To: John Haworth, Chair, Market Analysis Procedures (D) Working Group

From: Undersigned NAIC Consumer Representatives

Re: Response to AHIP and BCBSA's Comments on Market Conduct Annual Statement for Health

Date: May 18, 2017

The undersigned NAIC consumer representatives support the 2018 reporting year updates to the Health Market Conduct Annual Statement that have been proposed to the MAP Working Group. We have earlier submitted comments in support of these updates. These additional comments respond to the comments that AHIP and BCBSA have submitted, which generally opposed the proposed updates.

In particular, we support the current proposal for twelve denial code buckets. In the alternative, we would accept the five buckets proposed by industry for 2018 experience reporting with the more detailed reporting for 2019 and later experience years. While not as helpful as the proposed twelve buckets, the five would be a significant improvement over the current (2017 experience) MCAS claims denial reporting.

The primary contention of AHIP and BCBSA in opposing an update of the Health MCAS for 2018 is that the Health MCAS itself as well as proposed updates to it are unreasonably burdensome, and that it is therefore unreasonable to update the Health MCAS to require additional reporting. Their comments dramatically overstate the burden imposed by the Health MCAS reporting. They assert that the 2016 health MCAS consists of 1,686 data elements. But the number of reporting elements involved in the health MCAS is primarily a function of the fact that health carriers report separately for each of the markets in which some, but not all, carriers offer coverage. The number of data elements for any single market is not excessive, and the information requested—on enrollments, claims, and appeals—is reasonable and necessary. Moreover, it is data that the carriers almost certainly themselves track.

AHIP and BCBSA further contend that Congress is currently considering amendments to the ACA and that the Health MCAS should not be updated until this process is completed. Legislation being considered by Congress at this time is irrelevant to the Health MCAS discussion. Regardless of changes to the ACA that Congress may or may not make, carriers will still be enrolling and dis-enrolling members, processing claims, and responding to appeals—the issues addressed by the Health MCAS. In particular, current congressional debates are irrelevant to claim denial categorization—the primary issue addressed by the Health MCAS updates. None of the claims denials categories being considered are linked to ACA requirements or likely to be affected by potential changes in the ACA.

The changes before the MAP Working Group were recommended by a smaller working group that has been meeting almost weekly for the past several years with full participation of AHIP and BCBSA. Most of the changes were discussed by the MAP Working Group in 2016 as the initial Health MCAS was being finalized, but were put off until this year because of the need to get the initial Health MCAS finished. None of the proposals would alter existing MCAS data elements. There is nothing that will be learned from the initial Health MCAS reports, which will be filed late in 2018, that justifies waiting to make further changes in the Health MCAS. Waiting until the 2017 MCAS reports are filed would mean that changes could not be

implemented until 2020 for 2021 reporting at the earliest. Such a delay would be unreasonable and unnecessary.

AHIP and BCBSA do not object to the additional collection of information on mental health and substance use disorder prior authorizations or medical necessity denials or on pharmacy prior authorization. These data are vital for market analysis. They are necessary to determine compliance with the mental health parity legislation, which was adopted prior to the ACA and is not subject to amendments proposed under the AHCA. AHIP and BCBSA's proposed change in the definition of behavioral health, mental health, and substance use disorder services are acceptable.

We continue to believe that the dozen categories of denied, rejected, and returned claims identified by the Working Group are appropriate and would give regulators a comprehensive overview of the claims denial practices of particular carriers. Data on denials would provide a sound basis for market analysis, and in particular for identification of outliers. As we have noted before, the Departments of Treasury, Labor, and Health and Human Services are currently working on claim denials classification systems and it is only a question of who takes the lead in identifying appropriate categories—state regulators or the federal government. Federal regulators have been listening in on calls of the Working Group and are likely to follow if the NAIC takes the lead.

The MAP Working Group should commit itself to collecting information on all twelve proposed denial categories for the 2019 reporting year. If the Working Group is not willing to require this reporting for the 2018 Health MCAS, however, collection of denial numbers for the five categories recommended by AHIP and BCBSA would be a step in the right direction. It would at least give regulators some basis for market analysis concerning some of the most problematic grounds for claims denials.

Timothy Jost
Jackson Williams
Anna Howard
Andrew Sperling
Silvia Yee
Ashley Blackburn
Lincoln Nehring
Karrol Kitt
Deborah Darcy
Birny Birnbaum
Elizabeth Imholz
Amy Killelea
Peter Kochenburger
India Hayes Larrier
Harper Jean Tobin
Brendan Bridgeland
JoAnn Volk
Lori Unumb
Bendan Riley
Jesse O'Brien
Katie Keith
Claire McAndrew
Lucy Culp
Amy Bach
Debra Judy
Marguerite Herman
Sarah Lueck

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