To: Maria Ailor, Chair, Market Conduct Annual Statement Blanks (D) WG

From: Brent Kabler, Missouri Department of Insurance, Financial Institutions & Professional Registration

RE: Health MCAS

March 29, 2019

The following comments pertain to the items on "Attachment 2" from the materials distributed for the March 28 conference call, entitled **Recap of Clarifications and Decisions.**

Item #2: Agreed to review whether to post the Health MCAS scorecards for the 2018 data year.

As I noted during the call, I think it would behoove the WG to develop formal standards to govern the release of the aggregate data to ensure that 1. it is unlikely that any one reporting entity's data could be identified and 2. decisions re whether to release or withhold data don't have even the appearance of arbitrariness, but rather conform to generally accepted standards. Note that I am not taking a position on whether the company-level data *should* be confidential, which is probably a matter that is not within the WG's purview. I am just advocating for a non-arbitrary procedure to ensure that the data can be released given that company-level data *are* deemed confidential under the current procedures. I don't think simply withholding all data is a satisfactory solution. However, the Health MCAS data are particularly problematic due to the low numbers of market participants overall and also because of how thinly the markets are sliced into narrow categories, so that careful consideration should be given to the manner and format of any data release.

Fortunately, there are generally accepted confidentiality standards that govern data handling for most federal agencies. These standards are designed to minimize the probability that public data could be used to identify individuals that make up the data. For example, if a particular data cell was comprised of only two individuals, each could identify the data of the other simply by subtracting their own data value from the total. If a cell were composed of three individuals, two of those individuals could act in concert and identify the values of the third. If a cell total is dominated by a single individual (say, their data value comprised 80 percent of the total), then the aggregate value itself is a good approximation of that individual's value, regardless of the number of individuals that contribute to the total.

I recommend that a small group be formed to develop a formal proposal governing such standards. The following serves as a good reference re the federal standards:

OMB, Federal Committee on Statistical Methodology. 2005. **Statistical Policy Working paper 22 (Second Version).** Available at https://www.hhs.gov/sites/default/files/spwp22.pdf

#7. **Agreed to consider using the Financial Annual Statement (FAS) Schedule T definition of "situs."**

I'm not entirely sure what the purpose of this suggestion is. The current MCAS definition is taken from the Supplemental Health Care Exhibit (SHCE). To the extent that there are any substantive differences between the two definitions, I would argue that the SHCE definition should be retained. The SHCE captures many of the same line of business categories as does the MCAS, and is the exhibit to which the MCAS should most closely reconcile (see # 8 below).

#8 Agreed to revise the FAQ to remove the health line of business from the guideline that premium deviations more or less than 20% of the FAS Supplemental Health Care Exhibit (SHCE) should be explained. NAIC will include possible reasons for deviations in regulator training programs.

I don't agree with this recommendation. If the same allocation methodology is employed for both the SHCE and the MCAS, premium amounts should be roughly the same. fs Only the timing of the calculation should produce differences between the data sets, and I can't see how timing alone should produce differences in excess of 20 percent. Perhaps there is something I'm not understanding here, but I think it might be helpful for the WG to revisit this decision if only briefly. The data quality problems of the prior submission of the health MCAS rendered the data largely unusable. Removing any way to reconcile the data against other reports will only make data quality issues worse.

#21 Agreed that duplicate claim service lines are not required to be reported.

I recommend a stronger standard so that any implied discretion about how to report duplicate claim lines between reporting entities is removed. Simply make it a requirement that duplicate claim lines **should not** be reported. Currently, the FAQ indicates that duplicate claims **should** be reported:

"Duplicate claims should be reported. The reporting of duplicate claims accounts for all decision made on claims. A duplicate claim may have a different result (payment or denial) than the original claim."

Whatever the treatment of duplicate claims, I strongly encourage the WG to adopt a consistent standard for all carriers. I would make the case that duplicate claims **not** be captured, and only the final disposition of the claim report (i.e. a claim that was denied, subsequently resubmitted and then paid would be treated a single claim and a paid claim). It seems to me that the number of claims denied as their final disposition ("true denials" for lack of a better term) is extremely useful for market analysis in terms of identifying potential consumer harm. A claim that was miscoded, denied, resubmitted and then paid does not result in significant consumer harm.

If there is a concern regarding excessive denials for purely "technical reasons" (coding errors, etc), the practice will show up in the claim closing times – which should be calculated from the date the first in a series of claims was received to the date the final disposition was determined, regardless of the number of times the claim was resubmitted.

Other suggestions

1. I recommend that the addition of "number of claims pending at the beginning of the year," and "number pending at the end of the year" to the claims schedules. Currently, the blank only captures the number of claims received, but this doesn't represent all claims that will be adjudicated during the year and appear in other areas of the blank (such as claims closed). Without the initial number of open claims at the beginning of the reporting period no meaningful ratios can be calculated (such as percent of claims closed, for example). I believe all of the other blanks capture this data element.

2. Currently, the MCAS captures "number of new policies issued" and "number of policies renewed," as well as member months on new issues and renewals. It is not clear to me that these two categories are exhaustive of all business that could have been in force during the reporting period. For example, a policy that renewed in December of the prior year and terminated in June of the following year without being renewed would not appear in the current counts. I suspect we do want to capture all policies in the policy counts and member months. Perhaps add a category "member months for policies renewed *or otherwise in force* during any part of the year" and "number of policies in force as of Dec 31."