Draft: 7/24/23

Market Analysis Procedures (D) Working Group
Virtual Meeting
July 17, 2023

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 17, 2023. The following Working Group members participated: Jo LeDuc, Chair (MO); John Haworth, Vice Chair (WA); Crystal Phelps (AR); Maria Ailor and Tolanda Coker (AZ); Don McKinley (CA); Steve DeAngelis (CT); Susan Jennette (DE); Scott Woods and Pamela Lovell (FL); Erica Weyhenmeyer (IL); Shannon Lloyd (KS); Lori Cunningham (KY); Nina Hunter (LA); Salama Karim-Camara (MD); Timothy N. Schott (ME); Jeff Hayden (MI); David Dachs (MT); Martin Swanson and Robert McCullough (NE); Maureen Belanger (NH); Ralph Boeckman and Erin Porter (NJ); Leatrice Geckler (NM); Larry Wertel (NY); Landon Hubbart (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Melissa Gerachis (VA); Karla Nuissl (VT); Rebecca Rebholz and Mary Kay Rodriguez (WI); and Theresa Miller (WV). Also participating was: Tony Dorschner (SD).

1. Adopted its June 12 Minutes

LeDuc said the Working Group met June 12 to discuss data sources for market analysis, the standardized ratios for the Other Health Market Conduct Annual Statement (MCAS), and the exemption of fraternals from MCAS reporting.

Gerachis made a motion, seconded by Jennette, to adopt the Working Group's June 12 minutes (Attachment XX). The motion passed unanimously.

2. Adopted Other Health Insurance MCAS Ratios

LeDuc said clarifications were added to the proposed ratios and re-posted to the Working Group's web page. She said the changes were not substantive, and the ratios have been exposed for about six weeks.

Samantha Burns (America's Health Insurance Plans—AHIP) suggested that ratio 4 measuring the average days to a decision on denied claims should be limited to decisions made on clean claims because the time to receive the appropriate documentation to make a decision is often outside the control of the insurance company. She also suggested that ratio 10 measuring the number of complaints received per 1,000 policies should be limited to complaints received by the department of insurance (DOI).

Rodriguez said the complaint ratio is the same formula as used in other MCAS lines. She said the Other Health MCAS blank does not collect information on clean claims, only denied claims, and the days to make a decision on denials are collected in the MCAS blank. LeDuc noted that the ratios are used to determine whether an analyst needs to look more closely at a company, not to determine compliance.

Birny Birnbaum (Center for Economic Justice—CEJ) said the CEJ supports the proposed Other Health ratios, and there was no lack of clarity even if others may disagree with them. He said they are useful.

Rebholz made a motion, seconded by Geckler, to adopt the Other Health MCAS standard ratios (Attachment XX). The motion passed unanimously.

3. Discussed Lunch and Learn Trainings

LeDuc said she would like to continue the work Haworth began last year to determine what training needs exist and how best to meet the demand. She proposed that the Working Group sponsor "lunch and learn" trainings to all market analysts on a regular schedule. She said the name of these sessions could be something different than "lunch and learn" trainings. She said it would be regulator-only training, so actual live data can be used, and the attendees can bring in actual analysis for discussion. She said she is using the Casualty Actuarial and Statistical © Task Force's book club as a model. It would not be presentations as much as get-togethers to discuss and learn from fellow market analysts.

LeDuc said it could begin with a basic overview of a specific tool (e.g., the Market Analysis Prioritization Tool [MAPT], the Market Analysis Review System [MARS], or the Complaints Database System [CDS], depending on demand), the design of the tool itself, what the data means, and how the tool weighs and scores data. She said once that basic understanding is shared, additional lunch and learns could build on that groundwork and move into doing actual analysis using the tool.

LeDuc said it is best to keep very flexible and address topics that are most in demand, and then find an experienced state insurance regulator, or regulators, who can provide the training to meet that demand. She said she envisions this to be a monthly event.

Veronikis said it is a fabulous idea and would be helpful for training new analysts. Moore agreed that extra training is always welcome. Dorschner said this is a great idea for the smaller states who do not have the resources. Rodriguez said she supports the idea, and the iSite+ summary reports should be included as well. LeDuc said she agrees, and there are so many topics that the sessions could be daily and not get through everything.

Geckler said monthly is a good idea, and she asked when this would be implemented. LeDuc said she wants to start as quickly as possible, but in August there is the NAIC Summer National Meeting and the Insurance Regulatory Examiners Society (IRES) Career Development Seminar (CDS). Jennette said the NAIC Insurance Summit is in September.

Weyhenmeyer, Miller, Lovell, Gerachis, and Belanger expressed support for the idea.

LeDuc said she would work with Haworth and NAIC support staff to set up a schedule, and she will contact state insurance regulators to assist.

4. Discussed the Inclusion of Fraternal Insurance Companies in the MCAS

LeDuc said the attachment to the agenda helps get a big picture of how much premium fraternals account for by jurisdiction in actual dollars and as compared to non-fraternal business. She said in some jurisdictions, there is a very significant presence of business written by fraternals, but as a percentage of the market nationally, fraternals only account for about 2.5% of the written premium. She said the 2.5% is nearly $10 billion in premium. She said she sent each member of the Working Group state-specific information on the fraternal marketplace in their states.

LeDuc said comments were received from Maine, Pennsylvania, the CEJ, and several fraternal companies and trade associations.

Schott said Maine is statutorily unable to collect data from fraternals. They are not opposed to including them in MCAS reporting, but Maine could not require them to report.

Veronikis said she is still waiting to hear from the Pennsylvania department's legal staff to see if they have the authority to require fraternals to report the MCAS. She said the fraternals in Pennsylvania range in premium size from only $12 to up to $273 million. She said she always assumed the fraternals were small, and this surprised her. She said she wants to dig deeper.

Todd Martin (American Fraternal Alliance—AFA) said there should be a reason for making a change to the MCAS. He said nothing has changed in the fraternal marketplace since the last time fraternals were considered for inclusion in the MCAS by the Working Group. He said there is a very low incidence of market conduct incidents with fraternals, and other means are available for assessing and addressing market conduct issues. LeDuc said Missouri does not receive the complaint logs of fraternals. She asked if that was being offered. Martin said he thinks it could be.

Birnbaum said Martin's comments show a misunderstanding of the purpose of the MCAS. He said the purpose of the MCAS is not to respond to issues that arise, but to identify problems. He said it is in the company and state insurance regulator's interests to identify problems without the time and resources required for examinations. He said he reviewed the websites of the fraternals that submitted comments. He said some of them are larger than many life insurance companies that are required to file an MCAS. Additionally, the companies are no longer distinguished for special treatment by financial analysts, and they now file their financial annual statement on the Life statement blank. He said small fraternal companies would be exempt from reporting an MCAS due to the premium threshold, just as small life companies are.

Ailor said if fraternals are required to file an MCAS, analysts should have the ability to review them in the MARS. She said the analysts in Arizona were unable to open an MARS review on any fraternals. She said given the amount of business generated by fraternals, they should be seriously considered for inclusion in the MCAS. She also noted that the $50,000 premium threshold in the MCAS should be looked into to see if it is still the correct amount for a threshold. LeDuc said the threshold was set around 2004 when the MCAS was first developed, and she agreed that it should be reconsidered in a separate conversation.

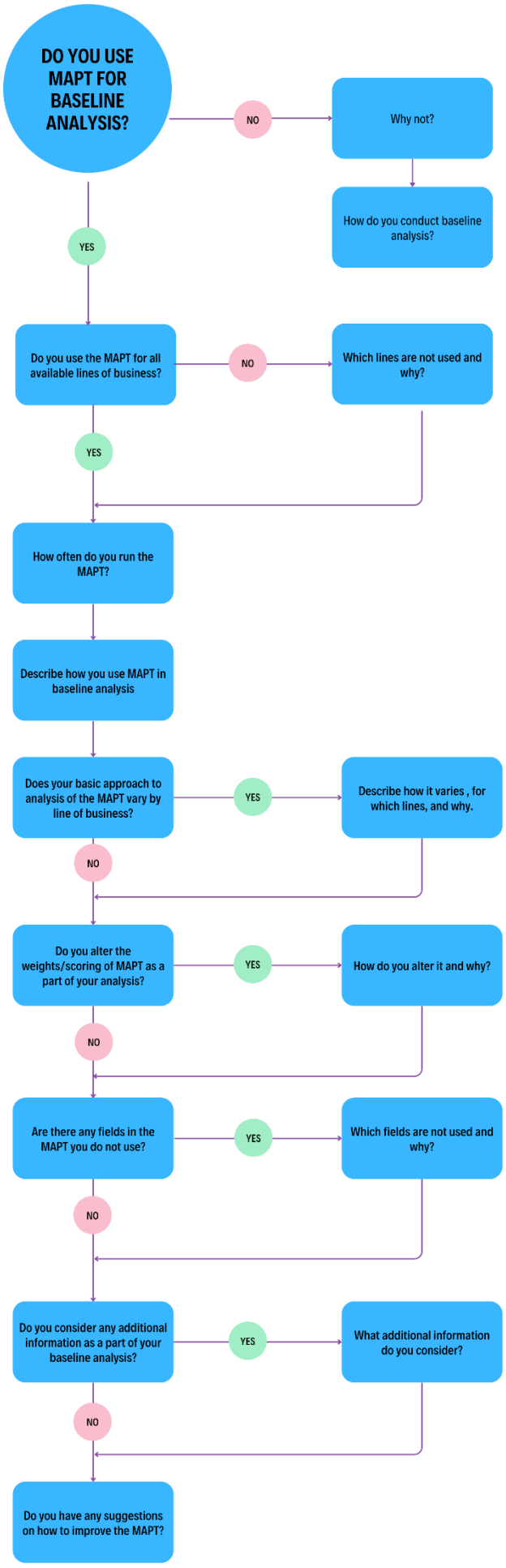
Swanson said Nebraska's position is unchanged from the 2019 position expressed by Director Bruce R. Ramge (NE) in his comments to the Working Group in 2019. Nebraska has very few complaints, and it utilizes its examination authority to do a good job in monitoring the fraternal market. He said adding fraternals to the MCAS is not needed.

Nuissl asked what the impact will be on fraternals to report the MCAS. She asked if fraternals capture all the data elements that need to be reported in the MCAS and whether it may be an undue hardship on the fraternal companies. Ailor said if the Working Group required them to file, they would be permitted adequate time to prepare. Martin said he would be happy to look at the Life MCAS blank to see what the lift may be for fraternals. Birnbaum said fraternals range in size, and whereas some small companies may have difficulties, the large fraternals would have the same systems in place as large life companies. He suggested that if the fraternals indicate that the data will be difficult for them to collect, they should be required to specify which data and the reasons.

Le Duc said this discussion will continue at the Working Group's next meeting.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

Sharepoint/Member Meetings/D CMTE/2023 Summer National Meeting/MAPWG/0717/07 MAPWG .docx


DO YOU USE MAPT FOR BASELINE ANALYSIS?
NO
Why not?
How do you conduct baseline analysis?
YES
Do you use the MAPT for all available lines of business?
NO
Which lines are not used and why?
YES
How often do you run the MAPT?
Describe how you use MAPT in baseline analysis
Does your basic approach to analysis of the MAPT vary by line of business?
YES
Describe how it varies , for which lines, and why.
NO
Do you alter the weights/scoring of MAPT as a part of your analysis?
YES
How do you alter it and why?
NO
Are there any fields in the MAPT you do not use?
YES
Which fields are not used and why?
NO
Do you consider any additional information as a part of your baseline analysis?
YES
What additional information do you consider?
NO
Do you have any suggestions on how to improve the MAPT?

2024 Market Conduct Annual Statement Ratios

Pet Insurance

Ratio 1. **The number of claims closed without payment compared to the total number of claims closed.**

$$\left(\frac{[\#\text{of claims closed without payment during the period (3-77)}]}{[\#\text{of claims closed during the period (3-68)}]}\right)$$

Ratio 2. **The number of claims closed with partial payment compared to the total number of claims closed.**

$$\left(\frac{[\#\text{of claims closed with partial payment during the period (3-72)}]}{[\#\text{of claims closed during the period (3-68)}]}\right)$$

Ratio 3. **The number of claims closed with full payment compared to the total number of claims closed.**

$$\left(\frac{[\#\text{of claims closed with full payment during the period (3-69)}]}{[\#\text{of claims closed during the period (3-68)}]}\right)$$

Ratio 4. **Percentage of claims unprocessed at the end of the period**

$$\left(\frac{\begin{array}{c}\text{Number of claims open at the beginning of period (3-66)} + \text{Number of claims opened during period (3-67)} \\ -\text{Number of claims closed during the period (3-68)}\end{array}}{\#\text{ of claims open at the beginning of period (3-66)} + \#\text{ of claims opened during the period (3-67)}}\right)$$

Ratio 5. **Percentage paid on partial payments of the amount requested on partial payments**

$$\left(\frac{[\text{Dollar amount of claims closed with partial payment during the period (3-74)}]}{[\text{Dollar amount requested for claims closed with partial payment during the period (3-73)}]}\right)$$

Ratio 6. **Percentage of claims closed with full payment beyond 60 days**

$$\left(\frac{[\text{total \#of claims closed during the period with full payment beyond 60 days } (\sum \text{3-83 through 3-86})]}{[\text{total \#of claims during the period with full payment closed over all durations } (\sum \text{3-81 through 3-86})\ ]}\right)$$

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Ratio 7. **Percentage of claims closed with partial payment beyond 60 days**

$$\left(\frac{[\text{total \#of claims closed during the period with partial payment beyond 60 days } (\sum \text{3-89 through 3-92})]}{[\text{total \#of claims closed during the period with partial payment over all durations } (\sum \text{3-87 through 3-92})\ ]}\right)$$

Ratio 8. **Percentage of claims closed without payment beyond 60 days**

$$\left(\frac{[\text{total \#of claims closed during the period without payment beyond 60 days } (\sum \text{3-95 through 3-98})]}{[\text{total \#of claims closed during the period without payment over all durations } (\sum \text{3-93 through 3-98})\ ]}\right)$$

Ratio 9. **Pre-existing condition - closed without payments to total claims closed without payment**

$$\left(\frac{[\text{\#of claims closed during the period without payment due to pre} - \text{existing condition exclusion } (3 - 100)]}{[\text{\#of claims closed during the period without payment (3-77)}]}\right)$$

Ratio 10. **Inadequate documentation - closed with partial payments to total claims closed with partial payment**

$$\left(\frac{[\text{\#of claims closed during the period with partial payment due to inadequate documentation } (3 - 110)]}{[\text{\#of claims closed during the period with partial payment (3-72)}]}\right)$$

Ratio 11. **Percentage of policies in-force during the period that provided only accident coverage**

$$\left(\frac{[\text{\#of policy/certificates in-force during the period that included accident-only coverage } (2\text{-}28 + 2\text{-}29)]}{[\text{\#of policies/certificates in force during the period } (\sum (2\text{-}28 \text{ through } 2\text{-}37)]}\right)$$

Ratio 12. **Non-renewals to policies in force**

$$\left(\frac{[\text{\#of company initiated policy/certificates non} - \text{renewals during the period } (2\text{-}46{+}2\text{-}47)]}{[\text{\#of policies/certificates in force during the period } (\sum (2\text{-}28 \text{ through } 2\text{-}37)]}\right)$$

Ratio 13. **Percentage of policies returned under "Right to Examine and Return the Policy" provision**

$$\left(\frac{[\text{\# of policies/certificates returned during the period under "Right to Examine" } (2\text{-}38 + 2\text{-}39)]}{[\text{total \# of policies issued during the period } (2\text{-}49 + 2\text{-}50)\ ]}\right)$$

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Ratio 14. **Cancellations/terminations at the policy/certificate holders request**

$$\left(\frac{[\#\text{of cancellation/terminations during the period at the policy/certificate holders request (2-40+2-41)}]}{[\text{total \#of cancellation/terminations during the period } (\sum 2\text{-}40 \text{ through } 2\text{-}45)\ ]}\right)$$

Ratio 15. **Applications denied for health status or condition to total applications received**

$$\left(\frac{[\#\text{ of applications denied for health status or conduction during the period (2-61)}]}{[(\#\text{ of applications received during the period (2-60)}]}\right)$$

Ratio 16. **Percentage of policies/certificates issued with a pre-existing condition exclusion**

$$\left(\frac{[\#\text{ of policies/certificates issued with a pre-existing condition exclusion during the period (2-64)}]}{[\text{total \# of policies issued during the period (2-49 + 2-50)}\ ]}\right)$$

Ratio 17. **Loss Ratio**

$$\left(\frac{\left[\begin{array}{c}\text{Dollar amount of paid claims closed with full payment during the period (3-70)}\\ +\text{Dollar amount of claims closed with partial payment during the period (3-74)}\end{array}\right]}{[\text{Direct earned premium during the period (2-58)}]}\right)$$

Ratio 18. **Average Dollars of Commission Per Policy/Certificate**

$$\left(\frac{\left[\begin{array}{c}[\text{Commissions incurred during the period (4-113)}]\\ -[\text{Unearned commissions returned to company during the period (4-114)}]\end{array}\right]}{\left[[\text{total \# of policies issued during the period (2-49 + 2-50)}\ ]\right]}\right)$$

Ratio 19. **Percentage Commissions to Written Premium**

$$\left(\frac{\left[\begin{array}{c}[\text{Commissions incurred during the period (4-113)}]\\ -[\text{Unearned commissions returned to company during the period (4-114)}]\end{array}\right]}{[\text{Direct written premium during the period (2-57)}]}\right)$$

Note: It is unclear to what extent commissions are paid on events other than new business (e.g., such as renewals)

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Ratio 20. **Lawsuits to Policies/Certificates in force during the period**

$$\left(\frac{[\text{\# of lawsuits opened during the period (5-117)}]}{[[\text{\#of policies/certificates in force during the period } (\sum \text{ (2-28 through 2-37)}]\ ]}\right)$$

Ratio 21. **Lawsuits opened during the period to claims closed without payment**

$$\left(\frac{[\text{\# of lawsuits opened during the period (5-117)}]}{[[\text{\#of claims closed during the period without payment (3-77]}\ ]}\right)$$

Ratio 22. **Percentage of lawsuits closed with consideration for the consumer**

$$\left(\frac{[\text{Number of lawsuits closed with consideration for consumer (5-120)}]}{[\text{Number of lawsuits closed during the period (5-118)}]}\right)$$

Ratio 23. **The number of complaints per 1,000 policies in-force during the period**

$$\left(\frac{[\text{\#of complaints received directly from any person or entity other than the DOI (5-115)}]}{\left(\left[[\text{\#of policies/certificates in force during the period } (\sum \text{ (2-28 through 2-37)}]\right] \div 1{,}000\right)}\right)$$