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Comments for the Center for Economic Justice

To the NAIC Market Analysis Procedures Working Group

Response to AHIP and ACLI Comments on Proposed Disability MCAS Scorecard Ratios

August 26, 2019

Summary

At the Summer National Meeting, the Market Analysis Procedures Working Group (MAP WG) requested technical comments on proposed scorecard ratios for the Disability Income MCAS line of business. The request for comments was so limited because the ratios had been fully vetted by a drafting group consisting of industry, regulator and consumer stakeholders over numerous phone calls during which every industry suggestion and concern was considered.

The comment letters submitted by AHIP and ACLI comment letters go far afield of the request for comments. The bulk of the AHIP comments are a request to clarify or reconsider data elements. In addition to being non-responsive to the MAP WG request for comments, ***the requested action is beyond the scope of the MAP WG's charge*** and is properly directed to the Market Conduct Annual Statement Working Group (MCAS WG) for any needed clarification of data elements and definitions.

The ACLI letter goes even further afield – questioning data elements, definitions, the MCAS process, even the application of MCAS to life insurance and disability insurance – while inexplicably seeking a delay in reporting. Mr. Lovendusky's comments on behalf of ACLI, instead of technical comments on the proposed scorecard ratios, questions not only the ratios themselves, but also questions the data elements and definitions adopted over a year ago.

Displaying no shame for a blatant effort to obstruct regulatory data collection to monitor the disability income insurance market, ACLI, based on egregiously false assertions about lack of clarity, requests a delay in collection of Disability MCAS data. Apparently, ACLI believes it can make regulators jump to their commands, no matter how ridiculous. ***In any event, the changes requested by ACLI are based on false claims, without any evidentiary support, beyond the scope of the request for comments and beyond the scope of the MAP WG charges. The ACLI comments must be rejected.***

Background

The Disability MCAS data elements and definitions were adopted – after development by a drafting group convening many times over many months with full industry participation – by the Market Regulation (D) Committee on July 10, 2018 (over a year ago). The minutes of that D Committee call state:

> Ms. Ailor said the Market Conduct Annual Statement Blanks (D) Working Group began drafting the Disability Income MCAS Data Call and Definitions in 2017 and adopted the data call and definitions on May 16, 2018. Ms. Ailor said the Disability Income MCAS Data Call and Definitions were developed with subject-matter experts (SMEs) of regulators, industry and consumers. Ms. Ailor said the development was coordinated with the Market Analysis Procedures (D) Working Group.

The issue before the MAP WG is the adoption of proposed scorecard ratios. Like the data elements and definitions, the scorecard ratios were developed by a drafting group meeting regularly and with full industry participation. Every concern of industry was considered. The ratios were fully vetted and ready for adoption at the Summer 2019 National Meeting, but industry requested more time for comments. The working group agreed to additional comments limited to technical comments on the ratios. The draft minutes of the meeting state:

> Birny Birnbaum (Center for Economic Justice—CEJ) said the industry representatives have been involved in the creation of the ratios for the last three of four conference calls, and they have had the opportunity to discuss with their member companies. He noted that there are no unexpected implications to companies by adopting the ratios because the actual data elements of the MCAS blank have not changed.
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> Randy Helder (NAIC) said the ratios need to be adopted by September to allow enough time to program them into the MCAS system for next year. Ms. Ailor said the Working has some time to request comments and decide by September. Ms. Dingus suggested that the Working Group could schedule its next conference call in the last week of August. Mr. Haworth agreed to set a conference call of the Working Group for the last week in August to consider adoption of the ratios. ***Mr. Birnbaum said comments should be limited to technical changes and not be allowed to question whether a ratio should be removed. Ms. Burns said there were no concerns with the ratios, and their comments would only be technical in nature.***

AHIP Comments

Despite Ms. Burns' promise on behalf of AHIP, Mr. Cashdollar's comment letter on behalf of AHIP is devoted to questioning data definitions and re-litigating ratios.

Ratios 2 and 3[1]

AHIP's purported comments about Ratios 2 and 3 are, in fact, not about the ratios. Rather, AHIP asks for clarification of a data element – when is a claim "received" and complains that long-term disability insurers cannot make initial claim decisions within 90 days. AHIP, despite full industry participation in the development of the data elements and definitions from 2017 to 2018, now asks to revise the data elements involved in Ratio 3. These comments, if they are to be addressed at all, should be addressed to the MCAS WG for any needed clarification of data definitions. ***For purposes of the MAP WG's adoption of the proposed scorecards, the comments are irrelevant and beyond the scope of the working group.***

Ratio 6[2]:

Despite being fully vetted by the drafting group, AHIP asks that Ratio 6 be eliminated. ***Again, despite the WG's request for technical comments, AHIP seeks to re-litigate a ratio.*** Ratio 6 is one of three complaint ratios:

- complaints for individual disability policies to number of individual policies (which is the same as number of lives in-force) (Ratio 4)
- complaints for group policies to number of lives in force on group policies (Ratio 5)
- complaints for group policies to number of group policies (Ratio 6)

These three complaint ratios provide different and complementary information. It is reasonable and necessary to develop complaint ratios separately for individual and group products because a ratio combining the complaint experience will lead to unreliable results that are not comparable across companies.

With individual policies, if the policyholder wants to register a complaint, it will be filed with the insurance department, producer and/or insurer. (For purposes of the ratios, we ignore the possibility of a complaint to another regulatory agency or third party organization – like the Better Business Bureau.)

[1] Ratio 2 is Percentage of claims processed with initial decisions after 45 days for short term coverage. Ratio 3 is Percentage of claims processed with initial decisions after 90 days for long-term coverage.

[2] Ratio 6 is the number of complaints relating to group policies to average number of group policies in force during the reporting period.

With group policies, the employer or the group organization is the policyholder and the individual insureds are the employees or group members to whom a certificate has been issued. In addition to the possibility of filing a complaint with the insurance department or insurance company, a certificate holder may also file the complaint with the employer or group administrator. In such a scenario, a significant number of certificate holders might encounter the same issue and complain to the employer or group administrator, who then files a single complaint about the common issue to the insurance company.

Further, individual and group products are sufficiently different to expect different complaint frequencies. We expect a higher frequency of complaints for individual policies because the insured is more actively engaged with the policy administration (application, underwriting, billing, coverage) than a certificate holder is with a group policy as the group policyholder makes many of the decisions that an insured under an individual policy is required to make.

Complaint frequencies for group products should be generated on the basis of both covered lives and average policies in force. To illustrate, assume companies D and E both have complaint ratios calculated on the basis of policies and both have 100 group policies in force and both have a 1% complaint ratio. But company D has 50,000 covered lives while company E has 5,000 covered lives. In this example, company E is producing a much higher frequency of complaints per covered life than company D. While this piece of information alone is not dispositive, it is very useful to supplement and interpret the related ratios.

If, after a few years of experience, individual and group product complaint frequencies are the same, the ratios can be simplified. But, initially, the more refined ratios are necessary to identify whether there are significant differences in complaint frequencies – as expected – between individual and group products.

Ratio 8:

AHIP requests the title of the ratio be changed from "Non-renewals and cancellations to average policies in force" to "***Insurer*** non-renewals and cancellations to average policies in force." CEJ has no objection.

Ratio 9:

AHIP requests the title of the ratio be changed from "Covered lives affected by non-renewals to average policies in force" to "Covered lives affected by **insurer** non-renewals to average policies in force." CEJ has no objection.

ACLI

Far from comments limited to technical issues with proposed Disability MCAS ratios, ACLI's letter offer comments on many things other than the proposed ratios. The ACLI comments must be rejected.

ACLI starts by questioning the MCAS development process, suggesting that ratios should be developed simultaneously with data elements and definitions. Putting aside the fact that Mr. Lovendusky did not participate in either the development of the data elements and definitions or the development of the ratios, his "I know better than everyone else" approach is unsurprisingly uninformed. As anyone who participates in the development of MCAS data elements and definitions knows, the usefulness of a data element and its potential use in a scorecard ratio are integral to such development.

ACLI's next comment is a request for definitions of "paid" and "denied." Again, putting aside the fact that these terms are explicitly defined in the data element definitions, these comments are unresponsive to MAP WG's request and the requested actions are ***outside the scope of the MAP WG and should be addressed to the MCAS WG.***

ACLI, without the benefit of participating in the extensive discussions during numerous conference calls to develop and refine the ratios suggests changing Ratio 1 – Percentage of claims denied. ***ACLI offers no rationale or explanation for the proposed change. The proposal must be rejected.***

ACLI, again without the benefit of participating in the extensive discussions during numerous conference calls, questions Ratio 6 – "More insight regarding this ratio is desired." We suggest the working group refer Mr. Lovendusky to the CEJ comments on the complaint ratios earlier in this comment letter. ***In any event, ACLI's effort to re-litigate the ratio is inappropriate and must be rejected.***

Regarding Ratio 7, percentage of lawsuits closed with consideration for the consumer, ACLI seeks to re-litigate both the data element and the related definition. ***ACLI's request is outside the scope of the MAP WG and must be rejected.***

Regarding Ratio 8, non-renewals and cancellations to average policies in force, Mr. Lovendusky asks if the ratio pertains to individual coverages – a question he could answer by simply looking at the Disability MCAS Data Call and Definitions. The ratio will be calculated for individual and group coverages. The application to individual and group coverages is important. In combination with Ratio 9 for group coverages, Ratio 8 provides a holistic view of non-renewals and cancellation by relating them to group policies (Ratio 8) and to covered lives on group policies (Ratio 9). ***ACLI's comment must be rejected.***

Regarding Ratio 9, covered lives affected by non-renewals to average policies in force for group coverages only, and again without the benefit of participating in the extensive discussions during numerous conference calls, Mr. Lovendusky questions the value of this ratio. Ratios 8 and 9 are complementary. Ratio 8 relates non-renewals and cancellation to average policies in force. For individual coverages, Ratio 8's denominator – average policies in force – is the same or similar to covered lives. For group coverages, Ratio 8 does not relate non-renewals and cancellations to covered lives – hence, the inclusion of Ratio 9 which does. ***ACLI's comment must be rejected.***

ACLI questions the usefulness of Ratio 10, average pending benefit determinations to claims received. ***ACLI's uninformed attempt to re-litigate the ratio is outside the scope of the request for comments and must be rejected.***

Based on ACLI's false claims about errors in data definitions, ACLI asks that the adoption of ratios be delayed and data definitions be reconsidered. ACLI has provided no actual evidence of errors in data definitions. Instead, the ACLI comment letter is an uninformed drive-by attack on all things MCAS. ***The request for delay and reconsideration must be rejected.***

Finally, not content to obstruct Disability MCAS ratios, ACLI concludes its diatribe by arguing that MCAS isn't needed for life insurance and annuities, based on a false history of the purpose and development of MCAS. ***Clearly, these comments are not appropriate and must not be considered by the MAP WG.***