Comments of the Center for Economic Justice

to the Pet MCAS SME Group

April 3, 2023

CEJ offers the following comments on issues identified in Hal's 3/31/23 e-mail.

Data regarding Pre-existing Condition Exclusions ("pre-x")

As a preliminary comment, MCAS is a data-reporting tool. Analysis of MCAS data may trigger follow-up questions or targeted exams regarding particular outcomes for the company or industry. For example, "what triggers a pre-x review?" is not an appropriate or useful interrogatory for MCAS for a few reasons:

- Representation by industry that all claims are reviewed for eligibility with such review including pre-x condition means no useful information in insurer responses;

- The question about pre-x triggers should be triggered by unusual MCAS pre-x data ratios – just like any claims-related outlier MCAS ratio; and

- Each non-data question requiring a narrative answer means more manual labor requirements for the insurer and slower MCAS submissions. An insurer can automate a data report reflecting data pulled from a database, but a question requiring a narrative response can only be automated though the use of a ChatGPT-like artificial intelligence tool, which would not produce a reliable response at the current time.

A data-driven approach would add three new data elements – two for underwriting and one for claims.

- Number of policies issued during the included a pre-existing condition exclusion
- Number of certificates issued during the period that included a pre-existing condition exclusion

and

- Number of claimant requests denied during the period for a pre-existing condition

    (See discussion below for "claimant request" versus "benefit request")

Regarding the specific items mentioned in Hal's 3/31/23 memo:

➤ Interrogatory: What triggers a pre-existing exclusion review (e.g., dollar, diagnosis, prescription, other)? Delete – see discussion above.
➤ Interrogatory: Does the company have a pre-existing exclusion in its product? Delete – question is better answered by addition of data elements indicating both whether and to what extent a pre-x is used.
➤ Interrogatory: Does the company have a threshold for applying the pre-existing exclusion review? Delete – see discussion above. This is more appropriate as a follow-up based on outlier pre-x outcomes.
➤ Interrogatory: For those products that contain a pre-existing condition exclusion, what triggers a pre-existing exclusion review of a claim (e.g., dollar, diagnosis, prescription, other)? Delete – same as first rog above.
➤ Interrogatory: What percentage of your business has pre-existing exclusions? – Delete – this information is better – far better – obtained through data elements. This percentage can be calculated from the proposed data elements above.
➤ Claims: Number of claims on a policy/certificate that has a pre-existing condition exclusion. Yes, but see proposed data element above and discussion of "claimant request" and "benefit request," below.

Tune-Up Underwriting Data Elements – X-out Certain Cells for Which No Data Exist

The current draft requests a number of data elements two or three times (e.g. in force at beginning of period):

- Policies
- Certificates
- Pets Covered

The current draft also contains two columns – one for individual policies and one for group policies.

X out the "individual" column cell for any question regarding certificates only because a certificate is only issued from a group policy.

For a data element asking for information about both policies and certificates (policies and pet lives), neither column would be x-ed out, since there could be a response in both columns.

Tune-Up Underwriting Data Elements – Specify Time Frame for Certain Data Elements

The following data elements refer to experience at a point in time:

- In force at beginning of period (data elements 30, 31 and 32)
- In force at end of period (data elements 64, 65 and 66)
- Applications pending beginning of period (data element 71)
- Applications pending end of period (data element 80)

Other data elements refer to experience "during the period." The following data elements simply refer to "policies in force" or "certificates in force" without a reference to a point-in-time or any timeframe:

- Include accident-only coverage (data elements 33 and 34)
- Include illness-only coverage (data elements 35 and 36)
- Include accident and illness coverage (data elements 37 and 38)
- Include wellness coverage (data elements 39 and 40)
- Include wellness as insurance benefit (data elements 41 and 42)

These data elements require the addition of a time reference.

We suggest converting these data elements from "policies (or certificates) in force" to "policies (or certificates) issued during the period.

Another option is to change these data elements to refer to "in force at beginning of period" and add corresponding data elements for "in force at end of period."

Tune-Up Claim: Distinguish Between Claimant Requests and Benefit Requests

Tune-Up Claims: Retain Four Columns Clearly Defined as Coverage and Not Types of Policies

In prior SME calls, industry explained that, like long-term care insurance, a pet insurer receives a claim request and determines both initial eligibility for benefits and on-going determination of benefit requests from this claim. Consequently, a "claimant request" requiring determination of eligibility may be accepted or denied and subsequent "benefit requests" may also be accepted or denied. Failing to distinguish between these two categories of claims means that "claim" denial data could refer either a claimant request or a benefit request rendering the "claim" data compromised for data analysis.

Separating out "claimant requests" from "benefit requests" is critical to distinguish between different types of claim denials AND critical for analyzing "claimant request" denials for accidents versus illness. As noted in a previous comment, the NAIC Pet Insurance Model Act does not define "illness" or "accident." Rather, the model defines pet insurance as providing coverage for "accidents and illnesses." However, the model law does include provisions that distinguish between accidents and illnesses. For example, waiting periods are permitted for illnesses, but not for accidents. Two definitions -- congenital anomaly or disorder and hereditary disorder -- specifically refer to illness. Consequently, regulators drafting the model understood the terms "accident" and "illness" to be sufficiently clear that definitions of these terms were not needed AND clearly recognized different treatment of claims based on accidents versus claims based on illnesses.

Consequently, it is relevant and necessary to ask insurers to report "claimant request" denials broken out by accident or illness. Since claimant request denials based on a pre-x are not possible for clams resulting from an accident, it is necessary to distinguish claimant request denials for accidents from illnesses (for which a pre-x exclusion may apply.)

We suggest limiting this break-out for accident versus illness to claimant requests – no accident vs. illness breakout for benefit requests – at this time.

First, insurers participating in the SME have represented they do not consider whether a claim is for an accident or illness. This makes sense following the approval of an initial claimant request, but not for the initial claimant request. For the initial claimant request, the insurer must apply different criteria for an accident claimant request than for an illness claimant request. Once the claimant request is granted, there would seem no business purpose in tracking benefit requests by accident or illness.

Second, once the initial claimant request is granted, there is no obvious reason why there would be a disparity between benefit request outcomes for accident or illness and no clear eligibility distinctions for accident versus illness benefit requests (following the granted claimant request). While we acknowledge that a disparity is possible and the only way to identify such a disparity is to collect the relevant data, we suggest the initial version of the Pet MCAS limit the break-out between accident and illness to claimant requests, largely in recognition of industry representations about their practices.

Based on the above, we suggest the following:

- Break the current "claims" schedule into two schedules "Claimant Requests" and "Benefit Requests;"

- Modify to the definitions and data elements for "Claimant Requests" and Benefit Requests" from the LTCI MCAS blank;

- Utilize three columns for "Claimant Requests" – Wellness, Accident and Illness; and

- Utilize two columns for "Benefit Requests" – Wellness and Accident & Illness

The LTCI MCAS provides a solid template for this type of claim and benefit arrangement through two schedules -- Claimant Requests (e.g., LTC MCAS 2021 items 31 to 46 for initial determination of eligibility for benefits) and Benefit Payment Requests (e.g. LTC MCAS 2021 items 47 to 58 for requests for benefits once eligibility has been granted).

Third Party Complaints

Hal's memo refers to the following interrogatory

Does the company require third parties it contracts with to forward insurance-related complaints to the company so the company may report the complaints in its complaint logs? If yes, does the company monitor the third parties to ensure insurance complaints are forwarded to the company?

> *There is concern about confusion related to the definition of "third parties". Companies may use third parties for areas of business that do not impact consumers. Companies may define third parties differently and lead to varied reporting.*

We suggest that this issue is best handled by tweaking the data element and definition of the existing data element "Number of complaints received directly from any person or entity other than the DOI. We suggest revising the data element to:

Data Element: Number of complaints received directly by the insurer from a consumer or through a producer or any third party utilized by the insurer.

<u>Definition</u>: Report the number of complaints received from any source other than the Department of Insurance. Direct sources include any mechanism established by the insurer for a consumer to communicate a complaint, such as e-mail, letter, social media or phone call. Indirect sources include any mechanism by which a producer or third party utilized by the insurer collects and transmits to the insurer a consumer complaint. Indirect sources may include, for example, a producer, pet retailer, veterinarian or third party administrator. If a consumer makes the same complaint through multiple sources (other than the DOI), report one complaint. For example, a consumer complains about a benefit request denial by writing to the pet insurer's third party claims administrator and directly to the insurer. Count this situation as 1 (one) complaint in this data element.