Draft: 7/9/19

Market Analysis Procedures (D) Working Group
Conference Call
June 13, 2019

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 13, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Pamela Lovell (FL); Susan Lamb (IL); Tate Flott (KS); Russell Hamblen (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Karen McCallister (NH); Ralph Boeckman (NJ); Angela Dingus (OH); Shelly Scott (OK); Jeffrey Arnold (PA); Michael Bailes (SC); Julie Fairbanks (VA); and Theresa Miller (WV).

1. Adopted its May 2 Minutes

The Working Group met May 2 and took the following action: 1) adopted its April 7 minutes; 2) received an update regarding automated Market Conduct Annual Statement (MCAS) analysis techniques; 3) discussed the draft short-term limited duration (STLD) medical data call template; 4) discussed proposed disability income MCAS scorecard ratios; and 5) discussed late MCAS filings.

Ms. Dingus made a motion, seconded by Mr. Pyle, to adopt the Working Group's May 2 minutes (Attachment __). The motion passed unanimously.

2. Adopted the STLD Medical Data Call Template

Teresa Cooper (NAIC) provided an update regarding Randy Helder's (NAIC) discussion with NAIC legal counsel regarding the potential centralized collection of data for the STLD medical data call. Ms. Cooper said NAIC legal counsel indicated that a contract would need to be drafted and approved by all participating states.

Ms. Rebholz said the STLD medical data call template (Attachment __) is ready for adoption by the Working Group, with two minor updates: 1) in Section I (Data Call Parameters), the examples should be updated to say forms are "marketed and/or sold" in a state; and 2) in Section II (General Data), #9 should be updated to say "Did the company market STLD forms."

Mr. Pyle made a motion, seconded by Mr. Flott, to adopt the STLD medical data call template with the described edits. The motion passed unanimously.

3. Discussed Disability Insurance MCAS Proposed Scorecard Ratios

Mr. Haworth said new comments regarding the disability MCAS proposed scorecard ratios (Attachment __) were received from the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP). Michael Lovendusky (ACLI) and Winthrop Cashdollar (AHIP) each said the draft ratios are not ready for consideration, and more time is needed to provide a revised draft for review.

Draft ratio 1 was discussed in detail with various suggestions for the denominator of the calculation. After discussion, Ms. Ailor suggested that the group of subject matter experts (SMEs) that drafted the disability income MCAS data call and definitions be reconvened to discuss and make any needed revisions to the draft ratios to ensure that the ratio results will provide the information needed by state insurance regulators. Ms. Rebholz and Mr. Arnold agreed with Ms. Ailor's suggestion. Mr. Haworth asked NAIC staff to setup a meeting of the SMEs for further discussion and drafting of the disability income ratios.

4. Discussed the Posting of 2018 Health MCAS Scorecards

Mr. Haworth said in 2018, it was decided that the public health MCAS scorecards would not be posted. He said there was a concern of having only one or two companies writing health business within a jurisdiction. He noted that state insurance regulators have access to aggregate state ratio calculations. A few states spoke up and indicated that they have a small marketplace, are concerned with the publishing of health ratios, and would prefer that their state's ratios not be published. Ms. Ailor said she respects the described concerns, and she suggested the calculation and posting of zone ratios. Mr. Haworth noted

that neighboring state marketplaces can be very different, and the zone ratios may not be meaningful. Ms. Rebholz suggested aggregating ratio calculations for states within set carrier count ranges. Birny Birnbaum (Center for Economic Justice—CEJ) said there is an assumption that aggregating data for ratio calculations when only a small number of carriers write business within a jurisdiction causes harm, but he said it is not harmful to the companies. He said the results are not sensitive commercial information, and they are of great interest to consumers and the public. He said the value to consumers outweighs any harm to companies. Mr. Haworth asked when the NAIC would need a determination regarding the health scorecard posting. Ms. Cooper indicated that having notice two to three weeks prior to the scheduled posting date would allow for programming updates.

Mr. Haworth asked that comments regarding the posting of health MCAS scorecard ratios be sent to the NAIC no later than July 9.

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

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Adopted by the Market Regulation and Consumer Affairs (D) Committee—July 15, 2019

Short Term Limited Duration Data Call

I. Data Call Parameters:

1. Definitions:
    a. **Data Call Period**: The period of review for this data call is **October 1, 2018 to March 31, 2019**. Data provided in response to this data call should be based on occurrences within this period – i.e. claims paid within the review period, a form issued, renewed or cancelled within the review period.
    b. **Form**: This means the policy/product issued under a specific form number – the unique identifier printed on the form itself.
    c. **Renew or renewal**: When a policy form is renewed or reissued to an insured or group of insureds with the same form number as the preceding policy/product. It is not a renewal if a policy is issued to an insured with a new form number.
2. If the reporting company markets multiple Short Term Limited Duration (STLD) forms within a state, a separate data call response must be submitted for each form. This data call should be completed separately for each STLD form being offered – even if some of the data/responses are the same across multiple forms.
3. The data call is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is sitused.
4. Entering the data:
    a. Section II – enter this information once regardless of the number of forms or states the company is reporting on. If the answer to Question #9 in Section II is "yes" -complete the entire data call. If the answer is "no" - no further information is required.
    b. Sections III. and IV - Complete these sections once for each STLD form the company is marketing. If the product will be marketed in more than one state, Sections III and IV should be completed with state-specific data for that form for each state.

    Example: A company markets two STLD forms – Form 123 and Form 456. Form 123 is marketed and/or sold in Nebraska; Form 456 is marketed in Wyoming, South Dakota and Montana. The answer to Question #9.B. in Section II is "2".
    - Form 123; the entire data call should be completed once with information specific to Form 123 and to Nebraska.
    - Form 456; Sections III and IV should be completed three times with information specific to Form 456 as that form is marketed and/or sold in Wyoming, South Dakota and Montana respectively.

II. General Data; Company Name and Contact Information:

1. Group Code
The NAIC Group code if the carrier is part of a holding company. If not part of a holding company, leave the field blank.

2. NAIC CoCode
The NAIC CoCode for the reporting company.

3. Carrier Name
Legal name of the insurance company.

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4. **Contact Name**
   The company contact person for the purposes of this report. First name, Last name.

5. **Contact Title**
   The contact person's business title.

6. **Contact Phone #**
   Phone number for the contact person filing the report.

7. **Contact email address**
   E-mail address of contact person filing the report.

8. **Past Marketing**: Did the company market short-term limited-duration (STLD) forms during the prior 3 years, 2016 through 2018? (Y/N)

9. **Current Marketing**: Did the company market STLD forms during the data call period? (Y/N)
   9.A. If No; Be sure Questions 1-9 in Section II are completed. No further information is required.
   9.B. If Yes, indicate how many distinct forms the company will market. NOTE: The full data call must be completed.

III. Form and State-specific Data Elements:

1. **Form Name:** Provide the name of the form being marketed.

2. **State:** Provide the two-letter abbreviation for the state in which the form is marketed. If the form is marketed in more than one state, complete this section with state specific data for each state.

3. **Form number:** Provide the form number exactly as it appears on the form.

4. **SERFF Tracking Number:** Provide the SERFF tracking number for the most recent submission that contains the form identified in the previous question. Fill this field with zeros (0) if the form is not filed through SERFF.

5. **Type of Insurance (TOI):** Provide the SERFF Type of Insurance code if the form is filed through SERFF.

6. **Number covered lives under individual plans:** Provide the total number of *unique* lives issued coverage under this form during the data call period**.** Do not report a form renewal as an additional life. NOTE: Group STLD coverage that is ultimately issued to an individual should be included in the responses to Questions 6, 7 and 8.

7. **Individual policies in force:** Provide the total number of individual policies in force on this form during the data call period.
   7.A. Provide the total number of individual policies in force as of the beginning of the data call period (October 1, 2018)
   7.B. Provide the total number of individual policies in force as of the end of the data call period (March 31, 2019)

8. **Individual policies renewed**: Provide the total number of individual policies renewed under this form with the renewal date occurring during the data call period.

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9. **Number of covered lives under group plans.** Provide the total number of *unique* lives issued coverage under group plans during the data call period. Do not report a form renewal as an additional life. **NOTE**: STLD coverage issued to an employer for their employees should be included in the responses to Questions 9, 10 and 11.

10. **Group certificates in force:** Provide the total number of group certificates in force on this form during the data call period.
    10.A. Provide the total number of certificates in force as of the beginning of the data call period (October 1, 2018)
    10.B. Provide the total number of certificates in force as of the end of the data call period (March 31, 2019)

11. **Group certificates renewed**: Provide the total number of certificates of coverage renewed for group members with the renewal date occurring during the data call period.

12. **Member-requested cancellations:** Provide the total number of member-requested cancellations that occurred during the data call period. **NOTE**: This number should include cancellations for non-payment of premium.

13. **Is health status used as a rating factor? (Y/N) If yes, provide the total number of denials issued based on health status. NOTE:** Rejecting an online application for a "yes" answer would constitute denial at the point of initial application purposes of this data call.
    13.A. At the point of initial application
    13.B. At the point of renewal

14. **Term of Form:** Provide the maximum term of the form in months.

15. **Number of Renewals allowed:** Provide the maximum number of times the form can be renewed.

16. **Prescription drugs covered? (Y/N)** Does the form offer coverage for prescription drugs? **NOTE**: a prescription drug discount card does not constitute prescription drug coverage for the purposes of this data call.

17. **Maximum policy limits:** Provide the maximum
    17.A. Annual policy limits that apply to the form.
    17.B. Lifetime policy limits that apply to the form.

18. **Total Annual Premium**: Provide the total annual premium collected from all policies issued in the state during the data call period for this form.

19. **Commission:** Provide the total amount of commission paid on all policies issued in the state during the data call period for this form.

20. **Other Fees:** Provide the total amount of other fees (non-commission) paid on all policies issued in the state during the data call period for this form.

21. **Claims received:** Provide the total number of claims received during the data call period for this form.

22. **Claims Paid:** Provide the total number of claims paid during the data call period for this form.

23. **Claims Denied:** Provide the total number of claims denied during the data call period for this form.

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24. Complaints Received: Provide the total number of complaints received during the data call period for this form. NOTE: A complaint means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee, or an enrollee's authorized representative, to the insurer. This includes complaints received from a State DOI and from an insured or their representative/provider.

IV. Interrogatories:

1. Does the form cover state-mandated benefits for this state? (Y/N) If yes, list the benefits covered:
    - 1.A. For individual policies
    - 1.B. For group policies

2. Describe how this form is marketed (i.e. Agency, Social Media, Email contacts, Telephone contacts, other).
    - 2.A. Do the marketing materials advertise coverage for mental health services, substance use disorder services, or organ transplants?
    - 2.B. List all websites on which this form is being sold.

3. Is a free look period offered for this form? (Y/N).
    - 3.A. If yes, what is the time frame for the free look period?

4. Describe how applications for this form are taken (i.e. Face-to-Face, Telephone, Internet, Mail, Other).
   4.A. Provide the number of individuals who were enrolled during the data call period by the following methods:
    - 4.A.1. online – either directly or via web broker
    - 4.A.2. by phone
    - 4.A.3. in person
    - 4.A.4. Other - specify

5. How does the company oversee producers and/or websites selling this form? Does the company monitor sales and conduct follow-up contact with consumers to verify that they understood the product?

6. Indicate the age range of individuals to whom the company will offer coverage.

7. Are there any restrictions applied to renewability? (Y/N)
    - 7.A. If Yes, what are those restrictions?

8. Does the company offer coverage with preexisting condition limitations or exclusions? (Y/N) If Yes;
    - 8.A. Provide the definition of a pre-existing condition as it appears in the form.
    - 8.B. Describe the range of effects of preexisting conditions which may include, for example, complete denial, waiting/look back period, exclusion of a medical condition or treatment, or any other limitation on coverage or benefit levels.

9. Indicate whether the form includes any dollar limits for specific benefits in addition to the annual and lifetime policy limits. (Y/N)
    - 9.A. If Yes, itemize the benefits.

10. Are riders/endorsements offered as part of the form? (Y/N)

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10.A. If Yes, list the form number for each rider/endorsement and specify the type of coverage it provides.

11. Indicate whether the form includes rescission provisions. (Y/N)

12. Is there an appeal process available to the insured? (Y/N) If yes, provide the following:
    12.A. A full description of the appeal process
    12.B. The total number of claims that were appealed during the data call period
    12.C. The total number of denied claims that were overturned on appeal during the data call period
    12.D. The total number of denied claims that were upheld on appeal during the data call period

13. Delegation of Tasks:
    13. A. Does the company delegate administration, claims, complaints, medical underwriting, pricing, producer appointments advertisement, lead generation, enrollment or marketing of STLD policies to third parties? (Y/N)
    13.B. Is there any other person or entity the company pays, directly or indirectly, for services associated with issuance and service of these contracts? (Y/N)

14. If Yes to either 13.A. or 13.B., for each of the following identify all applicable parties, and indicate whether each is properly licensed:
    14.A Administration
    14.B Claims
    14.C Complaints
    14.D Medical Underwriting
    14.E Pricing
    14.F Producer appointments
    14.G Marketing, advertisement, lead generation, enrollment
    14.H. Other – specify

15. **Association Name**: If the form is marketed through an Association, include the legal name of the Association linked to the form.

16. **Situs of Association**: Situs state where the Association is based. Use the two-letter abbreviation for the situs state.

17. **Trust Name**: If the form is marketed through a Trust, include the legal name of the Trust linked to the form.

18. **Situs of Trust**: Situs state where the Trust is based. Use the two letter abbreviation for the situs state.

19. **Administrator Name**: If the form is marketed through an Administrator, include the legal name of the Administrator linked to the form.

20. **Situs of the Administrator**: Situs state where the Administrator is based. Use the two-letter abbreviation for the situs state.

21. **Loss Ratio**: If claims data exists for the data call period, provide the Loss Ratio (incurred losses/earned premium) on an aggregate basis for the form.

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Parking Lot Items

Data Elements:

1. **Does the product have a provider network? (Y/N) If yes, provide:**
   - **1.A.** The number of claim denials for in-network claims
   - **1.B.** The number of claims paid for in-network services
   - **1.C.** The number of claim denials for out-of-network claims
   - **1.D.**The number of claims paid for out-of-network services

2.A. Total number of insurer-initiated cancellations prior to the policy expiration date.
2.B. Total number of rescissions

3. Is gender and/or industry of members used as a rating factor? (Y/N) If yes, provide the total number of denials based on gender and/or industry of members issued

- **3.A.** At the point of initial application
- **3.B**. At the point of renewal

NOTE: Rejecting an online application for a "yes" answer would constitute an "initial denial" for the purposes of these questions.

4. Renewal denials for health status
The total number of denials based on health status that are issued at the point of renewal.

5. Indicate whether the contract provides coverage for the following:

- **5.A.** Mental Health Services (Y/N)
- **5.B.** Substance use disorder treatment (Y/N)
- **5.C.** Maternity Care - in addition to complications of pregnancy (Y/N)
- **5.D.** Rehabilitation/habilitation services (Y/N)
- **5.E.** Durable Medical Equipment (Y/N)

6. Indicate whether the contract includes specific exclusions for the following:

- **6.A.** Gender Identity (Y/)
- **6.B**. Injury resulting from intoxication (Y/N)
- **6.C**. Other hazardous activity (Y/N)

7. Indicate whether the contract includes pre-existing condition limitations. (Y/N)

8. Indicate the range of deductibles available under the contract:

- **8.A**. for single coverage
- **8.B**. for family coverage

9. Indicate the range of copayments and co-insurance under the contract:

- **9.A**. for single coverage
- **9.B**. for family coverage

10. Claims submitted – Provide the total number of claims submitted during the reporting year for the following:

- **10.A.** Mental health services

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10.B. Substance Use Disorder services
10.C. Organ transplants
10.D. Cancer
10.E. Kidney stones
10.F. Gallbladder disease
10.G. Appendicitis

11. Claims Paid - Provide the total number of claims paid during the reporting year for the following:
11.A. Mental health services
11.B. Substance Use Disorder services
11.C. Organ transplants
11.D. Cancer
11.E. Kidney stones
11.F. Gallbladder disease
11.G. Appendicitis

12. Claims Denied - Provide the total number of claims denied during the reporting year for the following:
12.A. Mental health services
12.B. Substance Use Disorder services
12.C. Organ transplants
12.D. Cancer
12.E. Kidney stones
12.F. Gallbladder disease
12.G. Appendicitis
12.H. Pre-Existing Conditions
12.I. Gender Identity
12.L. Injury resulting from intoxication
12.K. Injury resulting from other hazardous activity

Interrogatories:

1. Does the company provide commissions or other incentives to producers for the sale of this product? (Y/N) If yes,
   1.A.Provide a copy of the producer commission schedule.
   1.B. What was the total commission paid from January 1 through December 31 of the reporting year?
   1.C. How does this commission or other incentive amount compare to those offered by ACA-compliant plans sold by the company?
   1.D. How much of the total commission amount was paid to the top five producers/agencies? List those producers/agencies.

2. Are any other (non-commission) fees charged for this product? (Y/N)
   2.A. If yes, describe those fees including the amount, and the basis for the fee.

2019 Market Conduct Annual Statement Ratios

Disability Income

Ratio 1 Percentage of claims denied

$$\left(\frac{\text{[Number of claims denials during reporting period (21)]}}{\text{[Number of claim denials during reporting period (21)]} + \text{[Number of paid claims closed during reporting period (22)]}}\right)$$

Commented [HR1]: Replaced Benefit Determinations with Claims Decisions

Ratio 2 Percentage of claims processed with initial decision after 45 days

Short-Term Only

$$\left(\frac{\text{[Number of claims processed with initial claim decision over 45 days (28)]}}{\begin{array}{l}\text{[Number of claims processed with initial claim decision within 1-14 days (25)]} \\ +\text{[Number of claims processed with initial claim decision within 15-30 days (26)]} \\ +\text{[Number of claims processed with initial claim decision within 31-45 days (27)]} \\ +\text{[Number of claims processed with initial claim decision over 45 days (28)]}\end{array}}\right)$$

Ratio 3 Percentage of claims processed with initial decision after 90 days

Long-Term Only

$$\left(\frac{\text{[Number of claims processed with initial claim decision over 90 days (33)]}}{\begin{array}{l}\text{[Number of claims processed with initial claim decision within 1-30 days (30)]} \\ +\text{[Number of claims processed with initial claim decision within 31-60 days (31)]} \\ +\text{[Number of claims processed with initial claim decision within 61-90 days (32)]} \\ +\text{[Number of claims processed with initial claim decision over 90 days (33)]}\end{array}}\right)$$

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Ratio 4 The number of complaints received directly from consumers per 1,000 individual policies in force during the reporting period

$$\left(\frac{[\text{Number of complaints received from consumers (83)}]}{\left(\begin{array}{c}[\text{Number of policies beginning of the reporting period (67)}]\\ +[\text{ Number of policies at the end of the reporting period (75)}]\end{array}\right) \div 1000}\right)$$

Commented [HR2]: Ratio 4 was split into three ratios in order to separately measure complaints on individual policies and complaints on group policies.

Ratio 5 The number of complaints received directly from consumers per 1,000 lives covered on group policies

$$\left(\frac{[\text{Number of complaints received from consumers (83)}]}{\left(\begin{array}{c}([\text{Number of lives covered at the beginning of the reporting period (76)}]\\ +[\text{ Number of lives covered at the end of the reporting period (82)}])\end{array} \div 2\right) \div 1000}\right)$$

Ratio 6 The number of complaints relating to group policies to average number of group policies in force during the reporting period

$$\left(\frac{[\text{Number of complaints received from consumers (83)}]}{\left(\begin{array}{c}([\text{Number of policies in force at beginning of reporting period (67)}]\\ +[\text{ Number of policies in force at end of the reporting period (75)}])\end{array} \div 2\right)}\right)$$

Ratio 7 The percentage of lawsuits closed with consideration for the consumer

$$\left(\frac{[\textit{Number of lawsuits closed with consideration for consumer (87)}]}{[\textit{Total number of lawsuits closed during the period (86)}]}\right)$$

2019 Market Conduct Annual Statement Ratios

Ratio 8 Non-renewals and cancellations to average policies in force

$$\left(\frac{[\text{Number of insurer non-renewals (71)} + [\text{Number of insurer cancellations}]\ (72)]}{([\text{Number of policies in force at the beginning of the reporting period (67)}] + [\text{Number of policies in force at the end of the reporting period (75)}])\ \div 2}\right)$$

Commented [HR3]: Added in insurer cancellations to numerator

Commented [HR4]: Changed denominator to an average of policies in force

Ratio 9 Covered lives affected by non-renewals to average policies in force

Group only

$$\left(\frac{[\text{Number of lives covered under insurer non-renewals (79)}] + [\text{Number of lives covered under insurer cancellations (80)}]}{([\text{Number of lives covered under policies in force at the beginning of the reporting period (76)}] + [\text{Number of lives covered under policies in force at the end of the reporting period (82)}])\ \div 2}\right)$$

Commented [HR5]: Added insurer cancellations to numerator

Commented [HR6]: Changed denominator to an average of policies in force

Ratio 10 Average pending benefit determinations to claims received

Commented [HR7]: Numerator and Denominator changed to more clearly measure pending benefit determinations to claims received.

$$\left(\frac{([\text{Number of pending benefit determinations, beginning of reporting period (17)}] + [\text{Number of pending benefit determinations, end of reporting period (23)}])\ \div 2}{[\text{Number of claims received during the reporting period (19)}]}\right)$$

Ratio 11 Rescissions after two years from issuance to total rescissions

$$\left(\frac{[\text{Number of rescissions after two years from policy issue (74)}]}{[\text{Number of rescissions within two years from policy issue (73)}] + [\text{Number of rescissions after two years from policy issue (74)}]}\right)$$

July 9, 2019

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Via email: Randy Helder, rhelder@naic.org; Teresa Cooper, tcooper@naic.org
Market Analysis Procedures (D) Working Group

RE: Request for Feedback on Making Health Scorecard Ratios Publicly Available

Dear Chair Haworth and Vice Chair Rebholz,

The Health Industry Interested Parties (HIIP) group appreciates the opportunity to provide feedback to the Market Analysis Procedures Working Group (MAPWG) to consider as it deliberates a recommendation to the Market Regulation and Consumer Affairs (D) Committee whether or not to make the 2018 Health Market Conduct Annual Statement (MCAS) Scorecard ratios publicly available.

During the June 13, 2019 conference call, the MAPWG discussed the premise of their prior year recommendation not to publish the 2017 state aggregated scorecard results because smaller states have a limited number of carriers or only a single carrier, and since demographics have not changed to date, the 2018 scorecard ratios should not be publicly available.

The HIIP group agrees with the MAPWG's prior year rationale for not making the scorecard ratios publicly available, and we would like to offer the following additional information for your consideration before making a final recommendation to the (D) Committee on whether or not to make the 2018 and beyond scorecard results publicly available.

Statistical Significance of Ratio Information

Health ratios produced from a statistically insignificant population base could result in misleading ratios because the parameters of the population base are not publicly available. As example, a carrier with low membership in a particular segment may have one catastrophic event that triggers a high level of out of network claims resulting in a ratio showing high level of out of network utilization that could lead to inaccurate conclusions regarding the carrier's network adequacy.

Current Scorecard Ratios Do Not Provide Comparable Results

Since the numerator and denominator populations contain dissimilar information, current scorecard ratios are not comparable. For example, the Health MCAS does not contain a collection field or instructions specific to terminated member months information. Therefore, ratios using member months will produce inaccurate ratios. Additionally, since the Health MCAS collects information for claims paid within the data-year regardless of the year received, ratios using claims paid and claims received data are not comparable and could result in misleading ratios. Similarly, for grievance data, year-over-year membership fluctuations may also result in misleading ratios, as grievance data is not limited to membership active in the reported data year.

Carriers' Reporting Methodology Information Not Available

Only state regulators and NAIC staff have pertinent information on a carrier's Health MCAS reporting methodology disclosed by each carrier in the Health MCAS Interrogatory/Comments sections. Differences in reporting methodologies and lack of available pertinent information will impact the conclusions drawn from applicable ratios.

Non-Comparable Health MCAS and Financial Annual Statement (FAS) Information

It is understood that the Health MCAS is a statistical report and not a financial report. Efforts to compare or correlate Health MCAS information or scorecard ratios to FAS information or ratios will result in erroneous comparisons and conclusions.

The HIIP group believes the Health MCAS data and ratios should primarily be a tool for market regulatory analysis. Given the complexity of the Health MCAS, unlike the simplistic nature of information for other MCAS lines of business, public reporting of Health MCAS ratios is not meaningful and may cause confusion and undue concerns regarding the ratios because pertinent information is not publicly available.

Thank you for your consideration of our comments, and we look forward to continued work with the MAPWG.

Sincerely,

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