



## **Comments of the Center for Economic Justice to the**

### **Disability MCAS Drafting Group**

**September 12, 2017**

CEJ submits comments in response to industry arguments to exclude credit disability and to offer suggestions on draft data elements and definitions.

#### **Credit Disability**

In addition to the usual objections to including consumer credit insurance (or any new line or type of insurance) in MCAS data collection, CCIA, AHIP and CCIA add a new argument – that credit disability is not disability insurance and, consequently, should not be included in a disability insurance MCAS. The claim is factually and logically incorrect – credit disability is clearly disability insurance.

The trades argue that credit disability is not disability insurance because

- a. The names are different;
- b. There are separate types of insurance in the NAIC product coding matrix;
- c. Disability income insurance is intended to replace income while credit disability is intended to pay a creditor; and
- d. Credit disability is a property/casualty coverage.

First, the fact that the names of the products are different is not particularly relevant to whether both products are versions of disability insurance. The defining factor for a major type of insurance is the type of benefit provided and perils insured against. In this case, the peril insured against is disability of policyholder and the benefit is money paid to or on behalf of the policyholder. The trades claim that disability income insurance pays to replace income while credit disability pays a loan obligation. This is incorrect. The payment of a disability income is based on a disability event affecting the ability to work; the benefit is not triggered by lost income.

Putting aside that the ACLI Fact Book is not an authoritative resource regarding the definition of coverages for purposes of MCAS, we note that the ACLI definition specifically defines credit disability as insurance providing a benefit “in case of disability.” The Fact Book also defines “disability” as “A physical or mental condition that makes an insured person incapable of working.” This is the trigger for a credit disability benefit.

Second, the fact that a particular line of insurance has multiple product definitions in the uniform coding matrix does not mean these products are not part of the same major type of insurance. There are many separate types of life insurance in the uniform coding matrix, but arguing that flexible premium adjustable life, credit life and indexed universal life are not all life insurance would be frivolous and false.

The actual entries in the uniform coding matrix demonstrate that disability income and credit disability are disability insurance – insurance that provides cash payment if the policyholder is disabled:

Type of Insurance (TOI)	Description
CR02 G Group Credit – Credit Disability	Makes monthly loan/credit transaction payments to the creditor <b>upon the disablement</b> of an insured debtor
CR02 Individual Credit – Credit Disability	Makes monthly loan/credit transaction payments to the creditor <b>upon the disablement</b> of an insured debtor
H11G Group Health – Disability Income	A policy designed to compensate insured individuals for a portion of the income they lose <b>because of a disabling injury or illness.</b>
H11G Group Health – Disability Income	A policy designed to compensate insured individuals for a portion of the income they lose <b>because of a disabling injury or illness.</b>

Third, CCIA, AHIP and ACLI seek to draw a distinction between disability income and credit disability based on the alleged purpose of the insurance. They argue that credit disability is intended to cover payment of a loan while disability income is intended to replace income. Of course, the purpose of credit disability is to replace the borrower’s income in the event of disability so the borrower does not default on the loan. This is precisely the same purpose as disability income insurance other than targeting the disability benefit to a particular purpose.

We would also note that credit disability is to disability insurance as credit life or mortgage life is to life insurance. Yet, the trades did not make this argument during the discussion of MCAS reporting for credit life.

Fourth, AHIPs claim that credit disability is a property/casualty coverage (and presumably not written by life/health insurers) is false. Credit disability (also known as credit accident and health) is written by both life/health insurers and property/casualty insurers and can be written by either type of insurer. Both life/health and property/casualty insurers are required to report credit disability in the Credit Insurance Experience Exhibit and their respective statutory annual statements

In sum, the argument that credit disability should be excluded from the disability insurance MCAS because credit disability is not disability insurance is factually and logically incorrect and should be quickly dismissed.

CCIA then offers a repeat of prior comments, including

- a. No evidence of systemic issues requiring further data reporting – complaints are low.
- b. Data already captured by the CIEE
- c. The lender maintains the data
- d. The market is small
- e. It will be a burden on an industry many small insurers
- f. Credit life was rejected; the same reasons hold

These arguments are factually incorrect, unsupported by empirical evidence and/o illogical.

First, CCIA invents a new purpose for MCAS – data reporting needed only when evidence of systemic issues are present. The purpose of MCAS is not to respond to a market problem but to allow market regulators to efficiently monitor markets to pro-actively identify market problems whether systemic or associated with a particular company.

Further, the level of consumer complaints is not dispositive of insurer or producer conduct. The fact that Wells Fargo's LPI insurer falsely placed 800,000 LPI auto policies over a five- to six-year period without significant consumer complaints is graphic and disturbing evidence of the limitation of consumer complaints. If complaints were sufficient for market analysis, then there would be no need for MCAS. Regulators long ago determined that complaints were not sufficient and that additional data was needed for market analysis. We ask regulators to kill this zombie argument once and for all.

Second, the data reported in the CIEE includes premium, claim and compensation dollars and is designed for assisting regulators with ratemaking and rate oversight. The CIEE is not designed for market analysis since it has no information on the number of policies or certificates, the number of claims filed, denied or paid, the timing of claims settlement, the number of complaints received directly by the insurer or lender or the number of suits by or against the insurer. Clearly, the CIEE is no more a substitute for MCAS than the Annual Statement State Page is substitute for the homeowners or auto MCAS.

Third, the fact that an insurer relies upon its producer to maintain some or all of the data required by the insurer to operate its business and respond to regulatory oversight is not a valid reason for failing to report data. By CCIA's logic, any insurer could avoid any responsibility to provide data to regulators by simply having its agents or third-party service providers hold those data. That premise has been routinely rejected, most recently with the recently-adopted NAIC cybersecurity model.

Fourth, while the credit disability has shrunk from the late 1990s, the net written premium has been relatively stable since 2010. The NAIC credit insurance report show the following net written premium by year:

<u>Year</u>	<u>NWP (\$Millions)</u>	<u>Loss Ratio</u>
2010	\$878	45.2%
2011	\$870	41.8%
2012	\$885	41.2%
2013	\$892	36.7%
2014	\$885	34.9%
2015	\$851	33.8%
2016	\$786	32.4%

These figures indicate millions of consumers purchasing credit disability annually as well as additional consumers who had purchased single premium credit disability in prior years. There are a significant number of consumers involved in this market. The 2016 ACLI Fact Book, showing ACLI's compilation of NAIC-provided annual statement date of life insurers, reported that in 2015 **15.6 million credit life insurance certificates in force up slightly form 2014**. Since credit life and credit disability are often sold together, this is an order-of-magnitude estimate of the number of credit insurance coverages in force (individual policies and certificates issued from group policies.). In addition the 2016 ACLI Fact Book shows an increase in credit life termination rates (lapse rate plus surrender rate) for credit insurance from 2010 to 2015, peaking at 23.1% in 2014 – four times greater than the rates for other individual and group life.

In addition, from 2010 to 2016, loss ratios have dropped dramatically. With current aggregate loss ratios of 32.5% -- down from 50.1% in 2001 and down from 45.2% in 2010 -- the low loss ratios are consistent with improper sales or claims settlements. The countrywide numbers mask even more troubling results in certain states with five year average loss ratios of 18.9% in Georgia, 23.5% in New Hampshire, 24.9% in Oklahoma, 26.2% in Texas.

These low loss ratios are consistent with sales and claims problems routinely found in add-on insurance markets, generally, and in consumer credit insurance markets, specifically. In the absence of actual MCAS data or a Wells Fargo-type scandal, it is difficult to imagine stronger evidence supporting inclusion of a product line in MCAS.

Fifth, while there is some cost to prepare and routinely report MCAS data, there is no evidence or basis to indicate or conclude that such reporting is an unreasonable burden. More relevant is whether the benefit exceeds the cost and here the answer is clearly yes. Routine reporting of data is a far more cost effective method of monitoring a market than through special data calls or market conduct examinations.

It should be pointed out that the real choice is not between MCAS and some other form of market monitoring but between MCAS and little or no monitoring of credit disability insurer market outcomes. The reality is that in the absence of MCAS and market conduct examinations, there is no routine monitoring of consumer credit insurance markets.

We would also note that the same data elements are relevant for credit disability as for other disability insurance products. Stated differently, the inclusion of credit disability is simply another column in the MCAS blank.

Sixth, CCIA falsely states that the A Committee approved exempting credit life from MCAS. While the MAP WG declined to add MCAS, **there was no vote specific to this issue at the D Committee, let alone the A Committee as claimed by CCIA.** Any reliance on CCIA claims must be seriously questioned when CCIA falsely states that a lettered committee with no oversight over either MAP or MCAS working groups has taken an action related to MCAS.

More relevant, however, are these facts that create even greater concern for credit disability than credit life, including

- Greater net written premium
- Dramatic reduction in aggregate loss ratios
- Greater dispersion in loss ratios among insurers.

## Comments on Disability Data Elements and Definitions

Unlike other types of insurance, disability insurance involves an initial claim presentation and settlement decision followed by ongoing benefit requests with associated documentation requirements and payment decisions. To make the claim settlement data elements useful, we suggest that separate definitions and data elements be created for “initial claim” and “benefit request,” with initial claim defined (roughly) as the initial request for eligibility for benefits while the benefit request is (roughly) defined as a request for benefits subsequent to initial eligibility approval. By separating out these claim/benefit request activities, data on claims paid and denied and time to settle/process a claim/benefit request will be more meaningful and avoid mixing of different categories. Data elements could include:

- Number of initial claim requests pending at beginning of reporting period
- Number of initial claim requests received during the period
- Number of initial claim requests approved during the period
- Number of initial claim requests denied during the period
- Number of initial claim requests denied
- Number of initial claim requests denied due to incomplete information
- Number of initial claim requests denied due to ineligibility for benefit due to pre-existing condition
- Number of initial claim requests denied due to ineligibility for any reason other than pre-existing condition
- Number of initial claim requests pending at end of reporting period
- Number of initial claim requests denied in less than 31 days
- Number of initial claim requests denied in 31 to 60 days
- Number of initial claim request denied in 61 to 90 days
- Number of initial claim requests denied in 91 or more days
- Number of initial claim requests approved in less than 31 days
- Number of initial claim requests approved in 31 to 60 days
- Number of initial claim request approved in 61 to 90 days
- Number of initial claim requests approved in 91 or more days
  
- Number of benefit requests pending at beginning of reporting period
- Number of benefit requests received during the period
- Number of benefit requests approved during the period
- Number of benefit requests denied during the period
- Number of benefit requests denied
- Number of benefit requests denied due to incomplete information
- Number of benefit requests denied due to end of eligibility for benefits

- Number of benefit requests denied due to exhaustion of benefits
- Number of benefit requests pending at end of reporting period
- Number of benefit requests denied in less than 16 days
- Number of benefit requests denied in 16 to 30 days
- Number of benefit request denied in 31 to 45 days
- Number of benefit requests denied in 46 or more days
- Number of benefit requests approved in less than 16 days
- Number of benefit requests approved in 16 to 30 days
- Number of benefit request approved in 31 to 45 days
- Number of benefit requests approved in 46 or more days

As discussed in last week's call, time to settle an initial claim or benefit request must be defined as the number of days from initial presentation of the claim or benefit request until the decision by the insurer evidenced by a written or electronic notice to the consumer providing the insurer's decision. A request by the insurer for additional information is not considered a decision.

Also, as mentioned by Brent Kabler in week's call, a re-opened claim should be reported as a new initial claim.