MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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Market Regulation and Consumer Affairs (D) Committee
Orlando, Florida
April 8, 2019

The Market Regulation and Consumer Affairs (D) Committee met in Orlando, FL, April 8, 2019. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Allen W. Kerr, Vice Chair, represented by Russ Galbraith (AR); Trinidad Navarro represented by Frank Pyle (DE); Jim Beck (GA); Colin M. Hayashida represented by Gordon I. Ito (HI); Stephen W. Robertson and Ronda Ankney (IN); Vicki Schmidt and LeAnn Crow (KS); Anita G. Fox represented by Michele Riddering (MI); Mike Causey represented by Tracy Biehn (NC); Barbara D. Richardson represented by Stephanie McGee (NV); Kent Sullivan represented by Doug Slape (TX); Todd E. Kiser and Tanji Northrup (UT); Michael S. Pieciak represented by Christina Rouleau (VT); and Mike Kreidler and John Haworth (WA). Also participating were: Tim Schott (ME); and Bruce R. Ramge (NE).

1. <u>Adopted its Feb. 8 Minutes</u>

The Committee met Feb. 8 and took the following action: 1) adopted its 2018 Fall National Meeting minutes; 2) discussed its charges and working groups; 3) adopted a June 30, 2019, filing deadline for the health Market Conduct Annual Statement (MCAS); and 4) adopted a June 30, 2020, deadline for the disability income MCAS.

Commissioner Kiser made a motion, seconded by Ms. Biehn, to adopt the Committee's Feb. 8 minutes (Attachment One). The motion passed unanimously.

2. <u>Adopted the Mental Health Parity Guidance and Data-Collection Tool for Mental Health Parity Analysis</u>

Director Ramge said on Dec. 19, 2018, the Market Conduct Examination Standards (D) Working Group adopted a new mental health parity guidance for market conduct examiners to be included in the *Market Regulation Handbook*. He said the first document for consideration is the Mental Health Parity Guidance, and the second document for consideration is the Data-Collection Tool for Mental Health Parity Analysis. He said the Compliance and Enforcement Division of the federal Center for Consumer Information and Insurance Oversight (CCIIO) assisted in the development of the documents.

Commissioner Kiser made a motion, seconded by Mr. Pyle, to adopt the Mental Health Parity Guidance (Attachment Two) and the Data-Collection Tool for Mental Health Parity Analysis (Attachment Three). The motion passed unanimously.

3. <u>Discussed the *Best Practices and Guidelines for Consumer Information Disclosures*</u>

Director Lindley-Myers said the guidelines were adopted in 2012 and have not been reconsidered since. She said the NAIC consumer representatives made a request to the Executive (EX) Committee at the 2018 Fall National Meeting to appoint a task force to consider standards for the development of consumer information disclosures. The Executive (EX) Committee's preference is to have the Market Regulation and Consumer Affairs (D) Committee review and update the existing guidelines rather than appoint a new task force.

Birny Birnbaum (Center for Economic Justice—CEJ) said there were more than 20 consumer information drafting activities occurring across multiple committees, task forces and working groups when the NAIC consumer representatives made the request for a new task force. He said the NAIC consumer representatives want to encourage a consistent approach to the development of effective consumer disclosures. Given that the guidelines for consumer information disclosures were adopted in 2012, he encouraged the Market Regulation and Consumer Affairs (D) Committee to update the guidelines, as appropriate, and establish a process through which the guidelines are used during the development of consumer disclosures across committees.

Director Lindley-Myers asked all parties to submit comments on the guidelines by July 1.

4. <u>Adopted Revisions to its 2019 Charges</u>

Director Lindley-Myers said the first revision to the charges is the addition of a charge for the review of the *Best Practices and Guidelines for Consumer Information Disclosures.* The second revision is to move the Advisory Organization Examination Oversight (C) Working Group from the Property and Casualty Insurance (C) Committee to the Market Regulation and Consumer Affairs (D) Committee. Director Lindley-Myers said the change in reporting for this Working Group is being

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proposed because the Market Regulation and Consumer Affairs (D) Committee has responsibility for the development of market conduct examination standards and the monitoring of multi-jurisdictional market conduct activities.

Commissioner Kreidler made a motion, seconded by Ms. Biehn, to adopt the revisions to the 2019 charges (Attachment Four).

Mr. Birnbaum said he supports the proposed amendments, and he suggested adding the following charge for the Advisory Organization Examination Oversight (C) Working Group: "Ensure that organizations that engage in advisory organization activities are properly licensed and subject to appropriate regulatory oversight." He said there has been a massive increase in organizations collecting data and providing pricing, underwriting, and claims settlement tools to insurers. He said these new organizations may not be familiar with insurance regulation laws or antitrust laws. He said the charges currently assume entities have properly identified themselves as advisory organizations, but he said there are many new entities acting as advisory organizations that have not been identified. He said it is important for state insurance regulators to ensure that all organizations engaging in advisory organization activities are properly licensed and subject to appropriate regulatory oversight.

Mr. Schott said he is the chair of the Advisory Organization Examination Oversight (C) Working Group, and he is uncertain about expanding the scope of the Working Group's charges to include the identification of entities that are acting as unlicensed advisory organizations. He said the other members of the Working Group should be aware of this discussion before the charges are amended.

Commissioner Robertson asked Mr. Birnbaum if he believes the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) should be licensed and audited by state insurance regulators. Mr. Birnbaum said he believes guaranty associations should be subject to oversight and audit, but said these associations are created under state laws that are separate from state laws regulating advisory organizations.

Director Ramge said he has concerns with the existing charge addressing the Market Regulation and Consumer Affairs (D) Committee's coordination with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA). He said health insurance markets vary by state, and the states should exercise caution in trying to implement uniform state enforcement of the ACA. He said he is not requesting that the charge be revised, but he said it would be better if the charge referenced providing policy recommendations regarding appropriate state enforcement of the ACA, rather than uniform state enforcement of the ACA.

Director Lindley-Myers said the motion before the Market Regulation and Consumer Affairs (D) Committee is to consider the addition of a charge for the review of the *Best Practices and Guidelines for Consumer Information Disclosures* and to move the existing charges of the Advisory Organization Examination Oversight (C) Working Group from the Property and Casualty Insurance (C) Committee to the Market Regulation and Consumer Affairs (D) Committee. She asked Mr. Birnbaum to discuss his proposed charge for the Advisory Organization Examination Oversight (C) Working Group with Mr. Schott and provide language for the Market Regulation and Consumer Affairs (D) Committee to consider prior to the Summer National Meeting. The motion passed unanimously.

5. <u>Adopted its Task Force and Working Group Reports</u>

Director Lindley-Myers said the reports of the Committee's task forces and working groups were circulated for this meeting. She reported that there is currently no chair for the Market Regulation Certification (D) Working Group, and the Working Group has not met in 2019. The Market Actions (D) Working Group met April 6 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.

Director Lindley-Myers asked if any of the chairs of the task forces, working groups, committee members or interested parties would like to make any comments on the reports. Hearing no comments, Mr. Pyle made a motion, seconded by Commissioner Beck, to adopt the following task force and working group reports: the Antifraud (D) Task Force, including its recommendation to not pursue the development of an NAIC database to be created and maintained by the NAIC Securities Valuation Office (SVO) specific to tracking the fraudulent financial reporting for chief executive officers (CEOs), directors and corporate officers; the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Market Conduct Annual Statement Blanks (D) Working Group (Attachment Five); the Market Conduct Examination Standards (D) Working Group (Attachment Six); and the Market Analysis Procedures (D) Working Group (Attachment Seven). The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

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Draft: 2/13/19

Market Regulation and Consumer Affairs (D) Committee
Conference Call
February 8, 2019

The Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 8, 2019. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Allen W. Kerr, Vice Chair, represented by Melissa B. Grisham (AR); Trinidad Navarro represented by Frank Pyle (DE); Jim Beck represented by Debra Peirce (GA); Vicki Schmidt (KS); Anita G. Fox represented by Michele Riddering (MI); Mike Causey represented by Tracy Biehn (NC); Kent Sullivan represented by Ignatius Wheeler (TX); Todd E. Kiser represented by Tanji Northrup (UT); Michael S. Pieciak represented by Christina Rouleau (VT); and Mike Kreidler and John Haworth (WA). Also participating was: Maria Ailor (AZ).

1. Adopted its Fall National Meeting Minutes

Mr. Haworth made a motion, seconded by Ms. Biehn, to adopt the Committee's Nov. 17, 2018 minutes (*see NAIC Proceedings – Fall 2018, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Discussed Charges and Working Groups

Director Lindley-Myers said the 2019 charges for the Committee, Task Forces and Working Groups have not been modified since their adoption last year. The charges have been posted on the NAIC website under each respective group. Director Lindley-Myers also announced the chairs of the Task Forces and Working Groups reporting to the Committee.

Superintendent John G. Franchini (NM) was appointed chair of the Antifraud (D) Task Force, and Commissioner Navarro was appointed vice-chair. Director Lori K. Wing-Heier (AK) was appointed chair of the Market Information Systems (D) Task Force, and Director Lindley-Meyers was appointed vice-chair. Director Larry Deiter (SD) was appointed chair of the Producer Licensing (D) Task Force, and Commissioner Mike Kreidler (WA) was appointed vice-chair.

Angela Dingus (OH) will be the chair of the Market Actions (D) Working Group, and Pam O'Connell (CA) will be the vice-chair. Mr. Haworth will be the chair of the Market Analysis Procedures (D) Working Group, and Cari Lee (WI) will be the vice-chair. Ms. Ailor will be the chair of the Market Conduct Annual Statement Blanks (D) Working Group, and Ms. Dingus will be the vice-chair. Director Bruce R. Ramge (NE) will be the chair of the Market Conduct Examination Standards (D) Working Group, and Russell Hamblen (KY) will be the vice-chair. The chair and vice-chair of the Market Regulation Certification (D) Working Group have not yet been determined.

The Auto Insurance (C/D) Working Group was disbanded during the Fall National Meeting. Director Lindley-Myers said the Property and Casualty Insurance (C) Committee will complete all additional work regarding the private passenger automobile insurance report.

3. Adopted June 30 Filing Deadline for the Health MCAS

Director Lindley-Myers said industry submitted the first filing of the Health Market Conduct Annual Statement (MCAS) in September 2018. While industry and regulators worked together to develop the health blank, industry representatives said they encountered issues that made it difficult to gather and submit complete data. To address these issues, the Market Conduct Annual Statement Blanks (D) Working Group held an interim meeting in January. Director Lindley-Myers said the Working Group adopted a recommendation to move the filing deadline for 2018 Health MCAS data from May 31 to June 30. Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) said he appreciated the Working Group holding the meeting and supports the change in the filing deadline for this year. Mr. Haworth made a motion, second by Mr. Pyle, to move the filing deadline for 2018 Health MCAS data from May 31 to June 30. The motion passed unanimously.

4. Adopted June 30, 2020, Filing Deadline for the Disability Income MCAS

Director Lindley-Myers said the Market Conduct Annual Statement Blanks (D) Working Group adopted the Disability Income MCAS blank and definitions on May 16, 2018, and the NAIC Executive (EX) Committee and Plenary adopted the blank and definitions on Aug. 7, 2018, at the Summer National Meeting. A filing deadline had not been established. Director Lindley-Myers said the first year a line of business was collected, the filing deadline has been delayed providing industry additional time to format their data and ask questions. She said the Market Conduct Annual Statement Blanks (D) Working Group has

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now adopted a recommendation of June 30, 2020, as the filing deadline for the first filing of the Disability Income MCAS. Mr. Haworth made a motion, second by Ms. Northrup, to establish June 30, 2020, as the filing deadline for 2019 Disability Income MCAS data. The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

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Mental Health Parity Guidance Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18
___________ (*Section in Chapter 24 of the Market Regulation Handbook TBD*)**—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination**

Introduction
The intent of **___________** (*Section in Chapter 24 of the Market Regulation Handbook TBD*)—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health insurers, but large group coverage may or may not include mental health and/or substance use disorder coverage. **___________** (*Section in Chapter 24 of the Market Regulation Handbook TBD*) strictly applies to examinations to determine compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) found at 42 U.S.C. 300gg-26 and its implementing regulations found at 45 CFR §146.136 and 45 CFR §147.160, and is to be used for plans that offer mental health and/or substance use disorder benefits.

Generally, MHPAEA regulations require that any financial requirement (FR) (e.g.. copayments, deductibles, coinsurance, or out-of-pocket maximums) or quantitative treatment limitation (QTL) (e.g., day or visit limits) imposed on mental health and substance use disorder (MH/SUD) benefits not be more restrictive than the predominant financial requirement or treatment limitation of that type that applies to substantially all medical and surgical benefits, on a classification-by-classification basis, as discussed below. With regard to any nonquantitative treatment limitation (NQTL) (e.g., preauthorization requirements, fail-first requirements), MHPAEA regulations prohibit imposing an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical (M/S) benefits in the same classification.

MHPAEA applies to major medical group and individual health insurance. Mental health and substance use disorder treatment are essential health benefits under the Patient Protection and Affordable Care Act, so examination of individual and small group ACA-compliant plans will include parity analysis. In the large group market, an insurer's plan is not required to cover mental health and/or substance use disorder services. If the insurer's large group plan does cover mental health and/or substance use disorder services, parity requirements apply. MHPAEA does not apply to excepted benefit plans, nor to short-term limited duration insurance. Some states may have mental health parity requirements that are stricter than federal requirements.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group, and large group insurance markets.

Examination Standards
Each examination standard includes a citation to MHPAEA or its implementing regulations, but additional information can be found in federal guidance documents and state law or state interpretation of federal law. Please note that the federal government periodically updates its guidance documents related to MHPAEA. Examiners should refer to the U.S. Departments of Labor, Health and Human Services, and the Treasury for any updates or new MHPAEA guidance. MHPAEA allows states to enact statutes or regulations that are stricter than federal requirements. Examiners should contact their state's legal division for assistance and interpretation of federal guidance, as well as any additional state requirements. Where there is a reasonable interpretation of MHPAEA, that reasonable interpretation should be given due consideration.

Collaboration Methodology
The development of state market conduct compliance tools for MHPAEA will result in enhanced state collaboration, to provide more consistent interpretation and review of parity standards.

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Mental Health Parity Guidance Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18
LIST OF QUESTIONS

Question 1.
Is this insurance coverage exempt from MHPAEA (45 CFR §146.136(f))? If so, please indicate the reason (e.g., retiree-only plan, excepted benefits (45 CFR §146.145(b)), short term, limited duration insurance,* small employer exemption (45 CFR §146.136(f)), increased cost exemption (45 CFR §146.136(g)).

**Under the Public Health Services Act (as added by HIPAA), short term limited duration insurance is excluded from the definition of individual health insurance coverage (45 CFR. §144.103).*

Question 2.
If not exempt, does the insurance coverage provide MH and/or SUD benefits in addition to providing M/S benefits?

Unless the insurance coverage is exempt or does not provide MH/SUD benefits (note that MH/SUD is one of the EHBs for non-grandfathered coverage in the individual and small group markets), continue to the following sections to examine compliance with requirements under MHPAEA.

Question 3.
Are all conditions that are defined as being or as not being a mental health condition, a substance use disorder or a medical condition defined in a manner that is consistent with generally recognized independent standards of current medical practice?

See 45 CFR §146.136(a). This section provides definition of "mental health benefits" and "substance use disorder benefits".

Question 4.
Does the insurance coverage provide MH/SUD benefits in every classification in which M/S benefits are provided?

Under the MHPAEA regulations, the six classifications of benefits are:
1) *inpatient, in-network;*
2) *inpatient, out-of-network;*
3) *outpatient, in-network;*
4) *outpatient, out-of-network;*
5) *emergency care; and*
6) *prescription drugs.*

See 45 CFR §146.136(c)(2)(ii).

Because parity analysis for this standard is at the classification level, data must be collected for each classification. An example data collection tool is provided, which collects information needed to answer this question.

Question 5.
If the plan includes multiple tiers in its prescription drug formulary, are the tier classifications based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up) determined in accordance with the rules for NQTLs at 45 CFR §146.136(c)(4)(i), and without regard to whether the drug is generally prescribed for MH/SUD or M/S benefits? Explain how the plan's tiering methodology for MH/SUD prescription drugs is comparable to and are applied no more stringently than the tiering methodology for M/S prescription drugs.

See 45 CFR §146.136(c)(3)(iii)(A).

Question 6.
If the plan includes multiple network tiers of in-network providers, is the tiering based on reasonable factors (such as quality, performance, and market standards) determined in accordance with the rules for NQTLs at 45 CFR §146.136(c)(4)(i), and without regard to whether a provider provides services with respect to MH/SUD benefits or M/S benefits? Explain how the plan's tiering methodology for MH/SUD network tiers are comparable to and are applied no more stringently than the tiering methodology for M/S network tiers.

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See 45 CFR §146.136(c)(3)(iii)(B).

Question 7.
Does the plan comply with the parity requirements for aggregate lifetime and annual dollar limits, including the prohibition on lifetime dollar limits or annual dollar limits for MH/SUD benefits that are lower than the lifetime or annual dollar limits imposed on M/S benefits? List the services subject to lifetime or annual limits, separated into MH/SUD and M/S benefits.

See 45 CFR §146.136(b). This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged. If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any M/S benefits, or it includes one that applies to less than one-third of all M/S benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. 45 CFR §146.136(b)(2). Also note that the parity requirements regarding lifetime and annual dollar limits only apply to the provision of MH/SUD benefits that are not EHBs because lifetime limits and annual dollar limits are prohibited for EHBs, including MH/SUD services.

Question 8.
Does the plan impose any financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximums) or quantitative treatment limitations (e.g., annual, episode, and lifetime day and visit limits) on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type that applies to substantially all M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR §146.136(c)(2). Because parity analysis is at the classification level and analysis is based on the dollar amount for expected benefits paid, data must be collected per classification. An example data collection tool is provided, which collects information needed to answer this question.

Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR §146.136(c)(1)(ii). Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, such as number of treatments, visits, or days of coverage. 45 CFR §146.136(c)(1)(ii).

If a plan includes a FR (copayment or coinsurance) or QTL (session or day limit) for MH/SUD benefits, the first step is to identify the comparison point by looking at M/S benefits for that classification. Determine whether the FR or QTL applies to at least two-thirds (“substantially all”) of the M/S benefits in that classification. For purposes of determining whether a type of FR or QTL applies to at least two-third of all M/S benefits in a classification, the FR or QTL is considered to apply regardless of the magnitude or level of that type of FR or QTL. For example, a copayment, coinsurance, session or day limit is considered to apply to the benefits regardless of the dollar amount, coinsurance percentage, or number of sessions or days for that type of FR or QTL. The portion of M/S benefits subject to the FR or QTL is based on the dollar amount of expected payments for M/S benefits in a year. If the type of FR or QTL applies to less than two-thirds of the M/S benefits in a classification, then that type of FR or QTL cannot be applied to MH/SUD benefits in that classification. If the type of FR or QTL applies to two-thirds or more of the M/S benefits in the classification, as determined under 45 CFR §146.136(c)(3)(i)(A), the examiner will go to the next step to look at the level of the FR or QTL, for example the specific copayment dollar amount, coinsurance percentage, or limitation on number of sessions or days.

If the type of FR or QTL is imposed on at least two-thirds of the M/S benefits in a classification, then the “level” (e.g., copayment dollar amount, coinsurance percentage, or limitation on number of days or sessions) is analyzed to determine the “predominant” level. In this second step, the examiner will look at the M/S benefits to which the FR or QTL applies and find the “predominant” level of the limitation—this means the specific dollar amount, coinsurance percentage, or limitation on number of sessions or days that applies to more than 50% of the M/S benefits in that classification subject to the FR or QTL. The FR or QTL imposed on MH/SUD benefits cannot be more restrictive than the predominant level.

If less than 50% of the M/S benefits that are subject to the FR or QTL in a classification are subject to a certain “level” of FR or QTL, levels of the FR or QTL can be combined to reach 50% of the M/S benefits in the classification, with the least restrictive level within the combination being the level that can be applied to MH/SUD benefits in the classification.

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Mental Health Parity Guidance Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18

Question 9.

Does the plan apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR §146.136(c)(3)(v). For example, a plan may not impose an annual $250 deductible on M/S benefits in a classification and a separate $250 deductible on MH/SUD benefits in the same classification. Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because those two terms are excluded from the meaning of financial requirements). 45 CFR §146.136(a).

Cumulative financial requirements and treatment limitations are also subject to the predominant and substantially all tests in Question 7.

Question 10.
Does the plan impose Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD benefits in any classification? If so, demonstrate compliance with parity requirements by completing the attached data collection tool.

Examples of NQTLs (not exclusive):

a) **Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;**

b) **Prior authorization and ongoing authorization requirements;**

c) **Concurrent review standards;**

d) **Formulary design for prescription drugs;**

e) **For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;**

f) **Standards for provider admission to participate in a network, including reimbursement rates;**

g) **Plan or insurer's methods for determining usual, customary and reasonable charges;**

h) **Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols);**

i) **Restrictions on applicable provider billing codes;**

j) **Standards for providing access to out-of-network providers;**

k) **Exclusions based on failure to complete a course of treatment;**

l) **Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan; and**

m) **Any other non-numerical limitation on MH/SUD benefits.**

Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

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Mental Health Parity Guidance Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18
See 45 CFR §146.136(c)(4) and pages 14-20 of the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) for analysis advice available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/out-activities/resource-center/publications/compliance-guide-appendix-a-mhpaea.pdf.

Question 11.

Does the insurer comply with MHPAEA disclosure requirements including (1) criteria for medical necessity determinations for MH/SUD benefits, and (2) the reasons for any denial?

See 45 CFR §146.136(d)(1) and (2).

Note that the state's grievance procedure and external review statutes may contain additional disclosure requirements.

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Data Collection Tool For Mental Health Parity Analysis Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18

DATA COLLECTION TOOL FOR MENTAL HEALTH PARITY ANALYSIS

Most parity analysis examines benefits by comparing MH/SUD to M/S within a classification. 45 CFR §146.136(c)(2)(i). The exception is aggregate lifetime or annual dollar limits (to the extent the plan is not prohibited from imposing such limits under Federal or State law), which are examined for the plan as a whole. 45 CFR §146.136(b). The following is intended to simplify data collection for parity analysis at the classification level. Examiners may find it helpful to identify a person with MHPAEA experience, from the state's legal or health policy division, to interpret results after data is received from the insurer.

GUIDANCE FOR PLACING BENEFITS INTO CLASSIFICATIONS:

MH/SUD and M/S benefits must be mapped to one of six classifications of benefits: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) prescription drugs, and (6) emergency care. 45 CFR §146.136(c)(2)(ii).

- The "inpatient" classification typically refers to services or items provided to a beneficiary when a physician has written an order for admission to a facility, while the "outpatient" classification refers to services or items provided in a setting that does not require a physician's order for admission and does not meet the definition of emergency care.
- "Office visits" are a permissible sub-classification separate from other outpatient services.
- The term "emergency care" typically refers to services or items delivered in an emergency department setting or to stabilize an emergency or crisis, other than in an inpatient setting.
- Some benefits, for example lab and radiology, may fit into multiple classifications depending on whether they are provided during an inpatient stay, on an outpatient basis, or in the emergency department.
- Insurers should use the same decision-making standards to classify all benefits, so that the same standard applies to M/S and MH/SUD benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for M/S benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits.

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS:

Types of Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR §146.136(c)(1)(ii). Types of Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, for example number of treatments, visits, or days of coverage. 45 CFR §146.136(c)(1)(ii). A two-part analysis applies to financial requirements (FRs) and quantitative treatment limitations (QTLs). In general, MHPAEA regulations require that any FR or QTL imposed on MH/SUD benefits not be more restrictive than the predominant level of financial requirement or treatment limitation of that type that applies to substantially all medical/surgical benefits in a classification.

If the plan applies a cumulative FR or QTL (a FR or QTL that determine whether or to what extent benefits are provided based on accumulated amounts), the FR or QTL must not accumulate separately from any established for M/S benefits in a classification.

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Data Collection Tool For Mental Health Parity Analysis Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS						
	Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR §146.136(c)(3)(iii)(B))	Inpatient Out-of-Network	Outpatient In-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR §146.136(c)(3)(iii)(B))	Outpatient Out-of-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services)	Emergency Care	Prescription Drugs
Does the plan provide MH/SUD benefits?						
Does the plan provide M/S benefits?						
Total dollar amount of all plan payments for M/S benefits expected to be paid for the relevant plan year						
List each financial requirement that applies to the classification for MH/SUD benefits:						
For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of financial requirement:						
For each level of each type of financial requirement that applies to at least 2/3rds of all M/S/ benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that financial requirement, that are subject to that level:						

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Data Collection Tool For Mental Health Parity Analysis Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS, CONT'D						
	Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR §146.136(c)(3)(iii)(B))	Inpatient Out-of-Network	Outpatient In-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR §146.136(c)(3)(iii)(B))	Outpatient Out-of-Network (Issuer can choose to have subclassifications for Outpatient Office Visits, and Other Outpatient Services)	Emergency Care	Prescription Drugs
Does the plan impose a separate cumulative financial requirement or QTL for MH/SUD benefits that accumulates separately from any cumulative financial requirement or QTL for M/S benefits?						
List each QTL that applies to the classification for MH/SUD benefits:						
For each type of QTL that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of QTL:						
For each level of each type of QTL that applies to at least 2/3rds of all M/S benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that QTL, that are subject to that level:						

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NON-QUANTITATIVE TREATMENT LIMITATIONS:

Non-Quantitative Treatment Limitations include but are not limited to medical management techniques such as step therapy and pre-authorization requirements. Coverage cannot impose a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification. Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

All plan standards that are not FRs or QTLs and that limit the scope or duration of benefits for services are subject to the NQTL parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

The following data collection chart is modeled after a tool used in federal MHPAEA examinations. Insurers who have completed "Table 5" for NQTLs may substitute those documents for completion of this chart.

NON-QUANTITATIVE TREATMENT LIMITATIONS			
Submit a separate form for each benefit plan design. Plan Name: Date: Contact Name: Telephone Number: Email: Line of Business (HMO, EPO, POS, PPO): Contract Type (large group, small group, individual): Benefit Plan Effective Date: Benefit Plan Design(s) Identifier(s):			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit	Summarize the plan's applicable NQTLs, including any variations by benefit	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits

Data Collection Tool For Mental Health Parity Analysis Adopted by the Market Conduct Examination Standards (D) Working Group 12-19-18

A. Definition of Medical Necessity What is the definition of medical necessity?			
NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT'D			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit	Summarize the plan's applicable NQTLs, including any variations by benefit	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits
B. Prior Authorization Review Process Include all services for which prior authorization is required. Describe any step therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			

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NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT'D			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit	Summarize the plan's applicable NQTLs, including any variations by benefit	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits
C. Concurrent Review Process, including frequency and penalties for all services. Describe any step therapy or "fail first" requirements and requirements for submission of treatment required forms or treatment plans. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
D. Retrospective Review Process, including timeline and penalties. Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			

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Outpatient, Out-of-Network: Other Items and Services:			

NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT'D			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit	Summarize the plan's applicable NQTLs, including any variations by benefit	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits
E. Emergency Services			
F. Pharmacy Services Include all services for which prior authorization is required, any step therapy or "fail first" requirements, any other NQTLs. Tier 1:			
Tier 2:			
Tier 3:			
Tier 4:			

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NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT'D			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit	Summarize the plan's applicable NQTLs, including any variations by benefit	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits
G. Prescription Drug Formulary Design How are formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions?			
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy:			
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in development of the formulary for medications to treat medical, mental health and substance use disorder conditions?			
H. Case Management What case management services are available?			
What case management services are required?			

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What are the eligibility criteria for case management services?			

NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT'D			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit	Summarize the plan's applicable NQTLs, including any variations by benefit	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits
I. Process for Assessment of New Technologies Definition of experimental/investigational:			
Qualifications of individuals evaluating new technologies:			
Evidence consulted in evaluating new technologies:			
J. Standards for Provider Credentialing and Contracting Is the provider network open or closed?			
What are the credentialing standards for physicians?			
What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers?			
What are the credentialing/contracting standards for unlicensed personnel;			

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e.g., home health aides, qualified autism service professionals and paraprofessionals?			
K. Exclusions for Failure to Complete a Course of Treatment Does the plan exclude benefits for failure to complete treatment?			

NON-QUANTITATIVE TREATMENT LIMITATIONS, CONT'D			
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit	Summarize the plan's applicable NQTLs, including any variations by benefit	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR §146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. Please include in this column an explanation of how the MH/SUD benefits compare to M/S benefits
L. Restrictions that Limit Duration or Scope of Benefits for Services Does the plan restrict the geographic location in which services can be received; e.g., service area, within the state, within the United States?			
Does the plan restrict the type(s) of facilities in which enrollees can receive services?			
M. Restrictions for Provider Specialty Does the plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?			
List of Documents Referenced Above *List each document referenced above, including reference to exhibit number, file name, or other identifying information for examiners.*			

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Draft: 4/3/19

Revision marks reflect proposed changes from adopted 2019 charges.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

The mission of the Market Regulation and Consumer Affairs (D) Committee is to monitor all aspects of the market regulatory process for continuous improvement. This includes market analysis, regulatory interventions with companies and multi-jurisdictional collaboration. The Committee will also review and make recommendations regarding the underwriting and market practices of insurers and producers as those practices affect insurance consumers, including the availability and affordability of insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
   A. Monitor the centralized collection and storage of market conduct data, national analysis and reporting at the NAIC, including issues regarding the public availability of data.
   B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
   C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
   D. Oversee the activities of the Antifraud (D) Task Force.
   E. Oversee the activities of the Market Information Systems (D) Task Force.
   F. Oversee the activities of the Producer Licensing (D) Task Force.
   G. Monitor the underwriting and market practices of insurers and producers, as well as conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
   H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
   I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
   J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
   ~~J.~~K. *Review the "Best Practices and Guidelines for Consumer Information Disclosures" (adopted October, 2012) and update as needed.*

2. The **Market Actions (D) Working Group** will:
   A. Facilitate interstate communication and coordinate collaborative state regulatory actions.

3. The **Market Analysis Procedures (D) Working Group** will:
   A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions. Provide recommendations by the Fall National Meeting.
   B. Discuss other market data-collection issues and make recommendations, as necessary.
   C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS). Provide recommendations by the Fall National Meeting.

4. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
   A. Review the MCAS data elements and the "Data Call and Definitions" for all lines of business collected in the MCAS and update them, as necessary, by June 1, 2019.
   B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate, by June 1, 2019.

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5. The **Market Conduct Examination Standards (D) Working Group** will:
   A. Develop market conduct examination standards and uniform market conduct procedural guidance, as necessary.
   B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models by the Fall National Meeting.
   C. Develop updated standardized data requests for inclusion in the *Market Regulation Handbook* by the Fall National Meeting.

6. The **Market Regulation Certification (D) Working Group** will:
   Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states' compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.

7. *The **Advisory Organization Examination Oversight (D) Working Group** will:*
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (includes rating organizations and statistical agents) to be more comprehensive, efficient and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data-collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).

Draft: 4/2/19

Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
March 28, 2019

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call March 28, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Melissa Grisham (AR); Kurt Swan (CT); Amy Groszos (FL); Lori Cunningham (KY); Teresa Fischer (MN); Brent Kabler and Teresa Kroll (MO); Guy Self (OH); Michael Bailes (SC); Ned Gaines (WA); and Theresa Miller (WV).

1. Adopted its Jan. 23–24, 2019, and Dec. 20, 2018, Minutes

The Working Group met Jan. 23–24, 2019, and Dec. 20, 2018. During its Jan. 23–24, 2019, meeting, the Working Group discussed the definitions and data elements of the health Market Conduct Annual Statement (MCAS) and discussed its next steps. During its Dec. 20, 2018, meeting, the Working Group took the following action: 1) adopted its May 30, 2018, May 16, 2018, and May 10, 2018, minutes; 2) approved the deadline for the first filing year of the disability income MCAS; 3) received an update on the private flood MCAS; and 4) received an update on the life and annuity MCAS review project.

Mr. Swan made a motion, seconded by Mr. Kabler, to adopt the Working Group's Jan. 23–24, 2019 (Attachment Five-A) and Dec. 20, 2018 (Attachment Five-B) minutes. The motion passed unanimously.

2. Discussed Items from the Jan. 23–24 Meeting

Ms. Ailor stated that the Jan. 23–24 meeting was prompted due to concerns expressed about challenges in completing the health MCAS by several industry representatives and trade organizations to Commissioner Allen W. Kerr (AR), who was chair of the Market Regulation and Consumer Affairs (D) Committee at that time. Commissioner Kerr agreed to a meeting to discuss these concerns.

Ms. Ailor detailed that the meeting was well-attended and led to much clarification regarding the data call and definitions, frequently asked questions (FAQ) and the MCAS guides. She directed the Working Group to the meeting materials, which contain a high-level summary of the decisions made at the meeting. She stated that these decisions have been added, as appropriate, to the health blank, the data call and definitions, and the FAQ, which are also contained in the meeting materials. She informed the Working Group that the health documents are being exposed and comments will be considered at the next meeting. She said comments should be submitted to Tressa Smith (NAIC) no later than April 18. She stated that the Working Group will begin holding regular conference calls with the health industry and consumer representatives, as agreed to during the Jan. 23–24 meeting.

Ms. Ailor asked Randy Helder (NAIC) to begin the discussion on the documents, as he has already received some comments and questions to which he would like to draw attention. Mr. Helder stated that recap item #12 clarified "a consumer at renewal," and many questions were received regarding what was meant by "consumer." He stated that this will be changed to specify "a group or individual at renewal."

Mr. Helder said the comments on the right-hand side of the documents point to the recap documentation to aid in the review of the changes to the documents.

Mr. Helder stated that recap item #6 treats a group policy as one policy, regardless of the number of products available to the group. The data call and definitions for the "number of policies renewed" generated questions from companies because it seemed to contradict the decision in recap item #6, and there were still scenarios for which the guidance was not complete. Mr. Helder stated that he has listened to the recordings from the meetings, and it appears that the intent was to count a change as a new policy issued if the change resulted in a new policy number or group number, or the policy went to another company code within the group.

Neil Lofquist (Kaiser Foundation Health Plan, Inc.—Kaiser) stated that Kaiser needs clarification on recap item #6 and recap item #12. He stated that Kaiser believes a new policy would be equal to a new group, new group number or a change in product. He stated that Kaiser believes the definition of "renewal" would be adding a new plan variation to a group. He stated that Kaiser would categorize a termination as a cancellation of the entire group and all policies within it, either by the group or due to nonpayment of a premium. He stated that he would like to confirm this logic is correct.

Ms. Ailor asked Mr. Lofquist to send written comments to Ms. Smith by April 18, so the Working Group can evaluate them and consider them at the next meeting.

Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) expressed appreciation for the productive meeting. He proposed to the Working Group that there have been working groups under the Financial Condition (E) Committee that have created a form to submit to the NAIC in order to submit topics and gather items for the upcoming open forum calls. He suggested that the Working Group consider a similar process.

Mr. Kabler stated that he would also submit written comments; however, regarding recap item #2 about posting the scorecards and data, he would like the Working Group to consider how the ratios are posted because of data concerns. He stated that it might be helpful for the Working Group to develop formal standards regarding how the data is released.

Ms. Ailor stated that she echoes Mr. Kabler's concerns, noting that they were considered when it was decided to not post the 2017 MCAS health scorecard information. Mr. Kabler suggested that a subject-matter expert (SME) group be formed for this.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that he does not believe the individual company data should be confidential because it is reported under the market conduct examination laws, which are treated as work papers. He stated that there has not been any serious examination that individual company information deserves confidential treatment. He asked that if the proposal by Mr. Kabler is considered, it be accompanied by a review of whether this information is confidential or if there is a greater benefit to making this information public. He stated that the view of the CEJ is that there is a much greater benefit to making the information public, as it is aggregate information.

Ms. Ailor asked for Mr. Birnbaum's comments to be submitted in writing, but said she is unsure if that decision would fall to the Working Group or would defer to the NAIC, because the data is collected under examination authority.

3. Exposed the Private Flood MCAS

Ms. Ailor stated that the private flood MCAS data call and definitions is ready to be exposed. She informed the Working Group that it has been posted on the Working Group's web page in the "Exposure Drafts" section. A small group of SMEs was formed to work on the blank and has been meeting on a regular basis for a few months.

Ms. Ailor stated that in order to capture the full market, the private flood MCAS collection reporting is broken down into different sections of stand-alone policies, as a rider to an existing policy or an endorsement to an existing policy, as well as reporting for first-dollar coverage and excess coverage in the different coverage types.

Ms. Fischer asked if lender-placed flood policies are included in this coverage. Ms. Ailor stated that they are not included as part of this data collection and are specifically excluded within the data call and definitions. Mr. Birnbaum replied that they are included on the lender-placed insurance MCAS data collection.

Ms. Ailor requested that comments be sent to Ms. Smith by April 18, so the comments can be reviewed and the private flood MCAS blank can be considered for adoption during the Working Group's April 25 conference call.

4. Received an Update on the Life and Annuity MCAS Review Project

Ms. Ailor stated that the Working Group is in the process of evaluating the blanks and adding additional levels of detail for both the life and annuity products. She stated that once the work is completed, it will be sent to the Working Group for review and consideration. She said anyone interested in joining the discussions should contact Cindy Amann (MO) and Ms. Smith.

5. Discussed Reviewing the Homeowners, Private Passenger Auto and LTC MCAS Data Elements and Data Call and Definitions

Ms. Ailor stated that one of the charges for the Working Group is to review the MCAS data elements and the data call and definitions for all lines of business and update them, as needed, by June 1, 2019. She noted that because there is a group currently working on the life and annuity MCAS, the Working Group needs to review the remaining lines of business. She stated that she would like to form an SME group to review the data elements and definitions for the homeowners and private passenger auto MCAS, as well as one for the long-term care (LTC) MCAS.

Ms. Ailor asked for a volunteer from the Working Group who would be willing to lead in these discussions. Mr. Kabler stated that he would be willing to participate and inquired if there had been any specific concerns to prompt this charge. Ms. Ailor stated that it is just a charge for the Working Group and asked Ms. Smith if there have been any specific concerns received for these lines of business. Ms. Smith informed the Working Group that she has not received any specific concerns regarding these lines of business.

Mr. Gaines stated that he would be willing to help with the homeowners and private passenger auto review.

Lisa Brown (American Property Casualty Insurance Association—APCIA) asked if interested parties would be able to participate in these discussions. Ms. Ailor informed her that they would be welcomed. Ms. Brown asked to participate in the homeowners and private passenger auto discussions.

Mr. Birnbaum asked to be included in the homeowners, private passenger auto and LTC review.

Ms. Ailor said anyone else interested in joining the discussions should contact Ms. Smith. She said the Working Group's next conference call is scheduled for April 25.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Draft: 2/27/19

Market Conduct Annual Statement Blanks (D) Working Group
Dallas, Texas
January 23 and 24, 2019

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Dallas, TX, Jan. 23 and Jan. 24, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Allen W. Kerr (AR); Kurt Swan (CT); Lori Cunningham and Patrick Smith (KY); Angela Nelson and Teresa Kroll (MO); and John Haworth (WA). Also participating were: October Nickel (ID); Laura Arp and Martin Swanson (NE); Katie Dzurec (PA); and Christina Rouleau (VT).

1. Heard Opening Comments

Commissioner Kerr welcomed the attendees to the interim meeting of the Working Group. He noted the attendance of consumer representatives, industry representatives and regulators.

Commissioner Kerr said he announced the interim meeting during the 2018 Fall National Meeting, right after the NAIC had received most of the initial Market Conduct Annual Statement (MCAS) filings from health companies that were due Sept. 30, 2018. He said that prior to the Sept. 30, 2018, filing deadline, representatives of a few major health insurance writers had contacted him concerning the MCAS filing, asking for some relief on the attestation requirements and the next filing due date. He said he was presented with examples of data elements and definitions they believed were causing confusion and would result in inconsistent reporting among the companies. He said that he referred the attestation and filing due date questions to the Market Analysis Procedures (D) Working Group and supports the Working Group's decision to insist on completed attestations and not to extend the filing due date. He noted that the industry representative also requested the formation of a new working group to address the concerns. He said that in keeping with the direction set by the Executive (EX) Committee, he did not agree to appointing another Working Group. However, he said an open, face-to-face meeting of the industry and regulators would be useful, and he decided a two-day meeting dedicated only to the health MCAS would be constructive for all sides.

Commissioner Kerr said he was looking forward to discussion among all stakeholders of the health MCAS filing and hoped everyone would walk away from the meeting with a greater understanding of the data needs of the regulators and consumers, and the capabilities of the industry to meet those data needs.

Ms. Ailor also welcomed everyone to the interim meeting. She thanked everyone for taking time to attend the interim meeting and said the number of attendees speaks to the value of the meeting.

Ms. Ailor said the MCAS is a valuable tool used by nearly all state insurance departments to help analyze their insurance markets and prioritize issues and resources. She said that although MCAS data reporting is new to health insurers, MCAS data has been collected for more than 15 years in other lines of insurance. She said the MCAS began as a tool used by individual states to collect state-specific market conduct data that was not otherwise available, such as nonrenewals, cancellations and claims timeliness. By 2010, half the states were collecting their own unique versions of MCAS data. She said this spurred the development of the uniform, centralized system in place today, where companies submit annual MCAS data one time, in one uniform collection tool through the NAIC. She said 48 states and the District of Columbia now participate in the MCAS.

Ms. Ailor said the Market Conduct Annual Statement Blanks (D) Working Group was appointed to: 1) create a transparent, collaborative process for adding additional lines of insurance to the MCAS; and 2) make changes to existing MCAS lines of business. She said the MCAS lines of insurance now include private passenger auto, homeowners, life, annuity, long-term care, disability income, lender-placed insurance and health insurance, while private flood is in development.

Ms. Ailor said that with each new state and line of business, there were new companies that did not previously have to file an MCAS. She said the regulators at the interim meeting are experienced with responding to and assisting companies that have never filed an MCAS, and they understand the types of issues that come up with first-year filings and recognize that companies that have never filed an MCAS before worry about what comes next. She said the regulators know the MCAS is new to health insurers, and while insurers are used to having to submit comprehensive financial statement data, the MCAS creates new questions.

Ms. Ailor said the Working Group understood that the health MCAS is different and took the unique step of doing a pilot launch of the blank prior to including it in MCAS reporting. She said this provided insurers and the states an unprecedented opportunity to work through definitions and data needs. She said the Working Group also worked diligently to develop robust MCAS tools to help filers understand what is, and is not, included. She welcomed the industry's input on how to improve the definitions and data elements.

Ms. Ailor said many of the issues and questions are not new, noting that many are addressed in the Frequently Asked Questions (FAQ) document or other guidance. She noted that with every new MCAS line of business, filers have questions about how to use the MCAS tool, what is included in the data fields, what the states will use the data for, whether the data is confidential and how to get the data. She said she was hopeful that these questions and concerns about the health MCAS would be answered during the interim meeting. She said she wanted to make the process as straightforward as possible.

Ms. Ailor said the Working Group cannot effectuate any changes to the next MCAS filing due in May. She said the MCAS revision process was developed to provide companies plenty of time to prepare for new data requests. According to the revision process, any changes approved by the Working Group before June 1 apply to the following data year, so any agreed changes at the interim meeting would apply to the 2020 data year, which is collected in 2021. Additionally, she said any decisions made by the Working Group need to be approved by the Market Regulation and Consumer Affairs (D) Committee prior to Aug. 1.

Ms. Ailor asked attendees to introduce themselves. The following individuals attended the interim meeting—Commissioner Kerr and Melissa Grisham (AR); Maria Ailor and Tolanda Coker (AZ); Kurt Swan (CT); October Nickel (ID); C.J. Metcalf and Erica Weyhenmeyer (IL); Lori Cunningham and Patrick Smith (KY); Jeff Zewe (LA); Jill Huisken (MI); Teresa Kroll and Angela Nelson (MO); Laura Arp and Martin Swanson (NE); Angela Dingus and Guy Self (OH); Katie Dzurec (PA); Stacie Parker and Matthew Tarpley (TX); Nancy Askerlund (UT); Melissa Gerachis (VA); Christina Rouleau and Marcia Violette (VT); John Haworth (WA); Samantha Burns (AHIP); Christine Cappiello and Lisa Combs (Anthem Blue Cross Blue Shield); Zane Chrisman and Christi Kittler (BCBS Arkansas); Kim Holland, Demetria Tittle and Joseph Zolecki (BCBSA); Karen Austin, Franca D'Agostino, Kirsti Ryan and Macie Taylor (Cigna); Sarah Lueck (Center on Budget and Policy Priorities); Michael Vahey and Robert Velick (HCSC); Holly Dolan (Highmark); Julia Hartnett and Stephen Popelack (Independence BCBS); Cynthia Cox (Kaiser Family Foundation); Monica Carroun, Brian Fontenot, and Kayla Gosserand (BCBS Louisiana); Zach Steadman and Jeffrey Thomas (Mitchell Williams); Andrea Clark (Molina Healthcare); Tammie Spah (Prime Therapeutics); Peggy Camerino (Torchmark); and Dianne Evans (United Healthcare).

Ms. Ailor invited interested parties to make opening remarks to begin the interim meeting.

Zach Steadman (Mitchell, Williams, Selig, Gates & Woodyard) thanked the Working Group for holding the interim meeting to address the industry's concerns and said they look forward to collaborative discussions.

Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) said the BCBSA understands the need for regulators to hear from companies, so the BCBSA held a series of conference calls with its member companies preceding this interim meeting to identify specific issues and general concerns.

Samantha Burns (America's Health Insurance Plans—AHIP) said AHIP's concerns fall into four categories: 1) conflicting or imprecise definitions; 2) data elements that are not captured by the industry; 3) the inability to capture some metal- and claim-level details; and 4) formatting challenges.

Mr. Zolecki said companies still do not have a clear understanding of purpose of the MCAS or the ratios being generated with the data. He said there are differences in the way the financial regulators collect data in the Supplemental Health Care Exhibit (SHCE) and the minimum loss ratio calculations that lead to discrepancies when comparing with MCAS data. He said that may create an inaccurate picture of the data. He noted that company systems are set up differently regarding the tracking of metal-level data than what is requested in the MCAS.

Demetria Tittle (BCBSA) said companies have questions about the meaning of the validation messages and they would like clarification on the purpose of the validation letters received from the NAIC. She also suggested a more formalized communications loop to better communicate guidance to companies about the MCAS filing, so companies get consistent responses and are more assured of receiving the guidance. She said companies would like more training, and she will provide suggestions for improved training, such as making the training downloadable.

Ms. Burns asked for an industry filing extension on the current filing from May 31, 2019, to a third quarter deadline and then continuing with a third quarter filing deadline for future years. Commissioner Kerr said the regulators need the data in the early part of the year because it is too old by September. He said April 30 is a drop-dead date. He advised companies to focus on making the deadline and not necessarily having perfect data. He said the data will continue to get better each subsequent year.

Ms. Ailor asked how the clarifications should be recorded. Ms. Dingus said they should be included in the FAQ document and, if necessary, in the Data Call and Definitions. Ms. Arp suggested that all industry questions that are answered should be in the FAQ document, so all companies will be sure to receive the same response. Mr. Zolecki said there should be a process to funnel questions to the NAIC for a single response, and he suggested regularly scheduled conference calls.

2. Discussed Data Elements That Apply to All Sections

Ms. Ailor said one of the questions received from the industry was whether the $50,000 threshold applies at the legal entity, state or segment size level. She said the MCAS guidance provided on the NAIC's MCAS web page provides an explanation that the threshold applies per state over all lines, both in and out of an exchange, written by the company. If a company's total premium over all its qualifying health products exceeds $50,000 in a state, it would need to report the MCAS to that state. She stated that this means if grandfathered business is a small portion of a company's overall business, it would be expected to be reported.

Kirsti Ryan (Cigna) said the interrogatories ask for the number of small groups and large groups. She said on the SHCE, groups are reported in terms of the number of certificates, the number of lives and the number of accounts. She asked for clarification on what is expected in the MCAS interrogatory. Mr. Haworth said, in the Interrogatories section, the expectation is for the company to report the number of groups. Questions about the number of lives and member months are included in the Policy Administration section of the MCAS.

Ms. Ryan asked for confirmation that the health MCAS is to be reported by the situs of the contract. Ms. Ailor confirmed MCAS data is to be reported by the situs of the contract. She noted that if there was a deviation to this, the company should note any deviations in its comments. Mr. Zolecki said that about 10 years ago, there was a discussion regarding the definition of "situs" for the annual financial statement Schedule T. He said, after two years of work, there was a good, clear definition of "situs." He recommended reviewing that definition. Ms. Ailor agreed that the Working Group would consider the Schedule T definition of "situs."

Ms. Ailor said a question was submitted asking if the reporting parameters are based on the SHCE methodology with respect to earned premiums, claims paid, member months, group data and policy data. Ms. Ailor said the MCAS has its own definitions and those dictate how the data is reported.

Dianne Evans (UnitedHealthcare) said many of the states are comparing the MCAS numbers to what is reported on the SCHE. She suggested training, so regulators are aware that the methodology for reporting the MCAS may in some cases differ from the SCHE. Mr. Zolecki said the FAQ document states that the premiums reported in the MCAS should be within 20% of what is reported on the SCHE. He said this should be removed from the FAQ document, because it indicates that there is a correlation.

Ms. Evans said that for group billing, UnitedHealthcare does not break down the premium by metal level or member level, so that distinction cannot be made when reporting the group billing premium in the MCAS. Mr. Haworth asked how rate determinations are made if that level of detail is not available. Ms. Evans said the actuaries have their own tables that are not accessible to her for reporting in the MCAS. Ms. Dingus advised the company to report as best as it can and put a note in the comments advising how it is reporting the premium. She also advised that UnitedHealthcare may need to begin efforts to obtain the information that is available in the other systems.

Mr. Zolecki said reporting the policy administration data by metal level is straightforward, but there are more difficulties with reporting prior authorizations, claims and consumer reviews by metal. He said claims are not handled any differently by metal level, and he recommended that they do not need to be reported by metal level. He mentioned that data is available to regulators in other reports. Ms. Ryan said that by breaking data down into multiple segments, the amount of data in each segment can lose its statistical significance. Ms. Ailor said market analysts do look at the population size when analyzing data.

Lisa Combs (Anthem Blue Cross and Blue Shield) said providing metal level data for grievance involves extra steps to tie the metal level of the policy with the consumer bringing the grievance. At the grievance stage, the metal level is not recorded.

Robert Velick (Health Care Service Corporation—HCSC) said HCSC handles grievances the same way. He said HCSC does not include metal level information in its claims, prior authorization and grievance data, noting that it adds complexity to merge the policy level information into the reporting.

Ms. Dzurec said gold and platinum plans have lower out-of-pocket maximums. She said it is important to see if prior authorizations, claims and grievances are denied more often for policyholders that reach the out-of-pocket maximums sooner. She said a few years of data would be helpful to see if that is a trend or an issue.

Ms. Ailor said this is the first year for reporting the health MCAS, and it will take a few years of trending and analyzing the data to determine its usefulness.

Ms. Nickel said if the data was only reported on the aggregate level to begin with, there may be trends that are overlooked.

3. Discussed Policy Administration

Ms. Combs said the FAQ document states: "It is intended that each product issued to a group as a policy be counted separately. If a contract includes multiple policies/products, you would count each policy/product separately. Likewise, if a product has multiple metal levels issued to the group, those would also need to be counted separately by metal level." She asked if that means three policies should be reported if a group had three products.

Ms. Dingus said the group policy should be reported once. She said the FAQ document would be revised to read as a group policy should be counted as one policy regardless of the number of products.

Mr. Zolecki proposed the following definition of "policy": "The definition of a policy as it relates to Individual MCAS reporting means to report the policy at the subscriber level. The definition of a policy as it relates to Small and Large Group MCAS reporting means to report the policy at the account level. A carrier may have several plan offerings and/or cost sharing offerings available under one account number."

Ms. Ryan said the MCAS blank asks for the number of member months on new and renewing policies, but it does not ask for the number of member months on policies that were terminated. Ms. Dingus said that was an oversight.

Ms. Ryan said the small group policies issued and renewed are not reported in-exchange or out-of-exchange, but they are required for large groups. She asked what the rationale for this was. Ms. Dingus said out-of-exchange totals for small groups may need be to be requested in future years.

Ms. Dingus said one submitted question asked if a policy is considered renewed if, within the same category, the product changes (e.g., if a group moves from a silver to a bronze plan). Commissioner Kerr said if the change involves copays or deductibles, that is only a change in coverage; but, if the product changes, it is a change in the contract and would be rewritten and considered a new policy. Ms. Dingus said if the policy number changes, it should be considered a new policy, not a renewal or termination. Ms. Ailor said this would be clarified in the FAQ document.

Ms. Dingus said another question concerns the categories for terminations. The categories are "termination for non-payment of premium" and "terminations initiated by the consumer." Ms. Ryan and Mr. Velick agreed that there are more termination categories than are listed. Ms. Dingus said it is understood that this is not exhaustive of all terminations, and she confirmed the NAIC's guidance that company-initiated terminations are not intended to be reported. Ms. Dzurec said if more information is required, additional termination categories could be added. Mr. Haworth suggested waiting until after more reporting periods to see if additional data is needed.

Ms. Ryan said the use of the term "consumer" in the data elements regarding terminations makes the question unclear whether it applies to group policies and, if so, whether it is at the account level or the subscriber level. Mr. Velick said the HCSC interpreted "consumer" to mean the decision-maker for the plan, whether it is a group or an individual.

Commissioner Kerr said for each of the questions regarding termination, the term "consumer" will consistently be replaced with "policyholder," and "lives" will be changed to "insured lives." He said this will also be clarified in the FAQ document.

4. Discussed Prior Authorizations

Ms. Ryan said the definitions for the Prior Authorizations section refers to the carrier; but in the definitions for the Grievances section, it refers to the carrier "or its designee." She said because the prior authorization definition did not say "or its designee," then perhaps prior authorization decisions made by vendors do not need to be reported. She asked if that was correct. Mr. Haworth said if the policy is written on the reporting company's paper, then it needs to be reported. He said "or its designee" would be added to the definitions in the Prior Authorization section.

Mr. Haworth said one of the submitted questions asked for clarification on whether partial authorizations should be considered approvals. Commissioner Kerr said doctors often submit many lines to get approval. He said approval of any portion is considered to be an approval.

Ms. Dzurec said the blank asks for total, approved and denied. She asked whether the difference between total and the sum of the approved and denied would equal the number of partials. Ms. Combs said it would not, because some requests are received in one year and decided in a different year. She also said some are withdrawn with no decision.

Mr. Velick noted that if the approvals and denials did not equal the total requested, the MCAS tool generates a warning message. Teresa Cooper (NAIC) said the warning message has been removed for the future filings, because companies may make approval/denial decisions in a different year than when the request was received. She said companies are to report the requests in the year they were received and decisions in the year they were made.

Ms. Dzurec asked whether it is helpful for regulators to know about partial approvals and, if so, it needs to be captured. If it does not matter, then perhaps partials should just be considered approved. Commissioner Kerr said they should be considered approved and it can be reconsidered in later years.

Ms. Rouleau said Vermont, by statute, considers partials as denials, which is appealable. Ms. Nelson said if any MCAS data indicates an issue, Vermont can follow up with a continuum or in the course of an examination. Ms. Rouleau said because Vermont is a small state, it is more difficult and counting partials as approvals would not necessarily indicate a problem. Ms. Arp noted that if a partial includes items the consumer wants to have covered, it will continue to be submitted until all that is left is a denial and that would then be reported as a denial.

Sarah Lueck (Center on Budget and Policy Priorities) said it is counterintuitive that a partial authorization would be an approval. She said consumers view this as a denial of some of their requested medical services. Commissioner Kerr gave the example of an authorization request for 25 visits to a chiropractor in which only 10 visits are approved, with the message that it will be reviewed again after 10 visits. He said it would be unfair to consider a partial approval as a denial. Ms. Nelson said the MCAS does not include a data element for partial authorizations at this point. After a few years of data, a new data element may be considered if it is necessary. She said the states have other data and consumer complaints they can rely on to spot any abuses in the prior authorization activities of companies.

Mr. Haworth said there is a question about whether mental health prior authorizations are to be included in the Prior Authorizations Excluding Pharmacy section data elements titled "Number of prior authorizations requested," "Number of prior authorizations approved" and "Number of prior authorizations denied," *in addition to* being included in the data elements titled "Number of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders," "Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders denied" and "Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved." Mr. Haworth said they should be included in both sections.

5. Discussed Claims Administration

Ms. Evans said UnitedHealthcare reported claims on the claim package level, not on the service line level. She noted that reporting on the service line level can overstate the number of claims and does not provide an accurate picture. Ms. Ailor said the Working Group decided that service line level is needed to get a full picture of industry claim activities, and it is clearly defined in the Data Call and Definitions.

Ms. Ailor said the industry comments included a request that duplicate claims not be considered denials, as counting duplicate claims would result in artificial and inaccurate reporting. Ms. Nelson agreed that including duplicate claims would result in erroneous data. Ms. Lueck asked if regulators can determine if duplicate claims are not actually duplicate claims. Ms. Ailor

said consumers will complain about wrongful denials. Ms. Nelson said the states can use a continuum option to get more information from companies.

Mr. Velick said the explanation of benefits (EOB) identifies which claims were denied because they were duplicates. Ms. Lueck said many consumers receiving EOBs do not necessarily review them or review them closely enough.

Zane Chrisman (Arkansas Blue Cross and Blue Shield) said if the provider does not receive a quick response to their claim, they will submit it again. It is not uncommon to have multiple denials to the same claim request because it is already paid, and the denial is because it is a duplicate. Mr. Velick said this is the largest category of denials.

Ms. Dingus said the FAQ document will be changed to state that duplicate claims are not reported.

Ms. Ailor said one question received from companies concerned the dates for claims received and claims paid. She said the FAQ document adequately explains how to report these. The claim receipt and claim paid are reported on the MCAS filing for the date it was received and the date it was paid. If a claim was received in 2018 but paid in 2019, the receipt of the claim would be reported in the 2018 data year filing, and the payment of the claim would be reported in the 2019 data year filing.

Ms. Ailor said another question concerned whether received claim lines included capitations, pended claim lines, and duplicates of paid or denied claims. Ms. Dingus asked why capitated claims would not be reported. Ms. Ryan said capitations are automated payments per an agreement with the provider, so they are not generally considered claims. Ms. Dzurec asked if an EOB is generated. She said from the consumer viewpoint it is the same as a claim. Ms. Ryan agreed and said an EOB is generated and sent to the consumer. Mr. Haworth noted that the FAQ document states that any claim resulting in an EOB should be reported, including capitations.

Ms. Ryan asked if incomplete claim lines and capitation encounters should be excluded for the turnaround time data elements. She said the FAQ document states that incomplete claims are not included in denied claims. Commissioner Kerr said if a claim is not paid, then it is denied. If a carrier receives a lot of incomplete claim requests, it should be pursuing an explanation from the provider. Ms. Dingus said she would like to see incomplete claims counted.

Mr. Haworth asked if it is possible to generate an EOB on an incomplete claim if it is incomplete because of typos on the policy or group number or other identifying information. Mr. Velick said no EOB can possibly be generated in that case, and it is not possible to track those requests.

Ms. Ailor said if a claim number can be generated and the claim closed without payment, it should be reported as a denied claim; however, if the request does not have enough identifying information to create a claim, it would be considered an incomplete claim.

Ms. Ailor said a series of questions were raised regarding “Claims Paid.” The first question was whether it would include capitations and pharmacy rebate dollars. Ms. Ryan said because the expectation is to follow the MCAS instructions and not necessarily tie back to the SHCE, then pharmacy rebate dollars would not be reported. Mr. Haworth agreed, but said capitations would be included. The second question was whether they should be reported if the member is no longer active. Ms. Ailor said they would continue to be reported.

Ms. Combs said there is difficulty fitting all claim denials into the denial reasons specified on the MCAS blank. She said NAIC staff advised that there is not an expectation that every denial would fit into one of the available categories. Ms. Ryan asked for clarification regarding whether behavioral health denials should be included in all claim denials *in addition to* being including in behavioral health denials. Ms. Ailor said the clarification would be made in the FAQ document.

6. Discussed Other Matters

Commissioner Kerr said the Working Group agreed to extend the next health MCAS filing due date to June 30. Ms. Lueck said this sends a message that the regulators are not taking the health MCAS as seriously as they should be. She asked that the Working Group strongly insist that all filing dates afterward will be April 30 each year. Commissioner Kerr agreed with Ms. Lueck’s request regarding future due dates and emphasized that April 30 is the due date for each subsequent year. He noted that the Market Regulation and Consumers Affairs (D) Committee will have to approve this extension.

Ms. Ailor said a question submitted asked how companies would be graded. She said the MCAS is just another source of data for regulators to use in conjunction with other data they receive from or about companies. The MCAS is not used to "grade" companies as such. She emphasized the confidentiality of the data.

Ms. Ailor said it is still too early to tell how useful each of the ratios may be or if any of them may be misleading if there is not a good correlation between the numerators and denominators. In any case, she noted that the ratios only lead the regulators to contact the carriers to seek additional information.

Ms. Dingus said that even though the ratios were not published for the September 2018 filing, Ohio has reviewed them and is still learning.

Mr. Haworth said an important aspect of ratios is how they trend over time for a company and in relation to other companies. He said he expected fluctuations in the first few filings.

Ms. Burns asked if the publication of the May 2019 ratio scorecards should be postponed due to the clarifications arising from the interim meeting. Commissioner Kerr said that will be a decision for later meetings.

Mr. Zolecki asked for improvements in the communication of decisions to all companies and asked for the NAIC to provide clearer explanations for the warning and error messages. Randy Helder (NAIC) agreed to provide explanations for the validations.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Draft: 12/26/18

Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
December 20, 2018

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Dec. 20, 2018. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Melissa Grisham (AR); Kurt Swan (CT); Lori Cunningham (KY); Cynthia Amann (MO); Michael Bailes (SC); John Haworth (WA); and Letha Tate (WV).

1. Adopted its May 30, May 16 and May 10 Minutes

The Working Group met May 30, May 16 and May 10. During its May 30 meeting, the Working Group discussed the private flood Market Conduct Annual Statement (MCAS). During its May 16 and May 10 meetings, the Working Group took the following action: 1) adopted its April 15 minutes; 2) adopted the MCAS revision process document; 3) adopted the disability income MCAS; and 4) discussed its next steps. Mr. Haworth made a motion, seconded by Mr. Swan, to adopt the Working Group's May 30 (*see NAIC Proceedings – Summer 2018, Market Regulation and Consumer Affairs (D) Committee, Attachment Twelve*), May 16 (*see NAIC Proceedings – Summer 2018, Market Regulation and Consumer Affairs (D) Committee, Attachment Thirteen*) and May 10 minutes (*see NAIC Proceedings – Summer 2018, Market Regulation and Consumer Affairs (D) Committee, Attachment Thirteen*). The motion passed unanimously.

2. Approved the Deadline for the First Filing Year of the Disability Income MCAS

Ms. Ailor said that the disability income MCAS does not currently have a due date. The current lines of business for 2019 will all be due on April 30, 2020. In the past, the first year a line of business is collected has been delayed, allowing industry additional time to format their data and ask questions. Ms. Ailor proposed a due date of June 30, 2020, for the 2019 data year for disability income. Ms. Dingus and Mr. Haworth agreed with the proposed date. Ms. Dingus made a motion, seconded by Mr. Haworth, to approve the June 30, 2020, deadline for the first filing year of the disability income MCAS. The motion passed unanimously.

3. Received an Update on the Private Flood MCAS

Ms. Ailor stated that a group of subject-matter experts (SMEs) has been meeting multiple times monthly to develop the private flood MCAS data call and definitions. The draft blank has been designed to collect things that are nuanced to the private flood lines of business in that they include stand-alone flood policies, endorsed homeowner flood policies and endorsements to other types of property policies. She stated the group has just concluded finalizing the interrogatories and underwriting sections and will begin working on the claims section at its next meeting on Jan. 10, 2019. Ms. Ailor asked for anyone interested in joining the discussion group to email Randy Helder (NAIC) or herself.

4. Received an Update on the Life and Annuity MCAS Review Project.

Ms. Ailor stated that Ms. Amann graciously agreed to oversee a group of SMEs to review the life and annuity MCAS. Ms. Ailor asked Ms. Amann for an update. Ms. Amann stated that a survey was distributed and was due in mid-October. She said the survey contained several questions requesting feedback from state insurance regulators regarding the life and annuity elements. She informed the group that the most recent meeting included discussion regarding the mixed desire for more granular reporting of the life and annuity elements, as well as the timeline for the life and annuity elements, which would be data collected in 2021 for the 2020 data year at the earliest. She reported that the review group is reviewing the results of the survey and will share them with the Working Group, along with any recommendations when the discussions have been completed. She also stated that there were some results from the survey that indicated a desire for more analysis and usage training by the state insurance regulators, and that will be included as a recommendation for the Working Group to pass along to the Market Analysis Procedures (D) Working Group. Ms. Amann said the next call will be in early January. Ms. Ailor asked for anyone interested in joining the discussions to email Ms. Amann and Tressa Smith (NAIC). Ms. Ailor said that there is not a scheduled meeting for the Market Conduct Annual Statement Blanks (D) Working Group.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Market Conduct Examination Standards (D) Working Group
Conference Call
March 13, 2019

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call March 13, 2019. The following Working Group members participated: Bruce R. Ramge, Chair, and Martin Swanson (NE); Russell Hamblen, Vice Chair (KY); Melissa B. Grisham and Mel Heaps (AR); Maria Ailor and Sarah Borunda (AZ); Bruce Glaser (CO); Kurt Swan (CT); Frank Pyle (DE); Debra Peirce (GA); Lindsay Bates (IA); Mary Lou Moran (MA); Jill A. Huisken and Gloria Mason (MI); Cynthia Amann, and Win Nickens (MO); Edwin Pugsley (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Dai How Bih and Sylvia Lawson (NY); Rodney Beetch and Angela Dingus (OH); Joel Sander (OK); Dennis Powell (OR); Constance Arnold (PA); Yolanda Tennyson (VA); Christina Rouleau (VT); John Haworth, Patrick McNaughton and Jeanette Plitt (WA); Barbara Belling, Sue Ezalarab, Darcy Paskey and Rebecca Rebholz (WI); and Desiree Mauller (WV).

1. Adopted its Dec. 19. 2018, Minutes

The Working Group met Dec. 19, 2018, and took the following action: 1) adopted its Nov. 29, 2018 minutes; 2) adopted a new mental health parity guidance document and a new data collection tool for mental health parity analysis, for inclusion in the *Market Regulation Handbook* (Handbook); 3) discussed new insurance data security pre- and post-breach checklists; and 4) discussed new standardized data requests for private passenger auto in-force policies, private passenger auto claims and personal lines declinations.

Ms. Plitt made a motion, seconded by Mr. Glaser, to adopt the Working Group's Dec. 19, 2018 minutes (Attachment Six-A). The motion passed unanimously.

2. Heard Opening Comments

Director Ramge welcomed returning Working Group members and new member states Arizona, represented by Ms. Borunda and Ms. Ailor; Delaware, represented by Mr. Pyle; Michigan, represented by Ms. Huisken; New Mexico, represented by Mr. Phillips; and Oregon, represented by Mr. Powell. Changes in Working Group member state representation in 2019 include Ms. Moran (MA), Mr. Nickens and Mr. Freilich (MO), Ms. Belanger and Mr. Pugsley (NH), and Ms. Mauller (WV).

3. Discussed its 2019 Tasks

Director Ramge said the charges of this Working Group, as adopted by the Market Regulation and Consumer Affairs (D) Committee, are to:

- Develop market conduct examination standards and uniform market conduct procedural guidance, as necessary.
- Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models by the Fall National Meeting.
- Develop updated standardized data requests for inclusion in the *Market Regulation Handbook* by the Fall National Meeting.

Director Ramge said the Working Group will not meet at the national meetings; it will accomplish its assigned tasks via regularly scheduled conference calls, to occur approximately every four to six weeks.

Regarding the adopted charges, the Working Group plans to develop new state insurance regulator guidance in 2019 regarding: 1) updated standardized data requests; 2) the *Insurance Data Security Model Law* (#668); and 3) the recently adopted *Travel Insurance Model Act* (#632), *Limited Long-Term Care Insurance Model Ac*t (#642) and *Limited Long-Term Care Insurance Model Regulation* (#643).

4. Reviewed Insurance Data Security Pre- and Post-Breach Checklists, Dec. 17, 2018, Draft

Director Ramge said the insurance data security pre- and post-breach checklists are a carryover item from 2018. The checklists, which were first distributed to the Working Group, interested state insurance regulators and interested parties on July 16, 2018,

were developed to correlate with the Model #668, which was adopted by the Executive (EX) Committee and Plenary on Oct. 24, 2017. The checklists, developed by state insurance regulator subject-matter experts (SMEs) in the fields of market examinations and financial examinations, provide examiners with guidance on evaluating the insurance data security of regulated entities. Director Ramge said the draft checklists were discussed during the Working Group's July 25, Aug. 29, Nov. 29 and Dec. 19, 2018 conference calls.

Emily Micale (American Council of Life Insurers—ACLI) presented a comment letter dated Feb. 20, 2019 and a brief overview of the suggested redlined changes to the checklists. She said the comment letter and suggested redlined changes to the checklists were developed to elaborate upon the Dec. 18, 2018, comment letter submitted by the ACLI.

Ms. Micale said pre-breach insurance data security assessment should be performed solely as part of a financial examination to promote efficiency and avoid the duplication of efforts. She said the proposed revisions to the checklists shown in track changes are suggestions from the ACLI to make the checklists better align with Model #668. However, she said the ACLI is not recommending the inclusion of a pre-breach checklist in the Handbook for use as part of a market conduct exam.

Director Range said that during the Dec. 19, 2018, conference call, he had asked the Working Group to make a decision whether to proceed with the review of the pre-breach checklist, and the Working Group subsequently voted during that call to proceed with the review of the pre-breach document and consider making some of the technical changes submitted by the ACLI.

Angela Gleason (American Property Casualty Insurance Association—APCIA) presented a comment letter dated March 6, 2019, which was submitted to the NAIC the morning of March 13, 2019. Ms. Nelson said the revisions suggested by the APCIA will, like the ACLI's comments, make the language of the checklists more consistent with Model #668. Ms. Gleason also suggested adding introductory language that examiners should take a more risk-focused approach to the assessment of insurance data security.

Ms. Plitt said the checklists are tools that can be used as guidance; the questions in each checklist represent a minimum of areas and issues to be addressed by regulated entities to assess if a regulated entity is adequately prepared in the event of an insurance data security breach. She said the checklists do not have to be used in their entirety; however, the checklists, pre- and post-breach, should both be made available to market examiners. She said regulated entities should routinely review and address fundamental security issues, and the questions in the checklists are an effective way for market regulators to engage companies in focusing on insurance data security. The issue of how often and by whom the questions are asked of the regulated entities, whether it be by market regulators or financial regulators, is not the issue; rather, someone needs to ask regulated entities the questions in the checklists.

Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) asked whether the Risk-Focused Surveillance (E) Working Group should be involved with the review of the redundancies that could occur as a result of market regulators and financial regulators asking identical questions of regulated entities regarding insurance data security.

Mr. McNaughton, chair of the IT Examination (E) Working Group, said he was part of the development of the draft pre- and post-breach checklists, noting that he is in agreement with: 1) the approach taken by both checklists; 2) the content of the checklists; and 3) ultimately, that the pre-breach assessment of insurance data security involves interaction with and consultation by both market and financial regulators. He said these are only checklists; the guidance in the checklists provides guidance to assess, at a basic level, the minimum of insurance data security-related processes and procedures that regulated entities should already be doing.

Director Ramge asked the SMEs who developed the initial draft of the pre- and post-breach checklists to reconvene and re-review both the pre- and post-breach checklists in light of the comments received from interested parties, and present revisions, if any, to the Working Group during its next conference call.

The due date for comments on the draft checklists was extended to April 16, 2019.

5. <u>Reviewed New Standardized Data Requests for Inclusion in the Reference Documents of the Handbook</u>

Director Ramge said two new private passenger auto standardized data requests and a personal lines declination standardized data request were developed by regulator SMEs for the Working Group's review, discussion and consideration of adoption. Director Ramge said the standardized data requests were initially distributed on Nov. 27, 2018 and were discussed on the Nov. 29 and Dec. 19, 2018 Working Group calls. When the standardized data requests are adopted, they will replace the private passenger auto portion of the NAIC personal lines standardized data request.

Director Ramge asked that comments be submitted on the standardized data requests by April 16, 2019.

6. Discussed Other Matters

Director Ramge asked the Working Group members to participate in as many Working Group conference calls as possible this year so the Working Group can accomplish the tasks that are planned in 2019.

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur in April.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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Draft: 1/14/19

Market Conduct Examination Standards (D) Working Group
Conference Call
December 19, 2018

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Dec. 19, 2018. The following Working Group members participated: Bruce R. Ramge, Chair, Laura Arp and Reva Vandevoorde (NE); Jim Mealer, Vice Chair, and Cynthia Amann (MO); Melissa Grisham and Mel Heaps (AR); Adam Boggess, Bruce Glaser and Damion Hughes (CO); Stephen Deangelis and Kurt Swan (CT); Kay Godfredson (IA); Lori Cunningham and Russell Hamblen (KY); Mary Lou Moran (MA); Melinda Domzalski-Hansen, Paul Hanson and Alley Zoellner (MN); Maureen Belanger, Jennifer Patterson and Win Pugsley (NH); Ralph Boeckman and Chanell McDevitt (NJ); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Rodney Beetch and Angela Dingus (OH); Katie Dzurec and Kelly Krakowski (PA); Julie Blauvelt and Yolanda Tennyson (VA); John Haworth and Jeanette Plitt (WA); Sue Ezalarab and Rebecca Rebholz (WI); and Barbara Hudson (WV).

1. Adopted its Nov. 29 Minutes

The Working Group met Nov. 29 and took the following action: 1) discussed new mental health parity-related guidance for inclusion in the *Market Regulation Handbook* (Handbook); 2) discussed new insurance data security pre- and post-breach checklists; and 3) discussed new standardized data requests for private passenger auto in-force policies, private passenger auto claims and personal lines declinations. Ms. Plitt made a motion, seconded by Mr. Pugsley, to adopt the Working Group's Nov. 29 minutes (Attachment Six-A1). The motion passed unanimously.

2. Adopted New Mental Health Parity-Related Guidance for inclusion in the Handbook

Director Ramge said that the two mental health parity-related exposure drafts before the Working Group consist of: 1) a general guidance document addressing mental health parity review, which includes a series of questions to be posed to health carriers by examiners, to be inserted in a chapter or area to be determined of the Handbook; and 2) a state insurance regulator data collection tool for mental health parity analysis. He said the drafts, which were developed with the assistance of regulator subject matter experts (SMEs) in mental health parity review, were circulated on July 9; they were initially discussed during the Working Group's July 25 conference call and subsequently during its Aug. 29 and Nov. 29 calls. Ms. Arp revised the two draft documents on Dec. 11, taking into consideration suggestions received from Maryland, the Association for Behavioral Health and Wellness (ABHW), and joint comments received from the NAIC consumer representatives.

Pamela Greenberg (ABHW) presented comments dated Dec. 5 and provided comments on the Dec. 11 exposure drafts. Ms. Greenberg asked that the Working Group consider adding a new question to the general guidance document: "Are all conditions that are defined as being or as not being a mental health condition, a substance use disorder or a medical condition defined in a manner that is consistent with generally recognized independent standards of current medical practice?" Ms. Arp made a motion, seconded by Mr. Mealer, to make this change to the document. Ms. Greenberg also suggested that the word "methodology" be used instead of "factors" in Question 4 and Question 5 in the general guidance document. Mr. Mealer made a motion, seconded by Ms. Plitt, to make this change.

Ms. Greenberg said she supports the addition of the federal Centers for Medicare & Medicaid Services (CMS) Table 5 in the non-quantitative treatment limitations (NQTL) data collection tool exposure draft. She suggested that a note be added to the NQTL table, in the explanation column, indicating that the regulated entity being examined explain how mental health/substance use disorder benefits compare to medical surgical benefits. Ms. Arp made a motion, seconded by Ms. Rebholz, to make the revision to the document.

Mr. Mealer made a motion, seconded by Ms. Dingus, to adopt both mental health parity exposure drafts to include all changes made during the conference call (Attachment XXX and Attachment XXX). The motion passed unanimously.

3. Reviewed Insurance Data Security Pre- and Post-Breach Checklists, Dec. 17 Draft

Director Ramge said the Insurance Data Security Pre- and Post-Breach Checklists, which were first distributed on July 16, 2018, were developed to correlate with the *Insurance Data Security Model Law* (#668), which was adopted by the Executive

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(EX) Committee and Plenary on Oct. 24, 2017. The checklists, developed by regulator SMEs in the fields of market examinations and financial examinations, provide examiners with guidance on evaluating the insurance data security of regulated entities. Director Ramge said that the draft checklists were initially discussed during the Working Group's July 25, Aug. 29 and Nov. 29 conference calls, and a revised draft was distributed on Dec. 17, 2018.

Director Ramge said the Dec. 17 draft incorporates language that had been adopted by the IT Examination (E) Working Group in October to address issues regarding collaboration and the states' adoption of the model, to date, raised by interested parties. Director Ramge said the difference between the exposure draft previously circulated and the Dec. 17 draft is the incorporation of the language "or legislation which is substantially similar to the model" so that the language then reads: "Note: The guidance that follows should only be used in states that have enacted the NAIC *Insurance Data Security Model Law* (#668) or legislation which is substantially similar to the model. Moreover, in performing work during an exam in relation to the Model Law, it is important the examiners first obtain an understanding and leverage the work performed by other units in the department including but not limited to financial examination-related work."

Robyn Anderson (Old Republic National Title Insurance Company) presented comments dated Dec. 13. She said that pre-breach examiner review should be performed by financial examiners in the information technology (IT)-related portion of a financial examination. Ms. Anderson said that the requirements set forth in the pre- and post-breach checklists differ substantially from the model, and thus could raise confusion and impose additional requirements beyond those set forth in the model. Ms. Anderson asked that the Working Group discard the pre-breach checklist and retain the post-breach checklist.

Angela Gleason (American Insurance Association—AIA) presented comments dated Dec. 17. She expressed concerns about the efficiency, scope, duplication and coordination of pre-breach market examiner review and pre-breach financial examiner review. Ms. Anderson said that placement of the pre-breach checklist in the Handbook reference documents does not lead to uniformity and that the correct placement of pre-breach review is in financial-related examinations.

Robbie Meyer (American Council of Life Insurers—ACLI) presented comments dated Dec. 18. She asked that the Working Group not consider inclusion of the pre-breach checklist in the Handbook for use as part of a market conduct exam. Ms. Meyer suggested that the best place for pre-breach review is in the context of a financial examination. Ms. Meyer added that if the Working Group retains the pre-breach checklist, the criteria in the pre-breach checklist, as well as the post-breach checklist, should be revised so that it tracks more closely to the model.

Ms. Plitt said that the pre-breach checklist would be a valuable tool for examiners, should a pre-breach review be deemed necessary, in the course of a market conduct examination; she therefore asked that the pre-breach checklist be retained in the Handbook. Director Ramge said that it had been previously suggested during the Working Group's Nov. 29 conference call that the pre-breach checklist be incorporated into the reference documents of the Handbook in order to make the resource readily available to market conduct examiners, while not incorporating the checklist directly into the Handbook.

Director Ramge asked the Working Group to decide: 1) whether to proceed with the review of the pre-breach checklist exposure draft, with the inclusion of language to be developed by NAIC staff, that market regulators coordinate with domestic financial regulators; or 2) whether to remove the pre-breach checklist, in its entirety, from the Working Group's review.

Ms. Plitt made a motion, seconded by Mr. Mealer, that the Working Group proceed with the review of the pre-breach checklist exposure draft, with the inclusion of language to be developed by NAIC staff, that market regulators coordinate with domestic financial regulators, and to also consider making technical changes outlined in comments received from the ACLI. The motion passed unanimously.

Director Ramge asked that comments be submitted on the pre- and post-breach checklists by Dec. 31.

4. Reviewed New Standardized Data Requests for Inclusion in the Reference Documents of the Handbook

Director Ramge said that two new private passenger auto standardized data requests and a personal lines declination standardized data request had been developed by regulator SMEs for the Working Group's review, discussion and adoption. When the standardized data requests are adopted, they will replace the private passenger auto portion of the NAIC personal lines standardized data request.

Birny Birnbaum (Center for Economic Justice—CEJ) said that when examiners review regulated entity claim settlement practices, the review of additional fields not listed in the claims standardized data request (e.g., rating factors) may be

necessary. Mr. Hamblen said that the intent of the standardized data requests is not to provide an all-encompassing listing of all fields that could be reviewed in examination; rather, the standardized data requests are a listing of most commonly used fields in a typical review of regulated entity market conduct practices. Mr. Hamblen said that states are encouraged to use the standardized data requests as a template and to build upon the template; states may remove fields or add fields as necessary, depending on the circumstances, scope and purpose of an examination. Mr. Birnbaum asked that the Working Group consider adding additional fields to the standardized data requests regarding a regulated entity's use of credit scores, price optimization tools and claim automation algorithms.

Director Ramge asked that comments be submitted on the standardized data requests by Dec. 31.

5. Discussed Other Matters

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur early in 2019, after the Working Group is reappointed by the Market Regulation and Consumer Affairs (D) Committee.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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Draft: 12/11/18

Market Conduct Examination Standards (D) Working Group
Conference Call
November 29, 2018

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Nov. 29, 2018. The following Working Group members participated: Bruce R. Ramge, Chair, and Laura Arp, (NE); Jim Mealer, Vice Chair, and Cynthia Amann (MO); Melissa Grisham and Mel Heaps (AR); Damion Hughes (CO); Kurt Swan (CT); Howard Liebers, David Moore and Cheryl Wade (DC); Lindsay Bates (IA); Russell Hamblen (KY); Mary Lou Moran (MA); Paul Hanson (MN); Maureen Belanger, Denise Lamy, Jennifer Patterson (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Sylvia Lawson (NY); Angela Dingus (OH); Richard Hendrickson (PA); Julie Fairbanks and Yolanda Tennyson (VA); Christina Rouleau (VT); John Haworth and Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Sue Ezalarab, Jo LeDuc, Darcy Paskey, Rebecca Rebholz and Mary Kay Rodriguez (WI); and Barbara Hudson (WV). Also participating were Theresa Morfe and Darci Smith (MD).

1. Discussed New Mental Health Parity-Related Revisions to the Handbook

Director Ramge said that the two mental health parity-related exposure drafts before the Working Group consist of: 1) a general guidance document addressing mental health parity review, which includes a series of questions to be posed to health carriers by examiners, to be inserted in a chapter or area to be determined of the *Market Regulation Handbook* (Handbook); and 2) a regulator data collection tool for mental health parity analysis. He said the drafts, which were developed with the assistance of regulator subject matter experts (SMEs) in mental health parity review, were circulated on July 9; they were initially discussed during the Working Group's July 25 conference call and subsequently during its Aug. 29 call. Ms. Arp revised the two draft documents on Oct. 18 to incorporate informal suggestions received from Mary Nugent (Center for Consumer Information and Insurance Oversight—CCIIO).

Ms. Morfe and Ms. Smith presented comments dated Oct. 31, 2018, indicating that Question 9 in the general guidance document be revised, and that numerous areas of the data collection tool in Section 1 – Financial Requirements and Quantitative Treatment Limitations and Section 2 – Non-Quantitative Treatment Limitations should also be revised. Ms. Morfe and Ms. Smith suggest incorporating the federal Centers for Medicare & Medicaid Services (CMS) non-quantitative treatment limitations (NQTL) Table 5 to the data collection tool.

Pamela Mobberley (Cigna) presented comments dated Oct. 31, 2018, on behalf of Pamela Greenberg (Association for Behavioral Health and Wellness—ABHW). Ms. Mobberley said that the language in the table of the data collection tool should be revised to clarify that the testing of financial requirements and quantitative treatment limitations (QTLs) applied to medical/surgical benefits dictates the type and/or level of the financial requirements and quantitative treatment limits, if any, that may be applied to the corresponding mental health/substance use disorder classifications of benefits. Such testing is based upon the percentage of expected plan payments for the medical/surgical benefits within each classification of benefits for the plan year.

Ms. Mobberley suggested that in the section addressing NQTLs, the content of the tool should align with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations by permitting flexibility in NQTL methodologies and processes, as long as such NQTL methodologies and processes are comparable to, and applied no more stringently, to mental health/substance use disorder benefits as compared to medical/surgical benefits within each classification.

Ms. Mobberley said that in regard to comments advocating for the data collection tool to incorporate the four-step NQTL analysis referenced within the recently amended Self-Compliance Tool published by the federal tri-agencies–the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury (Treasury Department—in April 2018, the ABHW has concerns the four-step NQTL analysis may be misinterpreted as requiring a prescriptive approach—such as requiring every NQTL to be based upon a list of factors and requiring every factor to be based upon an evidentiary standard and/or source information. Ms. Mobberley suggested that the data collection tool should clarify that the parity regulations governing NQTLs are not prescriptive and should not be misinterpreted as requiring that NQTLs or NQTL factors be based upon an evidentiary standard—the evidentiary standard being disclosed and defined only if an NQTL factor is based upon an evidentiary standard. Ms. Mobberley said that the four-step analysis referenced within the Self-Compliance Tool is merely proposed guidance that has not yet been finalized; the DOL will be

scheduling a meeting in January 2019 for interested parties to review and discuss the public comments submitted in response to the proposed guidance.
Ms. Mobberley suggested that the NQTL Table 5, which is used by CMS, be incorporated into the draft guidance before the Working Group. Regulator use of Table 5 will ensure a more consistent and uniform approach in parity enforcement efforts of NQTLs. Ms. Mobberley said that Table 5 is clear and easy to read, which will aid examiners in conducting efficient and productive NQTL examinations.

Andrew Sperling (National Alliance on Mental Illness—NAMI) presented Nov. 26 comments submitted jointly by the following NAIC consumer representatives: Ashley Blackburn (Community Catalyst); David Chandrasekaran (Training Consultant and Certified Application Counselor); Laura Colbert (Georgians for a Healthy Future); Deborah Darcy (American Kidney Fund—AKF); Anna Howard (American Cancer Society Cancer Action Network—ACS CAN); Debra Judy (Colorado Consumer Health Initiative—CCHI); Katie Keith (Out2Enroll); Sarah Lueck (Center on Budget and Policy Priorities—CBPP); James Roberts (Alaska Native Tribal Health Consortium—ANTHC); Carl Schmid (The AIDS Institute); Matthew Smith (Coalition Against Insurance Fraud—CAIF); Mr. Sperling; Lorri Shealy Unumb (Autism Speaks); and Silvia Yee (Disability Rights Education and Defense Fund—DREDF).

Mr. Sperling provided a broad overview of the NAIC consumer representatives comments, which fall into four general categories: 1) definition of mental health conditions and substance use disorders; 2) question 4 and question 5 relating to prescription drug formulary tiering and in-network provider tiering, respectively; 3) financial requirements and quantitative treatment limitations; and 4) non-quantitative treatment limitations.

Director Ramge said that the mental health parity drafts have been on the Working Group's agenda since July. He recognized the work that has been done thus far on the drafts, by the regulator SMEs, Ms. Morfe, Ms. Smith and Ms. Arp. Director Ramge said the mental health parity guidelines in the drafts could be adopted soon by the Working Group and subsequently revised as needed, as future final guidance is finalized by the tri-agencies. Mr. Mealer agreed and said that mental health parity guidelines for examiners is needed. He said guidelines can be put in place and subsequently revised as needed on subsequent Working Group conference calls.

Ms. Arp said that she would make additional changes to both draft documents, taking the comments from Ms. Morfe and Ms. Smith into consideration, as well as the comments from ABHW and the joint comments from the NAIC consumer representatives.

Director Ramge asked that comments be submitted to Petra Wallace (NAIC) on the mental health parity drafts by Dec. 13.

2. Reviewed Insurance Data Security Pre- and Post-Breach Checklists, Nov. 19 Draft

Director Ramge said the Insurance Data Security Pre- and Post-Breach Checklists, which were first distributed on July 16, were developed to correlate with the *Insurance Data Security Model Law* (#668), which was adopted by the Executive (EX) and Plenary Committee on Oct. 24, 2017. The checklists, developed by regulator SMEs in the fields of market examinations and financial examinations, provide examiners with guidance on evaluating the insurance data security of regulated entities. Director Ramge said that the draft checklists were initially discussed during the Working Group's July 25 call, and a revised draft was distributed on Nov. 19.

Director Ramge said the Nov. 19 draft incorporates language that had been adopted by the IT Examination (E) Working Group in October, for inclusion in Section III–General Examination Considerations of that Working Group's published financial examination guidance. The IT Examination (E) Working Group had received comments in October from the joint trade associations and the American Insurance Association (AIA), which were, for the most part, identical to comments the Market Conduct Examination Standards (D) Working Group received from these two entities in August. The IT Examination (E) Working Group subsequently adopted language to address the trade associations' and the AIA's concerns regarding collaboration of market and financial examiners and the states' adoption of Model #668. Director Ramge said that the same language is incorporated into the pre- and post-breach checklists draft for the Working Group's consideration.

Director Ramge said that a minor change had been suggested by NAIC staff to add "or legislation which is substantially similar to the model" so that the language then reads: "Note: The guidance that follows should only be used in states that have enacted the NAIC *Insurance Data Security Model Law* (#668) or legislation which is substantially similar to the model. Moreover, in performing work during an exam in relation to the Model Law, it is important the examiners first obtain an understanding and leverage the work performed by other units in the department including but not limited to financial examination-related work."

Director Ramge said the issue of what type of examiner (market, financial) should perform what type of review (pre-breach, post-breach) in an insurance data security-related examination would be difficult for NAIC leadership/state insurance departments to uniformly agree upon because staffing levels, departmental structuring, budget constraints, etc. vary greatly across all jurisdictions. Director Ramge said the purpose of the Handbook is not to specify how each jurisdiction should allocate market regulation staff and financial regulation staff with regard to pre-breach review and post-breach review when conducting an insurance data security-related exam.

Director Ramge suggested that the Handbook: 1) incorporate the post-breach checklist; and 2) make available, in the Handbook reference documents, examiner guidance that a jurisdiction may wish to use, in instances when conducting a market conduct-related pre-breach examination is warranted.

Director Ramge recommended that the post-breach checklist be incorporated within the relevant exam standard in Chapter 20 of the Handbook (the General Examination Standards chapter), and that language be included in the chapter itself stating that: 1) financial exam standards exist with regard to insurance data security and each state will want to coordinate with financial examiners to avoid duplication of efforts; and 2) each state will need to decide how to handle whether market examiners, financial examiners or a combination of the two perform pre-breach and post-breach review in an insurance data security review of regulated entities.

Director Ramge suggested that language be incorporated within the relevant exam standard in Chapter 20 stating that a pre-breach checklist is available and can be found in the Handbook reference documents on StateNet. Director Ramge provided the following sample language:

"Pre-breach examination of insurance data security is typically covered during financial examination, but for those jurisdictions or instances wishing to have such a review conducted by market conduct examiners, suggested review criteria are available in the reference documents of the *Market Regulation Handbook*."

Angela Gleason (American Insurance Association—AIA) asked if the Working Group will be considering the AIA's other comments, submitted in August. Director Ramge said that the Working Group will wait to review Ms. Gleason's comments during a subsequent Working Group conference call. Emily Micale (American Council of Life Insurers—ACLI) said that she would be submitting comments on the checklists. Mr. Mealer asked that the Working Group have more time to review the language of the pre- and post-breach checklists.

Director Ramge asked that comments be submitted to Ms. Wallace on the pre- and post-breach checklists by Dec. 13.

3. Reviewed New Standardized Data Requests for Inclusion in the Reference Documents of the Handbook

Director Ramge said that two new private passenger auto standardized data requests and a personal lines declination standardized data request had been developed by regulator SMEs for the Working Group's review, discussion and adoption. When the standardized data requests are adopted, they will replace the private passenger auto portion of the NAIC personal lines standardized data request.

Mr. Hamblen said for clarity of examiner use, two separate private passenger auto data requests were developed to address: 1) in force policies; and 2) claims. A third standardized data request was developed to capture fields typically used by regulators when evaluating regulated entity personal lines declinations (personal auto and homeowners). Mr. Hamblen said revisions were also made to the Contents section and the Uses section of each standardized data request, and the standardized data requests were edited to have the same format, style and consistency in field names/definitions as the standardized data requests that have been previously adopted by the Working Group.

Mr. Hamblen provided a brief explanation of the NAIC standardized data requests and their use. Mr. Hamblen said the NAIC standardized data requests offer uniform instruction to regulators with regard to obtaining data elements from regulated entities for the purposes of a targeted data call or an examination. Mr. Hamblen said the NAIC standardized data requests are designed to be used as a template or guide for regulators, noting that the states may tailor the standardized data requests for a specific or targeted purpose. Mr. Hamblen said the NAIC standardized data requests are not one-size-fits-all documents, and the states may remove fields or add fields as necessary, depending on the circumstances, scope and purpose of an examination.

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Birny Birnbaum (Center for Economic Justice—CEJ) asked how regulators would respond if a regulated entity said it does not capture the data requested in the standardized data request. Mr. Hamblen said that before asking for data, the Kentucky Department of Insurance (DOI) makes a practice of contacting the regulated entity to review the requested data fields and field descriptions in the standardized data request that will be used with the regulated entity, which provides the regulated entity with an opportunity to ask questions and obtain feedback about how the data is to be provided to the insurance department. Mr. Hamblen said that the Kentucky DOI would then work with the regulated entity to determine a workaround for such a situation. Mr. Mealer said that a DOI may also provide a reasonable amount of time for regulated entities to produce the data that is requested.

Director Ramge asked that comments be submitted to Ms. Wallace on the standardized data requests by Dec. 31.

4. Discussed Other Matters

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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Draft: 4/18/19

Market Analysis Procedures (D) Working Group
Orlando, Florida
April 7, 2019

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Orlando, FL, April 7, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Ryan James (AR); Maria Ailor (AZ); Pam O'Connell (CA); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Josh Rayborn (KY); Jeff Zewe (LA); Christopher Joyce (MA); Tim Schott (ME); Erica Bailey and Nour Benchaaboun (MD); Jill Huisken (MI); Paul Hanson and Kristi Bohn (MN); Teresa Kroll (MO); Jeannie Keller (MT); Laura Arp (NE); Ralph Boeckman (NJ); Paige Duhamel (NM); Stephanie McGee (NV); Stephen Doody (NY); Angela Dingus (OH); Christopher Monahan (PA); Michael Wise (SC); Nancy Askerlund and Tracy L. Klausmeier (UT); Christina Rouleau (VT); and Tom Whitener (WV). Also participating was: Andria Seip (IA).

1. Adopted its March 14 Minutes

The Working Group met March 14 and took the following action: 1) adopted its 2018 Fall National Meeting minutes; 2) received an update regarding automated Market Conduct Annual Statement (MCAS) analysis techniques; 3) discussed the short-term limited duration (STLD) medical data call template; and 4) discussed proposed scorecard ratios for the disability income MCAS.

Mr. Swan made a motion, seconded by Ms. Dingus, to adopt the Working Group's March 14 minutes (Attachment Seven-A). The motion passed unanimously.

2. Discussed the STLD Medical Data Call Template

Ms. Rebholz said the Working Group received comments regarding the draft from Iowa, Nebraska and Wisconsin, as well as comments from the NAIC consumer representatives and the Blue Cross and Blue Shield Association (BCBSA). She invited everyone who submitted comments to speak to the Working Group.

Ms. Seip said the data call asks whether the company's plan contains preexisting exclusion limitations. She suggested that this question should be followed up with a question regarding the time frame of the limitation.

Ms. Arp suggested adding "advertisement, lead generation, enrollment" to the list of activities that a company might delegate. Regarding preexisting limitations, she suggested asking about the range of effects of preexisting conditions, such as complete denial, waiting period or exclusions. She said clarifications should be made that for STLD plans issued to discretionary groups, associations or trusts, the reporting should be based on the residence of the insured instead of the situs of the group. She said if a company cannot report by the state of the insureds, the company could be given the option of reporting nationwide enrollment and then indicating the situs of the groups, associations or trusts.

Ms. Rebholz said she received some suggestions, including: 1) adding a request for agent commission schedules and, for total commissions, paid a breakdown of commissions paid to top producers; 2) asking how a company oversees agents and websites selling its product; and 3) adding a clarification that if an online application is not accepted because the applicant responded affirmatively regarding any health condition, it should be considered an "initial denial."

Katie Keith (Out2Enroll) thanked the Working Group for developing the data call and said this is a critical issue for consumers. She emphasized the urgency of the collection of the data, because many consumers misunderstand the coverage and limitations when purchasing STLD plans.

Justin Giovannelli (Georgetown University, Center on Health Insurance Reforms) said it is important to obtain group data by state. Additionally, he said the current data asks for the number of cancellations within 60 days. He said the data call should also ask for the number of cancellations at any time period, as well as the reasons for the cancellations. Regarding rating factors, he asked whether gender is used as a rating factor. He also noted, regarding coverage of benefits categories, that it would be helpful to include mental health services, maternity care and additional detail regarding prescription drug coverage to be sure

it does not include prescription drug discount cards. He supported the recommendations about agent commissions and preexisting conditions limitations. Regarding preexisting condition limitations, he suggested a question asking the insurer to specify the look-back period.

Birny Birnbaum (Center for Economic Justice—CEJ) said interrogatory question 6, question 7 and question 8 regarding deductibles, copayments and policy limits could be moved to the data element section of the data call. He said this would improve the ability to use this data in analysis. He also noted that the data element asking for a list of states where the product is filed is better suited as an interrogatory. He said the data call only collects information on the number of policyholder cancellations. He suggested that the number of insurer cancellations should also be included in the data call. He also said the total number of cancellations prior to policy termination should be collected, not just cancellations prior to 60 days.

Mr. Birnbaum suggested having the company include a copy of the policy if it was not filed in the NAIC System for Electronic Rate and Form Filing (SERFF). Mr. Haworth said the goal of the data call is to keep it short to speed up the implementation. He said its current format would provide enough data to enable state insurance regulators to determine what additional data is required and what data might not be needed. He said the question on SERFF filing identification was included to make it easier for state insurance regulators to look at the design of the policy. He agreed that if the product is not filed in SERFF, a copy should be included with the data call.

Joseph E. Zolecki (BCBSA) said he only has technical comments. He said it is unclear if the data call is an individual state data call or a national data call. He also said the data call asks for information on group coverage and coverage issued through an association or trust. He said most STLD plans are issued to an association or trust and then to individual subscribers. He suggested the data call should first ask about group coverage issued through an employer for their employees and then ask another question about other group coverage issued by an association or trust where there is no employee relationship. Additionally, he said medical loss ratio (MLR) should be defined to make it clear that this is for non-Affordable Care Act (ACA) products, and the question on state mandates should be clarified to indicate which market segment issuers should be comparing to, because state mandates differ by state. Finally, he said questions should be added for the number of rescissions, and claims denials related to preexisting conditions.

Ms. Ailor suggested data elements regarding fees associated with the products. She said additional fees are often added. She also suggested questions related to "free look" periods.

Mr. James said state mandates could be different between group products and individual products, noting that the question regarding state mandates should be broken up between the two. Regarding the operations delegated to third parties, he suggested asking whether the entities are licensed.

Ms. Kroll asked how the NAIC would be collecting the data. Randy Helder (NAIC) said state insurance department attorneys are working with the NAIC Legal Division to determine how to do a centralized collection and maintain state confidentiality statutes. Ms. Arp said the State Insurance Department Attorneys Roundtable discussed the issue, and no formal resolution was reached. She said the Working Group should complete the template and then contact them again.

Mr. Haworth said the drafting subgroup will meet again to review the comments and make revisions prior to the next Working Group meeting.

3. Discussed Proposed Disability Insurance MCAS Scorecard Ratios

Mr. Haworth said no comments were received on the proposed scorecards for the disability insurance MCAS. He asked if anyone would like to make comments.

Ms. Ailor said the denominator of scorecard ratio 4 should be "lives covered" instead of "policies in-force" because some policies can have multiple insureds. She said the number of lives covered allows for more accurate comparisons. Mr. Birnbaum agreed and suggested breaking out the scorecard ratios by group and individual.

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

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Draft: 3/27/19

Market Analysis Procedures (D) Working Group
Conference Call
March 14, 2019

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call March 14, 2019. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Melissa Grisham (AR); Maria Ailor (AZ); Pam O'Connell (CA); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Amy Groszos (FL); Stacy Rinehart (KS); Russ Hamblen (KY); Dawna Kokosinski (MD); Tim Schott (ME); Jill Huisken (MI); Laura Rickbeil (MN); Cynthia Amann (MO); Reva Vandevoorde, Laura Arp and Martin Swanson (NE); Karen McCallister (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Guy Self (OH); Joel Sander (OK); Jeffrey Arnold (PA); Michael Bailes (SC); Nancy Askerlund (UT); Julie Fairbanks (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were: Andria Seip (IA); Angela Dingus (OH); and Matt Gendron (RI).

1. Adopted its 2018 Fall National Meeting Minutes

Mr. Pyle made a motion, seconded by Mr. Schott, to adopt the Working Group's Nov. 16, 2018, minutes (*see NAIC Proceedings – Fall 2018, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*). The motion passed unanimously.

2. Received an Update Regarding Automated MCAS Analysis Techniques

Mr. Haworth said NAIC staff are doing good work in developing a Market Conduct Annual Statement (MCAS) analysis tool using Tableau. He said the homeowners line of business is near completion and includes analysis techniques such as standard deviation comparisons and five-year trending. He noted that it also contains a "pick-a-page" feature that improves on what is currently available.

3. Discussed the Short-Term Limited Duration Medical Data Call Template

Ms. Rebholz said the group of state insurance regulators has finished drafting the short-term limited-duration medical data call. She said the group attempted to include as much information as possible, while recognizing the need for a quick turnaround for the implementation of the data call. She said there are some data elements that could still be added, noting that the U.S. House of Representatives' Committee on Energy and Commerce request for information from companies includes data elements that might be considered for addition.

Ms. Rebholz said the data call includes identification of the NAIC System for Electronic Rate and Form Filing (SERFF) code and the type on insurance (TOI) code the company used in order to more clearly identify and confirm the product. It also includes group code data and information on contacts for follow-up questions. She referenced questions 33–36, which ask the company to identify associations and trusts that market its products. She said some associations have combined products from different companies to create coverage that looks more like a federal Affordable Care Act (ACA)-compliant plan. These questions will help to identify and locate these entities and those products.

Ms. Ailor asked if the NAIC will be collecting the data or if it will be up to the individual states. Randy Helder (NAIC) said the NAIC would ideally collect the data on behalf of the states. He said, however, that in order to ensure the confidentiality of the data provided, the data needs to first be received by the state before being centralized at the NAIC. This may be able to be accomplished in a manner like the MCAS. The NAIC would issue a call letter citing the statutory authorities of each participating state. He said the issue has been brought to the State Insurance Department Attorneys Roundtable, which will be discussing it at the Spring National Meeting to consider the best way to move forward with a centralized data call. Ms. Arp said she and Mr. Swanson will be attending the State Insurance Department Attorneys Roundtable.

Ms. Arp agreed that it is important to determine which associations or other entities are marketing the products. She also suggested questions asking how many people the company refused to write or renew based on the health status of the applicant. Mr. Haworth agreed and said if a product is marketed as compliant with the ACA, but the company is doing underwriting based on health, that is a concern.

Ms. Seip suggested adding data elements about pre-existing condition limitations that would capture the time frame of the limitation. She noted that different jurisdictions will have different allowable durations for a pre-existing condition exclusion.

Ms. Dingus noted that the data call asks for the SERFF code and asked whether the intention is to ask the company to complete a data call for each product it markets. Ms. Rebholz said it is the intention to collect the information at the product level. She said the data call should make that clear when it is sent to companies.

Mr. Gendron said there could be separate SERFF filings per state, as well as on the form and rate side. He suggested including this as an interrogatory to avoid multiple responses for one data element.

Ms. Arp said there are products that are used in certain states where group products are not required to be filed; as such, there would not be a SERFF filing number. She agreed it is important to think about. She said the companies will be reporting on products for which there are insured lives in a state.

Mr. Gendron said question 12 of the interrogatories asks for information on third-party administrators (TPAs) to which the insurer delegates administration, claims and other operational activities. He said some companies do not consider themselves TPAs. He said he would provide some suggestions in writing to make the list of activities more comprehensive to ensure complete identification of all third-party vendors. Ms. Dingus suggested a definitions page to cover what is expected. Mr. Swanson cautioned that a definitions page may be limiting, noting that the data call should be as broad as possible.

Justin Giovannelli (Georgetown University Center on Health Insurance Reforms) expressed appreciation on behalf of consumer representatives and noted that the data is important. He said this is a good beginning and he would be providing comments.

Mr. Haworth asked state insurance regulators and interested parties to submit comments to the Working Group by April 2.

4. Discussed Disability Insurance MCAS Proposed Scorecard Ratios

Mr. Haworth reviewed the first draft of the proposed scorecard ratios for the disability insurance MCAS. He said the first collection of disability income data will be June 30, 2021, for 2020 data. He said his goal is to have the scorecard ratios adopted by the 2019 Fall National Meeting.

Ms. McCallister said ratio six and ratio seven measure non-renewals against policies in force for both individual and group. She suggested it would be more useful to measure non-renewals against covered lives.

Mr. Haworth asked for comments and suggestions to be sent to the Working Group, but he did not specify a deadline for comments.

5. Received an Update on the Health MCAS Interim Meeting

Mr. Haworth said the Market Conduct Annual Statement Blanks (D) Working Group met in Dallas, TX, Jan. 23–24. He said state insurance regulators, as well as industry and consumer representatives, were present. Ms. Ailor said there was good attendance, a lot of ground was covered, and many clarifications and issues were discussed. She said she hopes to continue regular discussions between state insurance regulators and the industry.

Mr. Haworth said the Working Group's next meeting is scheduled for April 6 at the Spring National Meeting.

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

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