Market Conduct Annual Statement
Frequently Asked Questions

This Frequently Asked Questions (FAQ) document is not a formally adopted NAIC document. The document contains questions that have been asked by insurers to NAIC staff. When available, answers are taken directly from the Data Call and Definitions. In instances where the Data Call and Definitions do not provide answers to the specifically asked questions, NAIC staff collaborates with state insurance regulators to ensure the answer is consistent with the intent of the Data Call and Definitions. The FAQ document is not intended to replace the Data Call and Definitions. It should be noted that state insurance regulators have authority to provide state specific clarifications or guidance.

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- Who has to complete the MCAS?

  MCAS is collected on the state level. A company needs to file MCAS data to a participating state if it meets the following criteria in that particular state:

  - **Life/Annuity**: The company is licensed and reports at least $50,000 of individual life insurance premium (excluding credit life) for the data year or at least $50,000 of individual annuity consideration for the data year in that participating state. If the company meets the threshold for either individual life insurance or individual annuities in a state, but does not meet the threshold for the other line of business, reporting to the state should be made only for the one line of business that meets the threshold.

- **Property/Casualty**: The company is licensed and reports at least $50,000 in private passenger automobile insurance premium for the data year; or $50,000 in homeowners insurance premium for the data year; or both for that participating state. If the company meets the threshold for either private passenger automobile or homeowners insurance in a state, but not the other, reporting to the state should be made only for the one line of business that meets the threshold.

- **Long-Term Care**: The company is licensed and reports any individual long-term care insurance premium (stand-alone, life-LTC hybrid, annuity-LTC hybrid) for the data year for that participating state. All companies with any in-force individual LTC policies, individual Life-LTC hybrid products, or individual Annuity-LTC hybrid products are required to report data in MCAS. (Note: for Arkansas, there is a premium threshold of $50,000 for each of the LTC coverage types. Reporting to the state should be made only for the line(s) of business that meets the threshold.)

- **Health**: All companies licensed and reporting at least $50,000 of health earned premium for all coverages reportable in MCAS (includes both in-exchange and out-of-exchange) within any of the participating MCAS states. (Note: For Tennessee, submission of health MCAS data is voluntary as the Commissioner does not have authority to promulgate rules requiring companies that write accident and health insurance to file an annual statement concerning its market conduct. Tenn. Code Ann. § 56-8-107(c)(1).)

- The company is automatically exempt from filing in a particular participating state if:

  - The company is not licensed to do business in that state; or
  - The company reported less than the state threshold in premium or consideration in individual life, individual annuity, individual long-term care (stand-alone or hybrid), private passenger auto, homeowners and health insurance.

*See **Participation Requirements**.*

- How is the Financial Annual Statement premium amount determined that is used as the premium threshold for MCAS filings? If we have less than the premium threshold for a given state and line of business but the filing matrix indicates that the company is required to file. What do we need to do to remove the asterisk (*) that indicates required to file on the filing matrix?

  The premium amount is determined from the financial annual statement that a company files with the NAIC. These are the financial annual statement references used:
  - Private Passenger Auto – Direct Premiums Written, State Page, lines 19.1,19.2 and 21.1
  - Homeowners – Direct Premiums Written, State Page, line 4
  - Life – Ordinary premiums, State Page, line 1
  - Annuity – Ordinary considerations, State Page, line 2
  - LTC – Long-Term Care Experience Reporting Form 5, line 1 (Stand-Alone ONLY)
  - Health – Individual Comprehensive, Small Group Employer Comprehensive, Large Group Employer Comprehensive, and Student Health Plans reported on the Supplemental Health Care Exhibit Part 1, Health Premiums Earned

    Note: There may be premiums applicable to MCAS (particularly on the Homeowners and LTC Hybrid lines) that are not accounted for when the required to file field is indicated. Please see FAQs related to **Required to File** and **Coverage Types** for more information regarding this.

  Companies that file their financial annual statement as a Property company received a call letter requiring them to report any private passenger auto, homeowners, LTC or health business that exceeds the reporting thresholds.

  Companies that file their financial annual statement as a Life company received a call letter requiring them to report any life, annuity, LTC or health business that exceeds the reporting thresholds.

Companies that file their financial annual statement as a Health company received a call letter requiring them to report any life, LTC or health business that exceeds the reporting thresholds.

The required to file indicator on the filing matrix cannot be removed. The required to file indicator is populated based on the reported financial annual statement state page premiums. It is understood that there may be discrepancies between the state page premium and the premium that is applicable to MCAS reporting.

*See **Participation Requirements***

- If I don't have a Required to File asterisk in my filing matrix in a state and line of business where I have data to report, am I automatically exempt from filing?

  The Required to File asterisk is based on the information contained in your company's most recent financial annual statement (FAS). It is possible for a company to have met the threshold to report MCAS data (individual life, individual annuity, private passenger auto, homeowners, LTC, or health), but not appear on the Filing Matrix as Required to File. When the application opens for submissions in March, the LTC and health Filing Matrix may not have required to file asterisks. The FAS - LTC Reporting Forms 1 through 5 and the Supplemental Health Care Exhibit are not due until April 1. You will not see any "required to file" asterisks until your company's LTC Reporting Form 5 and Supplemental Health Care Exhibit are submitted.

  There may be premiums applicable to MCAS (particularly on the Homeowners and LTC Hybrid lines) that are not accounted for when the required to file field is indicated. If you have data to report that meets the filing thresholds but do not have a required to file asterisk, you must report this data. This is particularly important for the **LTC-hybrid** products. The policy and premium data for hybrid products are not collected in the FAS on a state level, so if the only LTC business your company writes is Life-LTC hybrid or Annuity-LTC hybrid, the Filing Matrix will not indicate that your company is required to file. Nevertheless, you must file an MCAS for the

LTC-hybrid business that you have in-force for each state in which you have this business. For Homeowners reporting, if you have premiums applicable to MCAS reporting on your state page in Line 1 (Fire) or Line 17 (Other Liability), combining these with the premiums reported on Line 4 (Homeowners) may put the company over the premium threshold, even though you don't have a required to file asterisk for that state.

It is the responsibility of the company to determine if they are required to file MCAS.

- What changes will there be this year?

  For a full description of the changes for the line(s) of business your company writes, please see the "**Summary of 2017 Changes**" document found on the **MCAS webpage**.

- When is the MCAS filing due date?

  The due date for submitting MCAS filings is April 30th of each year for all lines of business except Health. For the Health filing, the submission deadlines are as follows:

Data Year	Health Due Date	LPI Due Date	All Others Due Date
2017	September 30, 2017	N/A	April 30, 2017
2018	TBD	June 30, 2018	April 30, 2018
2019	TBD	April 30, 2019	April 30, 2019

- Do companies in a group file separately or as a group?

  Each company within a group must file separately for each state in which it meets the minimum threshold. Data for the members of a group or insurance holding company cannot be combined into a single filing.

*See **Participation Requirements**.*

- Whom do we contact if the company did not receive a call letter?

  If your company did not receive a call letter and you believe that your company should have been included based on business written, you should contact **mcas@naic.org**.

  Copies of the call letters for each MCAS line of business can be found on the **MCAS Web page**

  MCAS call letters are sent to all companies licensed to write business within the MCAS jurisdictions and which submitted financial data on the property/casualty, life or health statement types.

  *See **Participation Requirements**.*

- How do I request a waiver or an extension?

  To request a waiver or an extension, you must log into the online MCAS submission tool. Within the tool there is a section for requesting waivers and extensions. You will be able to make your request to one or more states. Requests should be made as early as possible. Do not wait until the data is due.

  It is not necessary to request a waiver if the company does not meet the ***Participation Requirements*** for a given state and line of business.

- I received a waiver last year. Do I have to request a waiver again this year?

  Companies exempt from filing in previous years are not automatically exempt from filing the current year. You must request a waiver each year.

  *See **Participation Requirements**.*

- Which jurisdictions participate in the MCAS?

Forty-nine jurisdictions are currently participating in MCAS. For a complete listing, please refer to the **Participating Jurisdictions** link.

MCAS Application

- *What is the role of the Market Conduct Contact?*
- *How do I assign users to input MCAS data for my company?*
- *I want to assign a user for my company but the individual does not have a User ID. How does this individual obtain a User ID?*
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- *I have already submitted my data for the current data year. How can I submit corrections/changes to the MCAS filings I've already submitted?*
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- *What are the system requirements for using the MCAS application?*

- What is the role of the Market Conduct Contact?

  The Market Conduct Contact is provided by the company on the Jurat page of the quarterly and annual financial statements. The Market Conduct Contact is the person that state insurance regulators contact for all market conduct matters with the company; therefore, the Market Conduct Contact is also the first person assigned an MCAS login for the company. That means that the Market Conduct Contact is the default MCAS Administrator for the company. Once signed into the application, the Market Conduct Contact designates which individuals will be able to view, enter and edit data for their company. The Market Conduct Contact will also designate who the company **MCAS Contact** will be for questions specific to the company's MCAS responses.

- How do I assign users to input MCAS data for my company?

  The MCAS Administrator will need to log in > From the drop down list, select the company and click "continue" > click on the "User Assignments" tab > then enter the MCAS ID for the person to be added. The newly assigned user will now be able to enter and edit MCAS data for the company(s) that they are assigned to.

- I want to assign a user for my company but the individual does not have a user ID. How does this individual obtain a user ID?

  Individuals can obtain a user ID and password to log into the MCAS application from the NAIC Help Desk. A link is available on the MCAS Web page (**MCAS Web page**) in the red box that says "Don't have an MCAS login? Click here to get it." After receiving the user ID and password, the user will be unable to view, edit or update data for any specific company until the MCAS Administrator has assigned them as a user for the company.

- Our Market Conduct Contact has changed. Whom do we notify so we can login to the MCAS application?

  The Market Conduct Contact change will be made at the NAIC when the revised annual or quarterly financial statement containing the new contact information is received.

- What is the role of the MCAS Contact?

  Jurisdictions and NAIC staff will contact the MCAS Contact if there are questions about the MCAS filing. The MCAS Administrator is shown as the MCAS Contact by default, but the role can be reassigned by the MCAS Administrator.

- I have already submitted my data for the current data year. How can I submit corrections/changes to the MCAS filings I've already submitted?

  Regardless of the line of business, re-filing for the current data year is handled much the same as the initial filing. The appropriate screen is accessed through the Filing Matrix where the most recently saved data is displayed. You will click on the green "filed" checkmark in the filing matrix on the state whose data you wish to edit. Changes are made by replacing the old values with new ones where needed. Once changed, the data may be saved, validated, and submitted again when ready. When the refiling is processed, the refiled data replaces the previously submitted data. Once the green check reappears, your data has been successfully resubmitted.

- When is the latest date I can submit changes to my MCAS filings?

  The last day to login to the MCAS system and submit data is indicated on the MCAS webpage in the Key MCAS Dates section. The system will stop accepting filings for any data year on the indicated date in order for preparations to take place for the next data-year filing.

  When the system becomes available for accepting the next year's filings, you will again be able to make changes to your prior-year data. However, before you are able to make any changes to any prior MCAS filing, you must get written approval from the state to which the MCAS was originally submitted. State contacts can be located at **www.naic.org/industry_mcas_states.htm**.

- What are the system requirements for using the MCAS application?

  The NAIC recommends using Internet Explorer (IE) or Chrome when working with MCAS. When using IE v9 or IE v10 please use compatibility view. In addition, individuals using any version of Internet Explorer (IE) might see some numbers appearing in purple or green shades, while others are black. This is a known anomaly with IE, and it has no adverse effect on the application or entered data. Incompatible browsers also may appear to upload your data (CSV file) or save it after entry (manual entry), but when you return to the filing matrix, your data has not saved. Using compatibility mode in IE or using Chrome should remedy this problem. Safari and Firefox are not supported browsers.

  A 800 x 600 screen resolution setting is **not** supported by the MCAS application. A higher resolution (i.e., 1024 x 768 or more) is recommended for the best viewing experience. Higher resolutions reduce the amount of screen scrolling needed to view an entire page.

Data Upload

- *Can I use a data upload file instead of manually entering all of the data?*
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- *I am uploading data for Stand-Alone Long-Term Care only from a CSV I created in Excel. I get an error saying that there are values missing in a record. What is this error and how do I fix it?*

- Can I use a data upload file instead of manually entering all of the data?

  Yes. There is a data upload feature. This feature allows the use of a comma delimited (.csv) file. You also can access the CSV Assistant tool (located on the **MCAS webpage**) to fill in your data to aid in the creation of your CSV file. Please be aware that the CSV data upload only works for the data year currently being filed.

- Where can I find the specifications for the data upload file?

  The **Data File Instruction Guide** can be found on the MCAS Web page.

- What if I upload or enter incorrect data?

  The data that you upload or enter is not submitted to state regulators until you click on the "Submit" button for each of the states to which you wish to submit data. Therefore, you are able to upload or enter the data as many times as you wish and make corrections until you are satisfied with the results. Please be aware that the csv data upload only works for the data year currently being filed.

- I am receiving error messages when trying to upload my data file. What am I doing wrong?

  Here are some things that you can check for:

  - Open your csv upload file in Notepad. This will show you the true layout of your file.
  - Remove all extra commas. When you save an Excel file as a .csv file, it will try to determine how many fields you want in each record. Because the comment records in your upload file contain less fields than the other records, you often need to delete the extra commas.
  - Remove all extra spaces. For example, for the State field, you should only have two characters with no extra spaces.
  - If you continue to have problems, you can try creating separate upload files: one for claims and another for underwriting. This can be done for the private passenger auto insurance and homeowners insurance lines of business.
  - You may also wish to use the CSV Assistant

- I uploaded or entered all my data and it appears to have uploaded/saved. When I go back in to the filing matrix, though, everything is blank! What happened to my data? Why didn't it upload/save? (My data appears to have saved/uploaded, but I don't see anything when I return to the filing matrix.)

  This is most often a compatibility issue. If you are on Internet Explorer version 10 and higher, you probably need to go into the Tools dropdown menu, then use the compatibility view. Chrome works without any adjustments if you have access to that browser. If you are trying to type in data, it will appear to save, but without confirmation and you will have no data in the filing when you go back to look at it again. If you are using a CSV upload, the file will act like it tries to upload or will throw a fast error and then do nothing when the issue is compatibility. You may also see the question related to the **MCAS system requirements**.

MCAS Submission

- *What is the Attestation?*
- *The data we are providing in MCAS may raise some additional questions. Whom should we contact?*
- *Do we provide jurisdiction specific or national data to each participating jurisdiction?*
- *Can we edit prior year's MCAS submission?*
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- *What types of coverage should be included in the report?*
- *The MCAS application returned a warning message regarding reported MCAS premiums expected to be within 20% (+/-) of the premiums reported in the Financial Annual Statement Filing. What does this warning message mean?*

- What is the Attestation?

  Before any filing will be accepted for submission, the company must provide the name of two individuals authorized to attest on behalf of the company that the data is complete and accurate. The attestation will be made by clicking a checkbox titled, "I attest." This checkbox is located immediately below the attestation wording. It is not necessary that the attester be the **Market Conduct Contact** or the **MCAS Contact**.

- The data we are providing in MCAS may raise some additional questions. Whom should we contact?

  Contact the jurisdiction to which the information is being provided. The contact information can be found on the **Participating Jurisdictions** link. You are also provided with a comment box for each section of the MCAS.

Be sure to use the comment boxes for any explanations of the data you are submitting. Comments about specific data elements can be made on the page where the data is entered. General comments about the company or the company data, as a whole, can be made on the Attestation page of MCAS.

- Do we provide jurisdiction specific or national data to each participating jurisdiction?

  Provide the jurisdiction-specific data that applies to each jurisdiction to which you are providing information; for example, only provide California information to California, and Ohio information to Ohio.

- Can we edit prior year's MCAS submission(s)?

  Yes, but you must first get the jurisdiction's approval to edit the data. With this approval, the NAIC will unlock your data and allow you to edit the data. Revisions may only be made for the three most recently reported data years. Once you have received approval from the needed jurisdiction(s), please forward it to **mcas@naic.org** to request the filing be unlocked.

- The MCAS application returned a warning message about the company data. The data is correct. How do I submit the data?

  There are two types of data validation messages: errors and warnings.

  A warning message means that the data appears unusual and may be incorrect. If, in spite of the warning, the data is correct as reported, you will be allowed the option to submit the data with warnings. Before submitting data with a warning message, provide an explanation in the comment box addressing the warning.

  An error message means the data is incorrect or incomplete and cannot be submitted as entered. You are not able to submit data with errors.

- Where do I find data definitions and reporting guidelines?

  The data definitions and reporting guidelines can be found on the MCAS Web page (**www.naic.org/industry_market_conduct_statement.htm**) under the Resources section.

- What types of complaints should be reported?

  You are only required to report complaints that were made directly to the company. If you are made aware of the complaint through the DOI, you do not need to report it. If you receive a complaint from a consumer and later hear from the DOI, still report it. They can be any type of complaint (claims, underwriting, marketing, etc.). Complaints also include those received from 3rd parties.

  "Directly from any person or entity other than the DOI" should be interpreted as directly from a source other than the DOI. Therefore, a complaint from the BBB or the Attorney General should be included. In the past, the Life companies had to report on MCAS both complaints "received from consumers" and "complaints received from the DOI". This was meant to be all-encompassing. The decision was made a few years ago to drop the "complaints received from the DOI" since the DOI's were already aware of those complaints. So what is left should be complaints other than those received from the DOI.

  Finally, you should treat social media complaints depending on the context. If the consumer lodges a complaint on a social media site set up by the company with the intent to communicate one-on-one with consumers and the consumer would have a reasonable expectation of a response then count it as a complaint. However, if the consumer is merely taking advantage of the medium to vocalize dissatisfaction in a large scale way but has no real expectation of a direct response then it would not.

- Some MCAS lines of business ask that lawsuit information be reported. How do I report the suits?

  You are to report one suit for each applicable claimant/coverage combination. So, if a suit seeks an award under HO Liability and HO Medical

Payments, you would report the suit under both the Liability coverage and the Medical Payments coverage. If the suit seeks award on multiple policies, you will count a suit for each policy.

If you are reporting to more than one state, you should report the lawsuit to the state in which the claim was reported on the MCAS. For example, if your MCAS reports a claim received in Indiana, but the lawsuit was filed in Michigan, you would report the lawsuit to Indiana.

If the lawsuit is a class action, only report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Also include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

You can find additional clarification for suits in the data call and definitions for each applicable line of business.

- What types of coverage should be included in the report?

  Please refer to the *Data Call and Definitions* for **Life and Annuity**, **Private Passenger Auto**, **Homeowners**, **Stand-Alone Long-Term Care**, **Hybrid Long-Term Care** and **Health** to determine data that should be included in MCAS filings.

- The MCAS application returned a warning message regarding reported MCAS premiums expected to be within 20% (+/-) of the premiums reported in the Financial Annual Statement Filing. What does this warning message mean?

  As a rule, MCAS checks if the premium reported on the state MCAS filing is within 20% (+/-) of the premium amount reported on the state Financial Annual Statement (FAS) Filing. If the premiums reported in the MCAS filing are outside the 20% tolerance, a warning message is displayed. The message will vary depending on the MCAS line of business. Below are the descriptions for this warning message and the lines of business where it applies:

1) HO: MCAS state Homeowners direct written premium reported is expected to be within 20% (+/-) of the Property/Casualty Financial Annual Statement (FAS) State Page Direct Written Premium (Line no. 4).
2) PPA: The reported MCAS state Private Passenger Auto direct written premium is expected to be within 20% (+/-) of the Property/Casualty FAS State Page Direct Written Premium (Line nos. 19.1 + 19.2 + 21.1).
3) ANNUITY: MCAS state Annuity Considerations (Fixed + Variable) are expected to be within 20% (+/-) of the Life, Accident and Health FAS State Page Part 1, Annuity Considerations (Ordinary + Industrial).
4) LIFE: For Life Premiums: The reported MCAS state direct premiums (Cash Value + Non-Cash Value) should be within (+/-) 20% of the Life, Accident and Health FAS State Page part 1, Life Insurance (Ordinary + Industrial) or within (+/-) 20% of the Health FAS State Page total direct life premium.
5) HEALTH: The reported MCAS state direct premiums (for all reported business) should be within (+/-) 20% of the Individual Comprehensive, Small Group Employer Comprehensive, Large Group Employer Comprehensive, and Student Health Plans reported on the Supplemental Health Care Exhibit Part 1, Health Premiums Earned.

There may be legitimate reasons for the MCAS reported premiums to vary from the FAS premiums by more than 20%. For example, companies may report applicable MCAS homeowners' premiums on lines other than line 4 of the Property/Casualty FAS State Page or companies may write creditor-placed coverage that is included in the premium amount reported on the FAS State Page lines. As such, the MCAS tries to allow for such instances while providing tolerance limits to ensure data quality. The warning descriptions above outline the specific line numbers on the FAS that the MCAS premium amounts are checked against.

Example: A company reports the following Homeowner data for a specific state:

<u>Homeowners Interrogatories</u>
Question 07: Does the company write in the non-standard market?
Response: Y

Question 08: If Yes, what percentage of your business is non-standard? Response: 50%

Question 09: If Yes, how is non-standard defined? Response: High-Risk Policy-holders.

Question 16: Additional state specific Underwriting comments (optional): Response: Most of the policies written are on high-risk policyholders. In addition, the company also writes some creditor-placed business.

Homeowners Underwriting Activity

Question 42: Dollar amount of direct premium written during the period: Response: $500,000

FAS State Page:

Line 4: Homeowners Multiple Peril: Direct Premiums Written: $1,000,000.

Using the above example, we observe that:

1) The company reports only $500,000 for the MCAS HO dollar amount of direct premium written during the period.
2) Calculating the tolerance limits, we note that the amount reported in the FAS ($1,000,000) exceeds the tolerance limits for the premium reported in the MCAS filing, and therefore yield the warning message.
   a. Upper Limit: (1+20%) x $500,000 = $600,000
   b. Lower Limit: (1- 20%) x $500,000 = $400,000

If you encounter this warning message, please review the premium amounts reported in the MCAS filing for accuracy and/or make corrections as needed. If the MCAS premiums reported are correct, please include comments regarding the difference in premium amounts within the provided comment areas found in the interrogatory section of the MCAS filing.

Health MCAS

- *What should I report if I don't collect data for a specific data element?*
- *What is the definition of "policy", as it pertains to Health insurance coverage?*
- *Who is the policy holder in a group policy or individual policy?*
- *What is meant by "Health Insurance Coverage"? (Updated 02/27/2018)*
- *Are Dental and Vision claims part of the Claims Administration if they are embedded in the medical policy (purchased as a package)?*
- *How should individuals that change products mid-year be accounted for?*
- *When reporting claims received and or claims denied, which date should we use as the anchor date for reporting?*
- *How are line items on bundled claims reported? (Updated 03/29/2018)*
- *Should duplicate claims be reported?*
- *How are claim payment adjustments reported?*
- *When a claim is received with insufficient data, would it count as a denial?*
- *Should the number of member months only include member months that occur during the reporting period, or should the number of months since inception of the policies that were issued or renewed during the reporting period be included?*
- *If a request for prior authorization includes multiple services, some of the services may be approved while others are denied. In this situation, should the prior authorization be reported as approved or denied? (Updated 03/23/2018)*
- *If a claimed service is included in a prepaid capitated service, should this be reported as a denied claim or a paid claim? (Updated 03/23/2018)*
- *Should second level internal reviews be reported in the MCAS? (Updated 03/23/2018)*
- *If a grievance includes multiple services, some of the services may be upheld while others are overturned. In this situation, should the grievance be reported as approved or denied? (Updated 03/23/2018)*
- *How should group policies be counted if multiple policy products are included within a single contract? (Updated 7/11/2018)*

- What should I report if I don't collect data for a specific data element?

  If the carrier does not currently collect the necessary information, a note should be added to the comments questions (line 8 and 18) on the MCAS Health Interrogatories section. It is expected that this information is available for reporting. Contact the state MCAS Contact if you have further questions.

- What is the definition of "policy", as it pertains to Health insurance coverage?

  The individual or group contract that outlines the coverages and the fees charged.

- Who is the policy holder in a group policy or individual policy?

  If the policy is a "group policy" then the policy holder is the group. If the policy is an "individual policy" then the individual is the policy holder.

- What is meant by "Health Insurance Coverage"? *(Updated 02/27/2018)*

  The following is the definition from the Data Call and Definitions:

  Health Insurance Coverage – Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. This is not intended to include excepted benefits as defined in 42 U.S.C. § 300gg-91(c). This is also not intended to include closed blocks not subject to Medical Loss Ratio (MLR) reporting under Centers for Medicare & Medicaid Services (CMS) guidance nor is it intended to include self-funded plans. (2017 MCAS Health Data Call and Definitions Documentation)

  Following are the excepted benefits found in 42 U.S.C. § 300gg-91:
  (c) Excepted benefits

For purposes of this subchapter, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1395ss (g)(1) of this title), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

In addition to the exclusions covered within the Health Insurance Coverage definition and the excepted benefits found in 42 U.S.C. § 300gg-91, the following should be excluded from health MCAS reporting:

- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

- Are Dental and Vision claims part of the Claims Administration if they are embedded in the medical policy (purchased as a package)?

  Yes, Dental and Vision claims should be included as part of the claims administration if they are embedded in the medical policy.

- How should individuals that change products mid-year be accounted for?

  For an individual that changes products during the reporting year:
  - If a new policy is issued, report as a new policy issued during the year.
  - Member months for the newly issued policy would be reported.
  - Member months for the previous policy would be reported as a renewed policy if applicable.
  - If the previous policy was terminated at the consumer's request, it would be reported as such.

  Member months are counted only for the months during the reporting period. No more than 12 member months should be counted for one individual.

- When reporting claims received and or claims denied, which date should we use as the anchor date for reporting?

  In an effort to create uniformity with the anchor date used for claims received and denied it is recommended that the received/determination date be used as the anchor date.

- How are line items on bundled claims reported?

  It has come to our attention that some carriers may not be able to report certain claims for bundled services by line of service as the Data Call requests. Carriers are to report claims for bundled services as they are capable of reporting, in the most practical and reasonable manner possible. Within the Interrogatories section of each Health MCAS submission,

carriers are to provide a written explanation of their coding and reporting methodology for services that are subjected to bundling. *(Updated 03/29/2018)*

- Should duplicate claims be reported?

  Duplicate claims should be reported. The reporting of duplicate claims accounts for all decisions made on claims. A duplicate claim may have a different result (payment or denial) than the original claim.

- How are claim payment adjustments reported?

  A claim payment adjustment would only be considered as a separate claim if it receives a different/new claim number. If the original claim number is used (reopened), it would be considered as part of the original claim and would be aged from receipt of the original claim.

- When a claim is received with insufficient data, would it count as a denial?

  Incomplete claims would not be included in the count of denied claims.

- Should the number of member months only include member months that occur during the reporting period, or should the number of months since inception of the policies that were issued or renewed during the reporting period be included?

  The request is for member months where policies were in force during the reporting period. The member months for an individual will never exceed 12 months.

  Example: A policy for one individual renewed in February of 2017, but was in force for the entire 12 months of 2017 would be counted as 12 member months.

  Note: The health MCAS definition of member months is taken directly from the financial annual statement supplemental health care exhibit instructions. The member months reported in the MCAS should be calculated in the same fashion as for the financial statement.

- If a request for prior authorization includes multiple services, some of the services may be approved while others are denied. In this situation, should the prior authorization be reported as approved or denied?*(Updated 03/23/2018)*

  If the company tracks prior authorizations at the service level, then the company should report prior authorizations based on the service level data. If the company does not track prior authorizations at the service level, then the company should report according to the level of data tracked by the company. A comment should be added to the submission to indicate how the data is reported.

- If a claimed service is included in a prepaid capitated service, should this be reported as a denied claim or a paid claim? *(Updated 03/23/2018)*

  If the Explanation of Benefits indicates that the service was paid or covered, then it should be reported as paid. If the Explanation of Benefits indicates that the service was denied, then it should be reported as denied.

- Should second level internal reviews be reported in the MCAS? *(Updated 03/23/2018)*

  Only first level internal reviews should be reported. However, one of the questions within the interrogatory section of the health MCAS asks if the company has an additional voluntary level of review for grievances. Second level reviews should be noted in response to this question.

- If a grievance includes multiple services, some of the services may be upheld while others are overturned. In this situation, should the grievance be reported as approved or denied? *(Updated 03/23/2018)*

  If the company tracks the grievances separately, then report separately. Otherwise partially overturned (found in favor of the member) are considered overturned. A comment should be added to the filing to indicate how this is reported.

- How should group policies be counted if multiple policy products are included within a single contract? *(Updated 7/11/2018)*

  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.

Homeowners and Private Passenger Auto MCAS

- *What if we reinstate a cancelled policy? Do we still need to report it as a cancellation?*
- *Should confirmed third-party claims be included in either automobile or homeowners claims?*
- *Within the "Homeowners Underwriting Activity" section, what does the data element, "Dwellings with policies in force at the end of the period" mean? How does this data element differ from "Policies in force at the end of period"?*
- *What if we have no private passenger auto/homeowner claims data to enter, but do need to report underwriting data? How can this be done?*
- *What if we send a cancellation notice to a policyholder, and the policyholder contacts us prior to the cancellation effective date and requests that the policy be cancelled? Do we report this as a company-initiated cancellation, or a cancellation at the insured's request?*
- *When calculating the number of days until company initiated cancellation for homeowners and private passenger auto business, the data call and definitions specify that the notice of cancellation is the date the cancellation notice was mailed to the insured. My company does not capture the mailing date within our system. What date do I use?*
- *The MCAS application returned a warning message regarding median days to final payment. I do not understand how to read the warning message. What does it mean?*

- What if we reinstate a cancelled policy? Do we still need to report it as a cancellation?

  If the cancellation is remedied and does not result in any lapse of coverage, do not count it as a cancellation. If the reinstatement resulted in any lapse of coverage, it should be counted as a cancellation.

- Should confirmed third-party claims be included in either automobile or homeowners claims?

  Yes, third-party claims should be included for either private passenger auto or homeowners claims.

- Within the "Homeowners Underwriting Activity" section, what does the data element, "Dwellings with policies in force at the end of the period" mean? How does this data element differ from "Policies in force at the end of period"?

  If your company covers only one dwelling on each policy written, the numbers reported for both fields would be the same. If your company writes policies that can insure multiple dwellings on the same policy, there would be a higher number of dwellings than policies. If your company writes renters policies that do not insure the dwelling, there would be a lower number of dwellings than policies.

- What if we have no private passenger auto/homeowner claims data to enter, but do need to report underwriting data? How can this be done?

  Within the interrogatory questions, companies can select the coverage(s) that are included in their in force policies, then all zeros can be entered for the coverage(s) if no claims are applicable. This allows for the entry of underwriting data while designating the coverage(s) that the company has included in its policies.

- What if we send a cancellation notice to a policyholder, and the policyholder contacts us prior to the cancellation effective date and requests that the policy be cancelled? Do we report this as a company-initiated cancellation, or a cancellation at the insured's request?

  If a cancellation notice is sent to the policyholder, and the insured notifies the company that they want to cancel the policy prior to the cancellation notice effective date, the cancellation should be reported as a company-initiated cancellation.

- When calculating the number of days until company initiated cancellation for homeowners and private passenger auto business, the definitions specify that the notice of cancellation is the date the cancellation notice was mailed to the insured. My company does not capture the mailing date within our system. What date do I use?

  If the mailing date is not captured in the company system, the cancellation processing date may be used in place of the mailing date as long as the processing date and mailing date are within a reasonable time apart that can be justified upon request.

- The MCAS application returned a warning message regarding median days to final payment. I do not understand how to read the warning message. What does it mean?

  The median days to final payment validation description will look something like this…**Col 1 Ln 26 should correspond to the date range of median claim reported.**

  Here is what it means…The system takes the number of claims that you reported as "closed with payment" and divides it by 2 (If the number of claims closed with payment is odd, then it rounds the division result up to the next whole number.) The result of the division is then compared to the number of claims that were reported as "closed with payment within 0-30 days". If the division result is less than or equal to the "closed with payment within 0-30 days", then the median days to final payment should be in the range of 0-30 days. If the result of the division is not less than or equal to the "closed with payment within 0-30 days" then the validation moves to the next bucket and compares the result of the division to the sum of the "closed with payment within 0-30 days" plus the "closed with payment within 31-60 days". If the division result is less than or equal to the sum of the "closed with payment within 0-30 days" plus "closed with payment within 31-60 days", then the median days to final payment should be in the range of 31 to 60 days…and so on.

Example

The company reports the following:

Number of claims closed with payment	25
Median days to final payment	82
Number of claims closed with payment within 0-30 days	7
Number of claims closed with payment within 31-60 days	5
Number of claims closed with payment within 61-90 days	10
Number of claims closed with payment within 91-180 days	2
Number of claims closed with payment within 181-365 days	1
Number of claims closed with payment beyond 365 days	0

1. Number of claims closed with payment divided by 2 is 25/2=12.5, which is then rounded up to 13.
2. Thirteen is compared to claims closed with payment within 0-30 days. 13 is not <=7
3. Comparison moves to the next bucket. 13 is compared to claims closed within 0-30 days plus claims closed within 31-60 days. 13 is not <= (7+5)
4. Comparison moves to the next bucket. 13 is compared to claims closed within 0-30 days plus claims closed within 31-60 days plus claims closed within 61-90 days. 13 is <=(7+5+10)
5. The median days to final payment should be in the 61-90 days range. 82 is within 61-90 days.
6. The validation passes.

Lender-Placed Home and Private Passenger Auto MCAS

- *Real Estate Owned (REO) is a term that describes property owned by a lender. If a company can distinguish between Real Estate Owned (REO) coverage and individual consumer coverage on a non-foreclosed-on property, should the REO coverage be reported?* *(Added 01/30/2018)*
- *Are the Lender-Placed underwriting data elements and suits data elements reported separately for each type of Lender-Placed business (Single-Interest Auto, Dual-Interest Auto, Single-Interest Home Hazard, etc.)?* *(Added 01/30/2018)*

- Real Estate Owned (REO) is a term that describes property owned by a lender. If a company can distinguish between Real Estate Owned (REO) coverage and individual consumer coverage on a non-foreclosed-on property, should the REO coverage be reported? *(Added 01/30/2018)*

  Real Estate Owned coverages are not to be included in MCAS reporting.

- Are the Lender-Placed underwriting data elements and suits data elements reported separately for each type of Lender-Placed business (Single-Interest Auto, Dual-Interest Auto, Single-Interest Home Hazard, etc.)? *(Added 01/30/2018)*

  Yes, each underwriting and suits data element is reported separately for each type of Lender-Placed business, as shown in the Lender-Placed insurance blank.

Life and Annuity MCAS

- *When reporting information that can be classified by issue state or by residence state, which should be used in relation to MCAS reporting?*
- *For annuity considerations, do we include business reported as "Other Considerations" or "Deposit-Type Contract Funds"?*
- *The life and annuity policy/contract surrender data elements request that surrenders be split according to the date of issuance. It is not clear where surrenders should be reported if the policy/contract is two, five or 10 years old. How should these be reported?*
- *When a joint life or joint annuity policy/contract is issued, what age and resident state do I report?*

- When reporting information that can be classified by issue state or by residence state, which should be used in relation to MCAS reporting?

  It depends. For some companies it is residence for some it is issue state. The difference rests on the company because it should be filed with the same methodology as the Financial Statement. "In determining what business to report for a particular state, all reporting companies should follow the same methodology/definitions used to file the Financial Annual statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations."

- For annuity considerations, do we include business reported as "Other Considerations" or "Deposit-Type Contract Funds"?

  No. MCAS is only collecting information on individual annuities that have an element of insurance risk.

- The life and annuity policy/contract surrender data elements request that surrenders be split according to the date of issuance. It is not clear where surrenders should be reported if the policy/contract is 2, 5 or 10 years old. How should these be reported?

The life and annuity policy/contract surrender data element date of issuance splits should be interpreted as follows:

Data element wording	Clarification
Under 2 years	< 2 years
Between 2 years and 5 years	>=2 years and < 6 years
Between 6 years and 10 years	>=6 years and < 11 years

- When a joint life or joint annuity policy/contract is issued, what age and resident state do I report?

  When a joint life policy or joint annuity contract is issued, the eldest policy holder/annuitant should be used to determine the reporting state and age bucket to report the issued policy/contract in.

Long-Term Care MCAS

- *What is the difference between "pending" benefit payment requests versus "pending" claimant request determinations for Long-Term Care?*
- *Is Schedule 6 on Long-Term Care referring to the amount of time between a benefit request and when the company makes the payment? Or is it the amount of time between subsequent payments after the initial payment?*
- *Are the number of benefit payment requests received during the reporting period referring to every transaction/payment made on any one policy with Long-Term Care?*
- *I'm receiving a warning on the Long-Term Care filing that I don't understand. It says, "WARNING: Sum of (Col 2 Ln 43 through Ln 46) => Sum of (Col 2 Ln 36 through Ln 42) x2 (LZAU050251)".*
- *I am uploading data for Stand-Alone Long-Term Care only from a CSV I created in Excel. I get an error saying that there are values missing in a record. What is this error and how do I fix it?*

- What is the difference between "pending" benefit payment requests versus "pending" claimant request determinations for Long-Term Care?

  The section on claimant request determinations is to be done on a "per claimant" basis which means that we are counting each individual who makes one or more requests for coverage under a policy or contract. It is NOT the actual benefit payment request. A benefit payment request is a request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment.

- Is Schedule 6 on the Long-Term Care referring to the amount of time between a benefit payment request and when the company makes the payment? Or is it the amount of time between subsequent payments after the initial payment?

  The data elements in Schedule 6 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes payment for an approved claimant (after satisfaction of the waiting or elimination period, if any).

- Are the number of benefit payment requests received during the reporting period referring to every transaction/payment made on any one policy with Long-Term Care?

  Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment. Benefit payment requests should be reported on a line-by-line basis.

- I'm receiving a warning on the Long-Term Care filing that I don't understand. It says, "WARNING: Sum of (Col 2 Ln 43 through Ln 46) should be => Sum of (Col 2 Ln 36 through Ln 42) x2 (LZAU050251)".

  The warning you are receiving should be read as "should be equal to or greater than". So, in this case, the Sum of (Col 2 Ln 43 through Ln 46) should be equal to or greater than twice the Sum of (Col 2 Ln 36 through Ln 42). Here is how the warning text appears in the MCAS User Guide: Number of LHLTC claimant request determinations made during the period => Two times the number of claimant requests denied, not paid, or closed without payment during the period.

  Basically, it is expected that you would be making twice the determinations as you are denying. We would absolutely expect that a company would be making at least as many determinations as they are denying (because each denial is a determination). Since the determinations that aren't denials are

either pending or approved, we would expect there to be as many of these as there are denials or more.

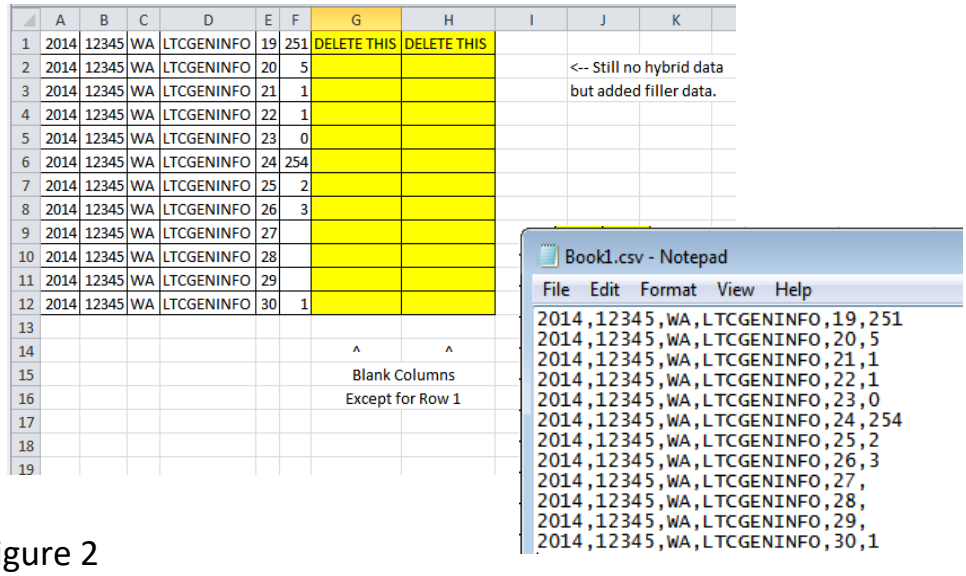
You can also read this warning as “the number of claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations”.

- I am uploading data for Stand-Alone Long-Term Care only from a CSV I created in Excel. I get an error saying that there are values missing in a record. What is this error and how do I fix it?

  This error most likely occurs because there are not places held for the data for the Hybrid LTC columns in the CSV file. You still need to have 8 columns of data (for all other schedules). If you have blank columns in Excel for the last two columns, saving as a CSV does not work because Excel does not know to create an “empty field” for those two. An example of how this would look follows in Figure 1. You can see that the blank columns don’t show in the CSV file because they are empty. You can add a title at the top next to your data so that it creates “empty fields” in the CSV file. Once you have saved the file as a CSV, open it in notepad and delete the text you added, leaving the commas. See Figure 2 for an example of how this looks. This will format the data so that all columns are included and it should upload properly. You also have the option of using the CSV Assistant.

Figure 1

No data is included in columns G and H. When it is saved as a CSV, only 6 columns of data appear.



	A	B	C	D	E	F	G	H	I	J	K
1	2014	12345	WA	LTCGENINFO	19	251	DELETE THIS	DELETE THIS			
2	2014	12345	WA	LTCGENINFO	20	5				<-- Still no hybrid data	
3	2014	12345	WA	LTCGENINFO	21	1				but added filler data.	
4	2014	12345	WA	LTCGENINFO	22	1					
5	2014	12345	WA	LTCGENINFO	23	0					
6	2014	12345	WA	LTCGENINFO	24	254					
7	2014	12345	WA	LTCGENINFO	25	2					
8	2014	12345	WA	LTCGENINFO	26	3					
9	2014	12345	WA	LTCGENINFO	27						
10	2014	12345	WA	LTCGENINFO	28						
11	2014	12345	WA	LTCGENINFO	29						
12	2014	12345	WA	LTCGENINFO	30	1					
13											
14							^	^			
15							Blank Columns				
16							Except for Row 1				
17											
18											
19											

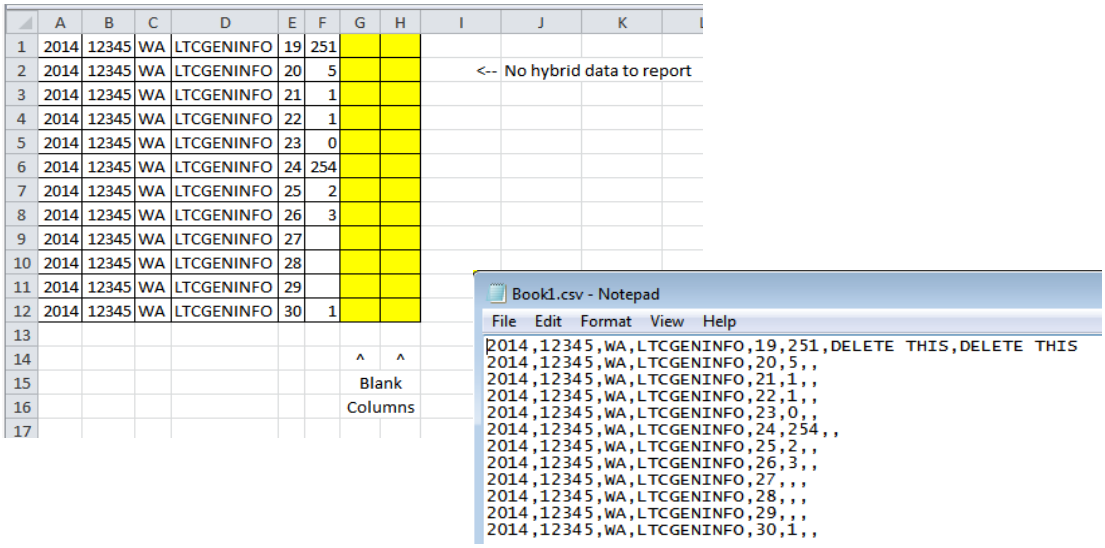
Book1.csv - Notepad

File Edit Format View Help

```
2014,12345,WA,LTCGENINFO,19,251
2014,12345,WA,LTCGENINFO,20,5
2014,12345,WA,LTCGENINFO,21,1
2014,12345,WA,LTCGENINFO,22,1
2014,12345,WA,LTCGENINFO,23,0
2014,12345,WA,LTCGENINFO,24,254
2014,12345,WA,LTCGENINFO,25,2
2014,12345,WA,LTCGENINFO,26,3
2014,12345,WA,LTCGENINFO,27,
2014,12345,WA,LTCGENINFO,28,
2014,12345,WA,LTCGENINFO,29,
2014,12345,WA,LTCGENINFO,30,1
```

Figure 2

The filler data included in columns G and H forces Excel to create a column for these fields. When it is saved as a CSV, all 8 columns of data appear. You can then just delete the words “DELETE THIS” from the CSV file when it is opened in Notepad.



	A	B	C	D	E	F	G	H	I	J	K
1	2014	12345	WA	LTCGENINFO	19	251					
2	2014	12345	WA	LTCGENINFO	20	5				<-- No hybrid data to report	
3	2014	12345	WA	LTCGENINFO	21	1					
4	2014	12345	WA	LTCGENINFO	22	1					
5	2014	12345	WA	LTCGENINFO	23	0					
6	2014	12345	WA	LTCGENINFO	24	254					
7	2014	12345	WA	LTCGENINFO	25	2					
8	2014	12345	WA	LTCGENINFO	26	3					
9	2014	12345	WA	LTCGENINFO	27						
10	2014	12345	WA	LTCGENINFO	28						
11	2014	12345	WA	LTCGENINFO	29						
12	2014	12345	WA	LTCGENINFO	30	1					
13											
14							^	^			
15							Blank				
16							Columns				
17											

Book1.csv - Notepad

File Edit Format View Help

```
2014,12345,WA,LTCGENINFO,19,251,DELETE THIS,DELETE THIS
2014,12345,WA,LTCGENINFO,20,5,,
2014,12345,WA,LTCGENINFO,21,1,,
2014,12345,WA,LTCGENINFO,22,1,,
2014,12345,WA,LTCGENINFO,23,0,,
2014,12345,WA,LTCGENINFO,24,254,,
2014,12345,WA,LTCGENINFO,25,2,,
2014,12345,WA,LTCGENINFO,26,3,,
2014,12345,WA,LTCGENINFO,27,,,
2014,12345,WA,LTCGENINFO,28,,,
2014,12345,WA,LTCGENINFO,29,,,
2014,12345,WA,LTCGENINFO,30,1,,
```

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