Ratios has illuminated errors in the Definitions but then marched in combination to market, likely will lead to data collections and analyses which might be useless at best, and possibly even misleading.

Consequently, the ACLI requests postponement of the adoption of the Ratios and reconsideration of the Definitions and Data Call elements in a new, conjoined consideration. Should this request be unacceptable, the ACLI respectfully requests that the inclusion of Disability Income in MCAS be accompanied with a specific sunset of 31 December 2025. This would enable the NAIC to proceed with Disability Income within MCAS on an experimental basis for a period of time sufficient for all interested parties to evaluate its efficacy.

The Intent, Purpose, and Future Direction of MCAS

The investigations, considerations and discussions among ACLI members about this matter have led to more general concerns about the operation of the Market Conduct Annual Statement. Once upon a time, many years ago, insurance companies were troubled that market conduct examinations of a company might be undertaken severally by different states, without coordination, at substantial company expense. Regulators responded to the concern and consequently organized coordinated, multi-state examinations.

Multi-state examinations helped to relieve some redundancies and improved the regulatory environment but did not necessarily make examinations more risk-focused on company practices easily understood to be unacceptable. This led to creation of a statistical targeting mechanism, i.e., a market conduct annual statement based upon data collection followed by statistical analyses. The new system created a mechanism automatically spotting company practices anomalous to generally acceptable market conduct. Regulators could then efficiently focus examination upon the anomalous company practices.

The MCAS was first built to collect and analyze data on lines of insurance business which are mandated by law to be purchased by consumers. Mandated insurances have heightened consumer protection considerations because they are mandated. Mandated insurance coverages have statutory requirements standardizing the coverage for all consumers enabling meaningful data collection, analyses and identification of anomalous behavior by MCAS.

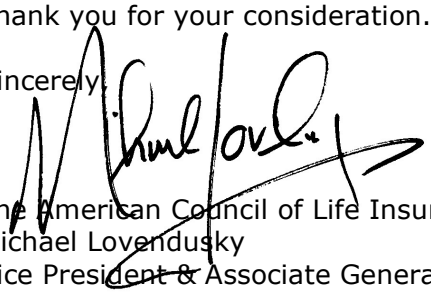
What the ACLI believes all interested parties might be learning from the effort to include Disability Income in MCAS is that its effectiveness may be less than for other lines. With all good intention we might be trying to force MCAS on a line where it will not lead to the same mutually desired result of more efficient and risk-based examinations.

The ACLI is concerned that non-mandated, lines of insurance, such as life and disability income, may not fit within the MCAS mechanism. Because these lines are sold, not bought, the products and product management are not standardized. Data collection about them might be useful or it might generate numerous false positives. If numerous false positives are generated from MCAS data elements, definitions or ratios, they will mislead regulators to examine companies for statistical anomalies which are anomalous because they relate to non-standardized products or product managements. At some point the wisdom of cost-benefit analysis of including the life insurance line in MCAS arises.

The ACLI respectfully signals concern here that the Disability Income shoe may not fit. More time might beneficially be taken now to improve the fit, perhaps delaying data collection by a year. Alternatively, we shall proceed together in a test which, if unsuccessful, might prove that niche, supplemental and specialty lines of insurance, generally, do not fit within the MCAS.

Thank you for your consideration.

Sincerely,



The American Council of Life Insurers
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