

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

From: The undersigned NAIC consumer representatives

Re: 2018 Health Market Conduct Annual Statement

Date: April 25, 2017

We write as consumer representatives to the NAIC to support the 2018 changes to the Market Conduct Annual Statement for Health currently under consideration by the Market Analysis Procedures (D) Working Group.

The recommended changes were developed by a drafting group chaired by John Haworth that included regulators, a market analyst, and representatives of insurers, trade groups, and consumers. The progress of the group was actively monitored by representatives from the Department of Labor and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services. The drafting group has met numerous times by conference call over the past year and thoroughly debated all of the proposed changes.

The most significant change proposed for 2018 is that the MCAS health blank would begin collecting information on claims denials. Although the original MCAS health blank collected data on the total number of denials, that information is of little value for market analysis without more granular information on the reasons why insurers have denied particular claims. The lack of specific denial information was recognized as a major gap in the 2017 blank in Market Analysis Procedures Working Group discussion of the Health MCAS proposal in 2016, but the pressure of time to get the blank in place made it impossible to develop a classification system for the 2017 blank version. The 2018 changes would provide the needed denial code granularity.

The twelve categories of denial codes agreed upon by the working group capture all possible denials. Preliminary analysis indicates that the “other” category will include relatively few codes.

Some of the categories will capture denials of incomplete or not “clean” claims. Carriers have the option of pending these claims and requesting additional information rather than denying them. But if a carrier denies a claim for lack of information or for a billing error, the claim remains denied unless the provider or enrollee takes further action. It remains a denial and should be tracked.

Our only suggestion regarding the denial codes is that the “Coordination of Benefits” category could be better defined as: “This category includes claims that were denied or adjusted due to the existence of two or more **forms of coverage**. . .” rather than “two or more insurance policies” to capture situations where one of the forms of coverage is a public program or a certificate of group coverage.

The drafting group discussed the proposed denial code classifications with a regulator from Maryland. Maryland has collected denial code information for many years using a very similar classification. Maryland reported that carriers have not had significant problems reporting codes.

The Departments of Labor and Treasury have [proposed](#) revisions to the form 5500, which collects information from group health plans, to begin collecting claims denial information from ERISA plans beginning with 2019. The Centers for Medicare and Medicaid Services are also

considering the collection of denial code information from qualified health plans. By adopting the proposed coding classifications for 2018, the NAIC is getting out of the gate first and the federal government will likely follow. This preserves the primacy of state regulation and will reduce the burden imposed on carriers.

The 2018 changes would also begin the collection of data on medical necessity denials and prior authorization requests, approvals, and denials for mental health, behavioral health, and substance use disorder services. Mental health parity laws—which are independent of and predate the Affordable Care Act—prohibit carriers from imposing qualitative or quantitative limits on mental or behavioral health or substance use disorder services that are not imposed on medical services. Many states have also adopted these or similar requirements into state law. Given the current opioid epidemic sweeping much of the country, coverage of these services is more important than ever.

The additional questions on mental health, behavioral health, and substance use disorder services would give market analysts the necessary information to determine whether plans are complying with federal and state requirements. The proposed definition for covered services comes directly from the federal regulations and should be familiar to carriers. We assume that carriers are already tracking this information to ensure their compliance with federal and state law and will not be unduly burdened in providing the information to the MCAS. We only suggest one minor correction—that the term "Behavioral Health Benefits" be defined to include "substance use disorder issues" rather than "substance abuse issues," to be in accord with current usage.

We urge you to adopt the changes proposed by the drafting committee.

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