

Market Conduct Annual Statement 2020 Data Year Filings

Health

Data Elements & Validations



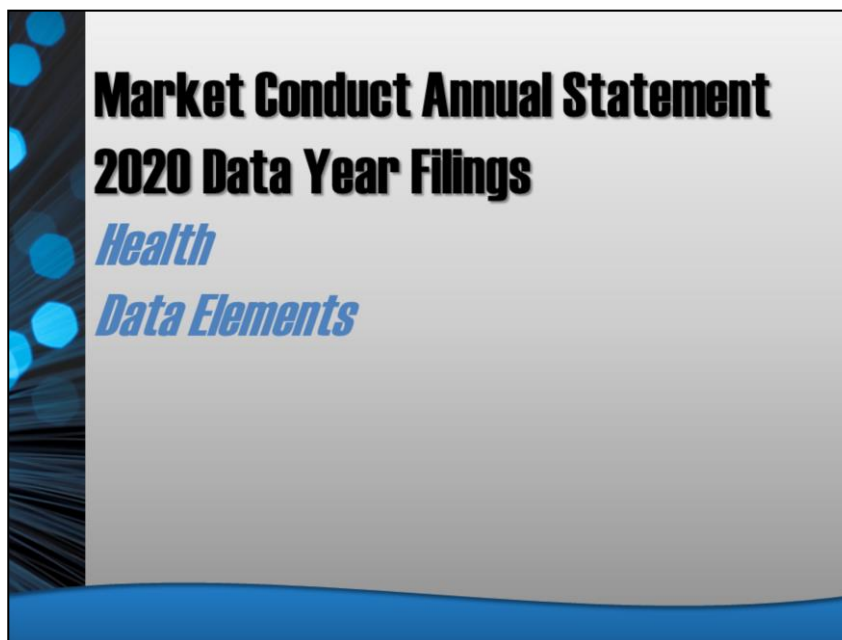
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Hi...I'm Leana Massey .

In this section of the Market Conduct Annual Statement training we will be reviewing the data elements that must be provided for the Health MCAS.

Health MCAS Resources

Visit the MCAS Web page at:
http://www.naic.org/mcas_main.htm

- Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- MCAS User Guide
- CSV Data Upload Instructions

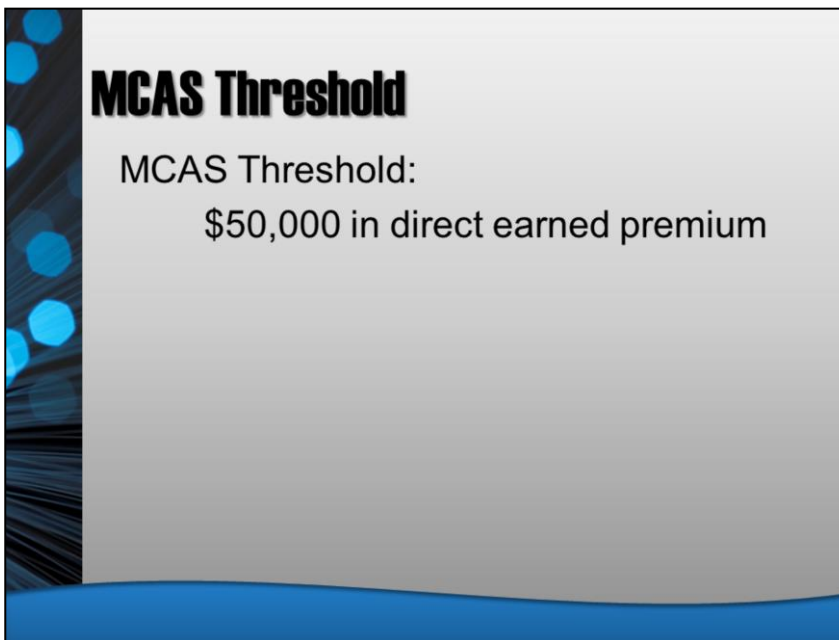
Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

The available resources include:

- A Listing of Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- Copy of the Call Letter
- MCAS User Guide
- And CSV Data Upload Instructions



The health MCAS data reporting period is January 1st through December 31st of the reporting year, and the health MCAS filing deadline is June 30th. This filing deadline extension was previously granted for data years through 2021. The Health MCAS due date for the 2022 data year will roll back to April 30th unless another extension is granted.



Companies reporting at least \$50,000 of earned premium for MCAS applicable health insurance, in a MCAS participating jurisdiction, are required to submit health MCAS data to those participating jurisdictions where they meet the premium threshold. There are currently 49 participating MCAS jurisdictions.

What business is included in the health MCAS?



➤ Medical care benefits

- Hospital or medical service policy or certificate.
- Hospital or medical service plan contract.
- Health maintenance organization contract

Health insurance business reported in the MCAS includes:

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.

What business is NOT included in the health MCAS?



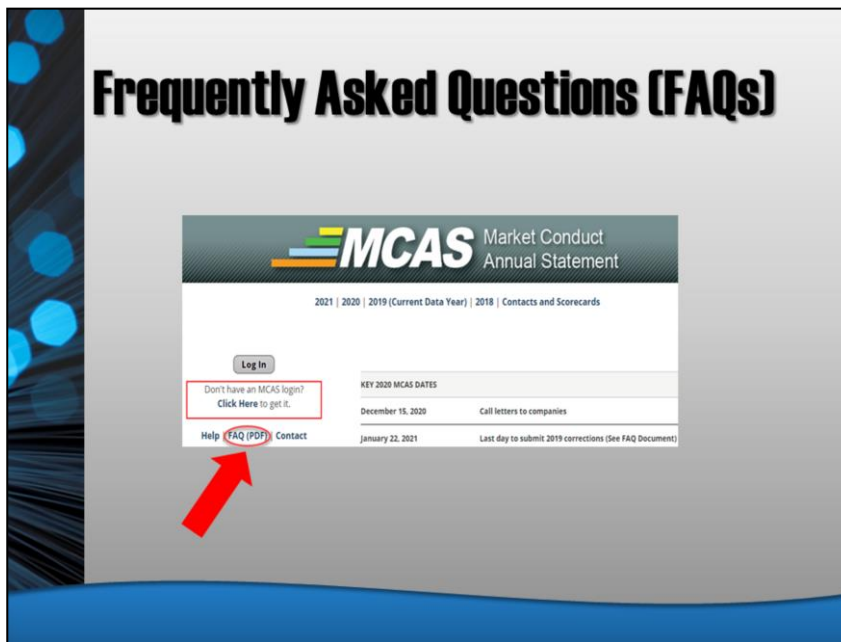
- Excepted benefits as defined in 42 U.S.C. § 300gg-91(c) (listing provided in the MCAS FAQs).
- Closed blocks not subject to Medical Loss Ratio reporting under CMS guidance.
- Self-funded plans.
- Government plans.

The reported data should NOT include:

- excepted benefits as defined in 42 U.S.C. § 300gg-91(c).
- closed blocks not subject to Medical Loss Ratio (MLR) reporting under Centers for Medicare & Medicaid Services (CMS) guidance
- self-funded plans
- Or Government plans such as Medicare, Medicare Advantage, Medicaid, Federal Employee Plans and TriCare.

A listing of the excepted benefits can be found in the MCAS Frequently Asked Questions

Frequently Asked Questions (FAQs)



The MCAS Frequently Asked Questions or FAQs document can be found on the MCAS webpage. We will refer to questions found in the FAQ document throughout this tutorial.

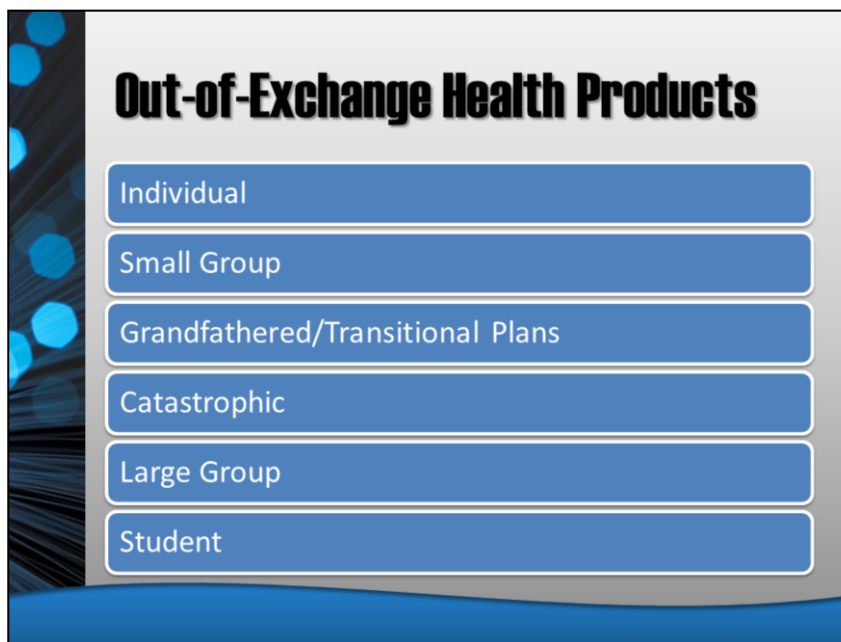


Data is to be reported separately for plans offered through an Affordable Care Act Exchange program and those offered outside the Exchange program.



The data reported for In-Exchange health products is broken out according to types of products. There is reporting for:

- Individual
- Small Group
- Catastrophic
- Multi-State – Individual
- And Multi-State – Small Group



The data reported for Out-of-Exchange health products is broken out for:

- Individual
- Small Group
- Grandfathered/Transitional Plans
- Catastrophic
- Large Group
- And Student plans

Definitions of the in-exchange and out-of-exchange products can be found in the data call and definitions document.

Metal Level Reporting – In-Exchange

Bronze, Silver, Gold and Platinum level reporting is required for the following in-exchange product types:

Individual

Small Group

Multi-State (Individual)

Multi-State (Small Group)

In addition to the product type breakouts, data is to be reported according to the product metal level for some of the in-exchange and out-of-exchange products.

In-Exchange metal level data is to be reported for:

- Individual
- Small Group
- Multi-State – Individual
- And Multi-State – Small Group product types

Metal Level Reporting – Out-of-Exchange

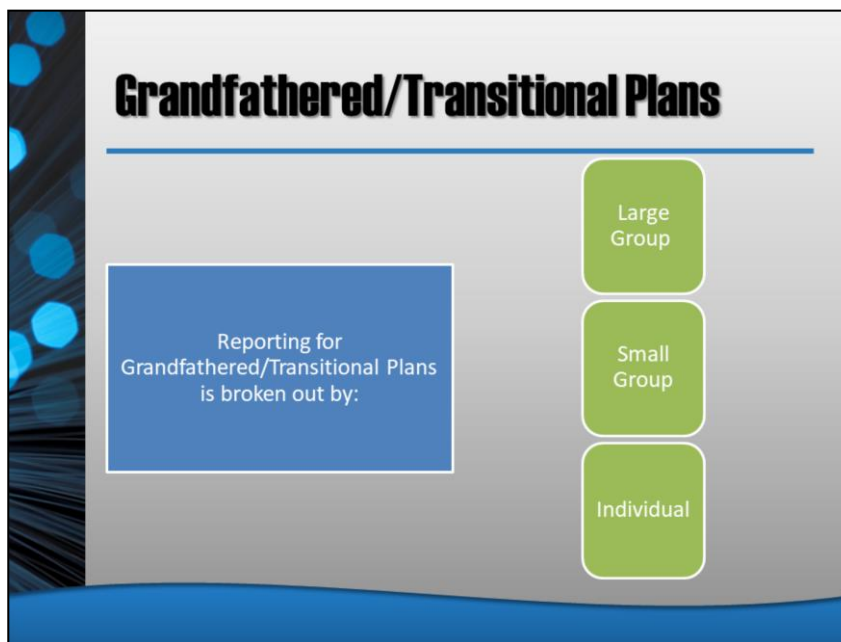
Bronze, Silver, Gold and Platinum level reporting is required for the following out-of-exchange product types:

Individual

Small Group

Out-of-Exchange metal level data is to be reported for:

- Individual
- And Small Group product types



Out-of-Exchange Grandfathered and Transitional plans are to be reported with breakouts for:

- Large Group
- Small Group
- And Individual products



Reporting Totals for Product Types

In addition to metal level or break out reporting, it is required to report totals for those products with breakout reporting.

For those products that have reporting breakouts, total values must also be reported. The total values must equal the sum of the values reported with breakout reporting.



Exceptions

Metal Level, breakout and total reporting are not required for all data elements.

You will find greyed out cells on the health MCAS blank that indicate specific data that is not to be reported.

However, there are exceptions to the breakout reporting. It was determined that some data elements would not be reported for specified product types. There are also some data elements for which only total amounts are required.

Exceptions

You will find “greyed out” cells on the health MCAS blank that indicate specific data that is not to be reported.

IN-EXCHANGE																	
	Individual health insurance coverage other than transitional, grandfathered, multi-state, catastrophic or student				Small Group health insurance coverage other than transitional, grandfathered, or multi-state policies				Catastrophic	Multi-State (Individual)				Multi-State (Small Group)			
	Bronze	Silver	Gold	Platinum	Total	Bronze	Silver	Gold		Platinum	Total	Bronze	Silver	Gold	Platinum	Total	
Policy Administration																	
19	Earned premiums for Reporting Year:																
20	Number of new policies issued during the period:																
21	Number of policies renewed during the period:																
22	Member months for policies issued during the period:																
23	Member months for policies renewed during the period:																
24	Number of policy terminations and cancellations initiated by consumer:																
25	Number of policy terminations and cancellations due to non-payment of premium:																
26	Number of lives impacted on terminations and cancellations initiated by the policyholder:																

As shown on the slide, data elements that are not to be reported for specific product types and/or breakouts are denoted by the “greyed out” cells on the health MCAS reporting blank.

When entering data into the MCAS submission application you will see the data elements that are not to be reported, however they are not fillable. You will be unable to enter data for these elements.

Health Entry Sections:

- Interrogatories
- Policy Administration
- Prior Authorizations (Excluding Pharmacy)
- Prior Authorizations (Pharmacy Only)
- Claims Administration (Excluding Pharmacy)
- Claims Administration (Pharmacy Only)
- Consumer Requested Internal Reviews (Including Pharmacy)
- Consumer Requested External Reviews (Including Pharmacy)

Both In-Exchange and Out-of-Exchange data elements are divided into eight sections:

- Interrogatories
- Policy Administration
- Prior Authorizations (Excluding Pharmacy)
- Prior Authorizations (Pharmacy Only)
- Claims Administration (Excluding Pharmacy)
- Claims Administration (Pharmacy Only)
- Consumer Requested Internal Reviews (Including Pharmacy)
- Consumer Requested External Reviews (Including Pharmacy)

Interrogatories

	Response (Yes/No)	Comments
01 In-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		--
02 In-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		--
03 In-Exchange - Does the company have Catastrophic data to report? (Y/N)		--
04 In-Exchange - Does the company have Multi-State (Individual) data to report? (Y/N)		--
05 In-Exchange - Does the company have Multi-State (Small Group) data to report? (Y/N)		--
06 In-Exchange - Number of small groups in-force at the end of the reporting period.	--	--
07 In-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		--
08 In-Exchange Comments:	--	Comment (if necessary)
09 Out-of-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		--
10 Out-of-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		--
11 Out-of-Exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)		--
12 Out-of-Exchange - Does the company have Catastrophic data to report? (Y/N)		--
13 Out-of-Exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)		--
14 Out-of-Exchange - Does the company have Student Coverage data to report? (Y/N)		--
15 Out-of-Exchange - Number of small groups in-force at the end of the reporting period.	--	--
16 Out-of-Exchange - Number of large groups in-force at the end of the reporting period.	--	--
17 Out-of-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		--
18 Out-of-Exchange Comments:	--	Comment (if necessary)

December 31, 2020

The first section of questions that you will see in the data entry screen is the interrogatories. The interrogatories provide one location for all comments and questions that require a text response.

There are questions that ask the company to indicate if they have data to report for each of the in-exchange and out-of-exchange products. Only a yes/no response is required for each of these questions.

Companies are asked to provide the number of groups in-force at the end of the reporting period. These counts are to reflect the number of group contracts in place as of December 31st.

Interrogatories

	Response (Yes/No)	Comments
01 In-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		--
02 In-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		--
03 In-Exchange - Does the company have Catastrophic data to report? (Y/N)		--
04 In-Exchange - Does the company have Multi-State (Individual) data to report? (Y/N)		--
05 In-Exchange - Does the company have Multi-State (Small Group) data to report? (Y/N)		--
06 In-Exchange - Number of small groups in-force at the end of the reporting period.	--	--
07 In-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)	--	--
08 In-Exchange Comments:	--	Comment (if necessary)
09 Out-of-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		--
10 Out-of-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		--
11 Out-of-Exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)		--
12 Out-of-Exchange - Does the company have Catastrophic data to report? (Y/N)		--
13 Out-of-Exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)		--
14 Out-of-Exchange - Does the company have Student Coverage data to report? (Y/N)		--
15 Out-of-Exchange - Number of small groups in-force at the end of the reporting period.	--	--
16 Out-of-Exchange - Number of large groups in-force at the end of the reporting period.	--	--
17 Out-of-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)	--	--
18 Out-of-Exchange Comments:	--	Comment (if necessary)

For both in and out-of-exchange, the interrogatories ask if the company has an additional voluntary level of review for grievances. This would be a level of review beyond the normal internal appeals process.

Lastly, the interrogatories ask for any comments that the submitter would like to add. Any areas of your data that may cause questions, or that generated a warning message when validating your data, should be explained fully in these comment areas. At the end of this tutorial, we will discuss the MCAS validations in more detail along with the importance of using the comments sections.

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FAQ: Data Reporting

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 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.

The first FAQ that we'll review deals with data the company is unable to report...If your company is unable to report data for a specific data element within the health MCAS, a note should be added to the Interrogatories section of the filing to explain the reason for the company's inability to report.

It is expected that any company unable to report some of the requested data will work to enable the reporting in future years.

Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of insured lives impacted by rescissions.

The policy administration data elements reflect data for:

- Premium
- Policy counts
- Member months
- Terminations
- And rescissions

Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of insured lives impacted by rescissions.

The reported earned premium should correspond to only that business that is applicable to MCAS reporting.

If some of your company's business is not applicable for MCAS reporting, then you will not be able to directly tie the MCAS premiums to the earned premiums reported by state in the Financial Annual Statement Supplemental Health Care Exhibit

Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of insured lives impacted by rescissions.

January 1, 2020 – December 31, 2020

The data elements related to new policies issued, policies renewed, and member months for those policies issued and renewed, are limited to those policies that are issued and renewed during the reporting period.

So, only policies issued or renewed from January 1st through December 31st will be included.

The Data Call and Definitions specify that in determining if a policy was issued or renewed, if the policyholder number remains unchanged, the policy or contract should be considered as renewed.



FAQ: Policy Administration

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.

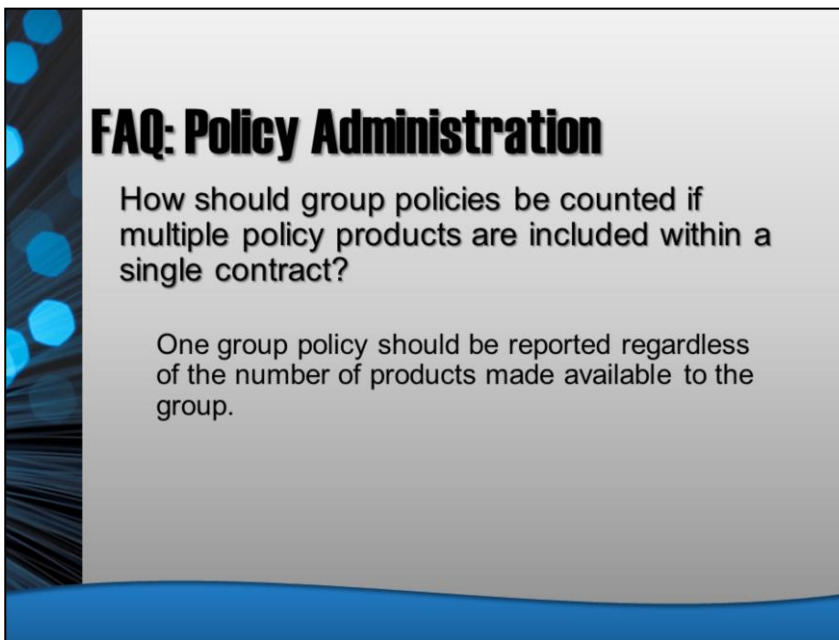
Who is the policy holder in a group policy or individual policy?

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.

For the health MCAS, a policy should be considered as the individual or group contract that outlines the coverages and fees charged.

The policy holder for a group policy is the group

And, the policy holder for an individual is the individual.

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FAQ: Policy Administration

How should group policies be counted if multiple policy products are included within a single contract?

One group policy should be reported regardless of the number of products made available to the group.

When reporting the number of group policies, one group policy should be reported regardless of the number of products made available to the group within a single contract.



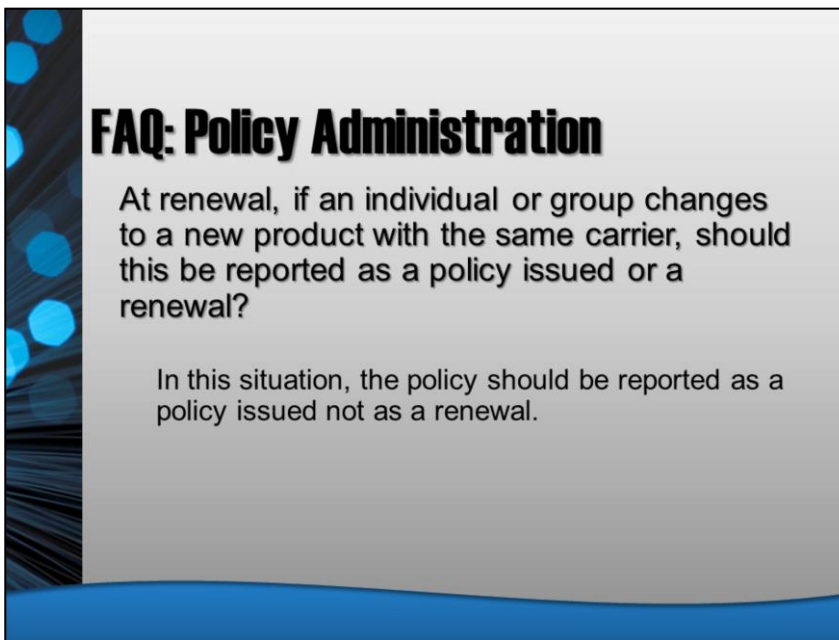
FAQ: Policy Administration

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

- 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.

When individuals change products during the data year, the following should be considered:

- 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.


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FAQ: Policy Administration

At renewal, if an individual or group changes to a new product with the same carrier, should this be reported as a policy issued or a renewal?

In this situation, the policy should be reported as a policy issued not as a renewal.

At renewal, if an individual or group changes to a new product with the same carrier, the policy should be reported as a policy issued not as a renewal.



Member Months

Member months for policies issued – The sum of total number of lives insured on policies (contracts) issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Member months for policies renewed – The sum of total number of lives insured on policies (contracts) renewed on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

The concept of “Member Months” can be a bit confusing. In the simplest of terms, a policy that is issued to a member on January 1st and remains in-force through December 31st of the same year would equal 12 member months. The member’s policy was in-force for 12 months of the year.

Keep in mind that only those member months that occur during the data year should be included. So, a policy for an individual renewed on October 15th of the current data reporting year, and in force for the entire 12 months of that same data reporting year, would be counted as 12 member months. Member months that the policy was in force outside of the data year being reported would not be included

The language used in the member months definitions was taken from the Financial Annual Statement Supplemental Health Care Exhibit Instructions. The definition of Member Months for Policies Issued reads...”The sum of total number of lives insured on policies (contracts) issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.”

Policies are not always issued or terminated on the first day of a given month. So, the purpose of using a pre-specified day is to allow for consistent consideration of months where policies were in force.

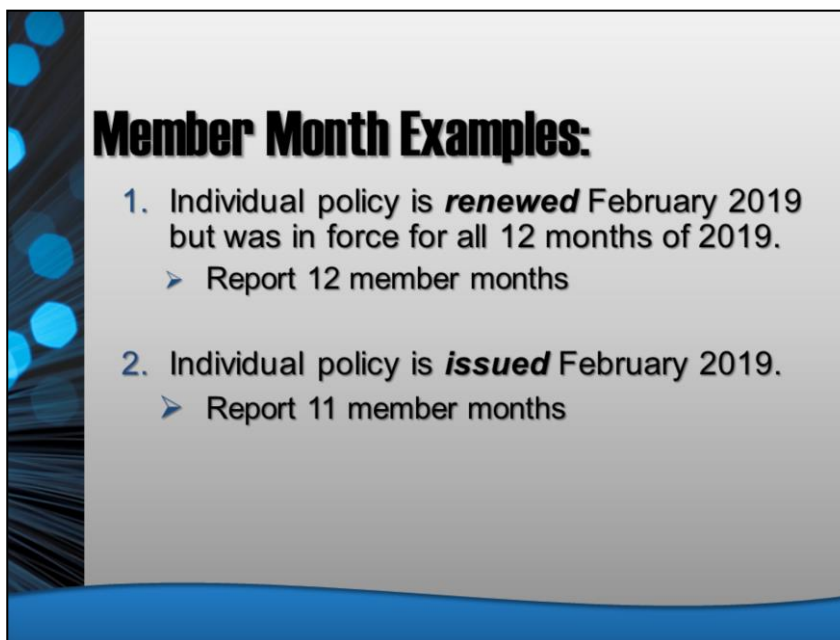


FAQ: Member Months

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.

Remember...member months should only include member months where policies were in force during the reporting period. This means that the member months for an individual will never exceed 12 months.

A graphic with a grey background and a blue wavy border at the bottom. On the left side, there is a vertical strip with a dark blue background and several glowing blue circles of varying sizes. The text is centered on the grey background.

Member Month Examples:

1. Individual policy is **renewed** February 2019 but was in force for all 12 months of 2019.
 - Report 12 member months
2. Individual policy is **issued** February 2019.
 - Report 11 member months

Let's review a member months reporting example...

If a policy is **renewed** in February, during the reporting period, and the policy was in force for all 12 months during the reporting period, you will report 12 member months.

If a policy is **issued** in February, during the reporting period, you will report 11 member months.

Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of insured lives impacted by rescissions.

The next section of questions deal with the number of policy terminations and cancellations and the number of lives impacted by terminations and cancellations.

Terminations and Cancellations



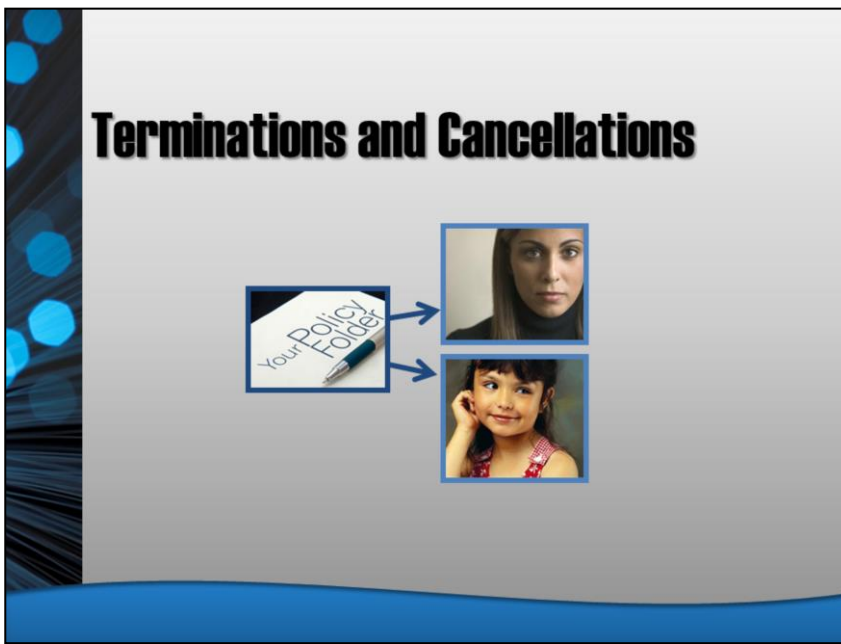
Insured's Request



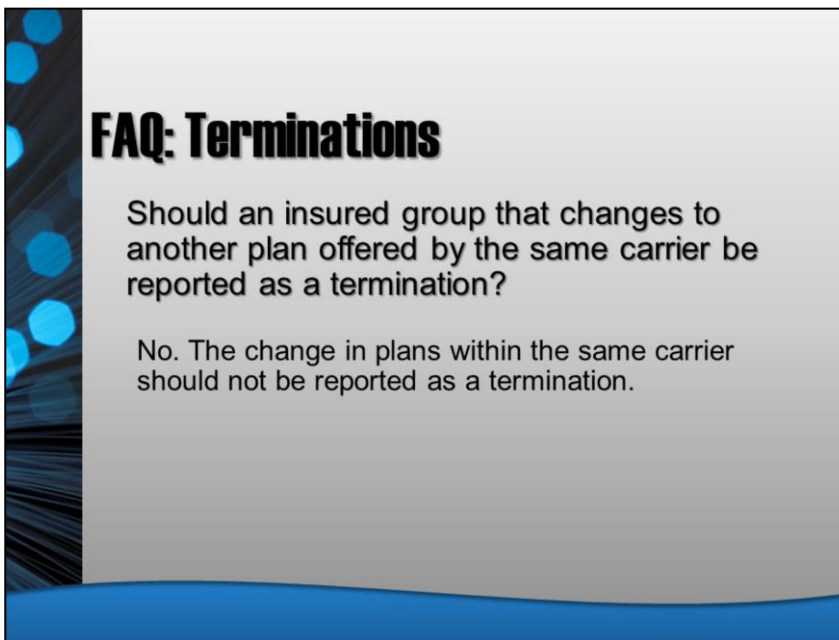
Non-Payment of
Premium

Terminations and Cancellations are to be reported separately if the termination was at the insured's request vs. if the termination was due to non-payment of premium

Terminations and Cancellations



The number of lives impacted by Terminations and Cancellations will not always be equal to the number of policies or contracts terminated. A single policy or contract may cover more than one person.

A slide titled "FAQ: Terminations" with a decorative blue and black background on the left side. The text on the slide asks a question and provides an answer.

FAQ: Terminations

Should an insured group that changes to another plan offered by the same carrier be reported as a termination?

No. The change in plans within the same carrier should not be reported as a termination.

An FAQ was added to clarify that if an insured group changes to another plan offered by the same carrier, this change should NOT be reported as a termination.

Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of insured lives impacted by rescissions.

The final policy administration data elements deal with the reporting of rescissions.

To rescind a policy means to retroactively cancel the entire policy. This is sometimes done if a mistake is found on the application for insurance. According to HealthCare.gov, rescissions are illegal under the Affordable Care Act, except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverages.

Prior Authorizations Excluding Pharmacy

Prospective Utilization Review Requests

Number of prior authorizations requested.
Number of prior authorizations approved.
Number of prior authorizations denied.
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.
Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved.

Now we'll move to the Prior Authorizations Excluding Pharmacy section of reporting.



Prior Authorizations Excluding Pharmacy

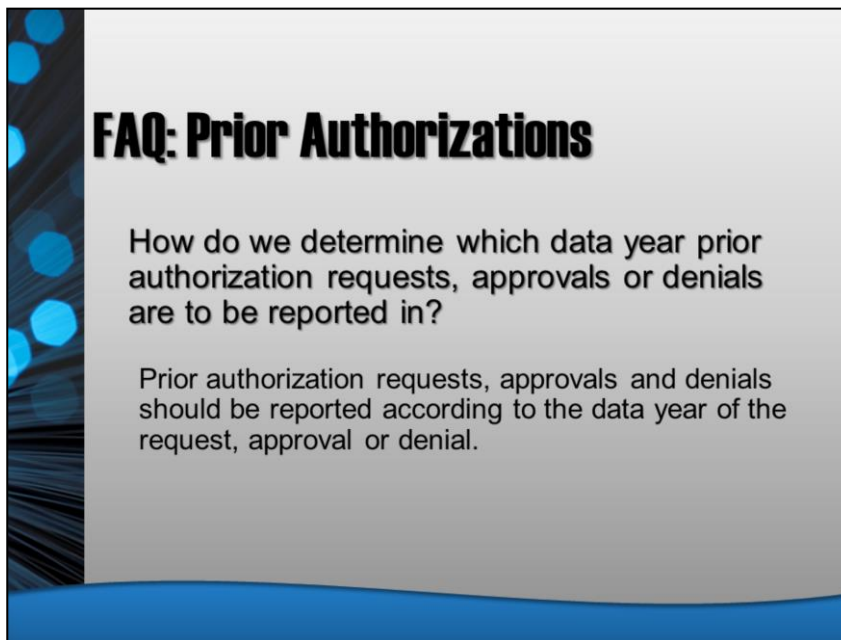
Prior Authorization – A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification.

A Prior Authorization is ...” A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification.”



You are to report the number of Prior Authorizations:

- Requested
- Approved
- And Denied.



FAQ: Prior Authorizations

How do we determine which data year prior authorization requests, approvals or denials are to be reported in?

Prior authorization requests, approvals and denials should be reported according to the data year of the request, approval or denial.

Prior Authorization requests, approvals and denials should be reported according to the data year of the request, approval or denial.

So, if a prior authorization was requested during the reporting period, report it as a request.

If a prior authorization was approved during the reporting period, report it as an approval.

If a prior authorization was denied during the reporting period, report it as a denial.



FAQ: Prior Authorization – Multiple Services

If a request for prior authorization includes multiple services, some of the services may be approved while others are denied. Should the prior authorization be reported as approved or denied?

- Partially approved prior authorizations should be reported as approved.

The FAQs include a question regarding prior authorizations that include multiple services and how to report the prior authorization if some services are approved and others are denied.

You are to report all partially approved prior authorizations as approved.

Prior Authorizations Excluding Pharmacy

Prior Authorizations reported in questions 30, 31 and 32 for in-exchange and questions 109, 110 and 111 for out-of-exchange you are asked to indicate how many Prior Authorizations for mental health benefits, behavioral health benefits, and substance use disorders were:

Requested

Approved

Denied

Of the Prior Authorizations reported in questions 30, 31 and 32 for in-exchange, and questions 109, 110 and 111 for out-of-exchange, you are asked to indicate how many Prior Authorizations for mental health benefits, behavioral health benefits, and substance use disorders were:

- Requested
- Approved, and
- Denied



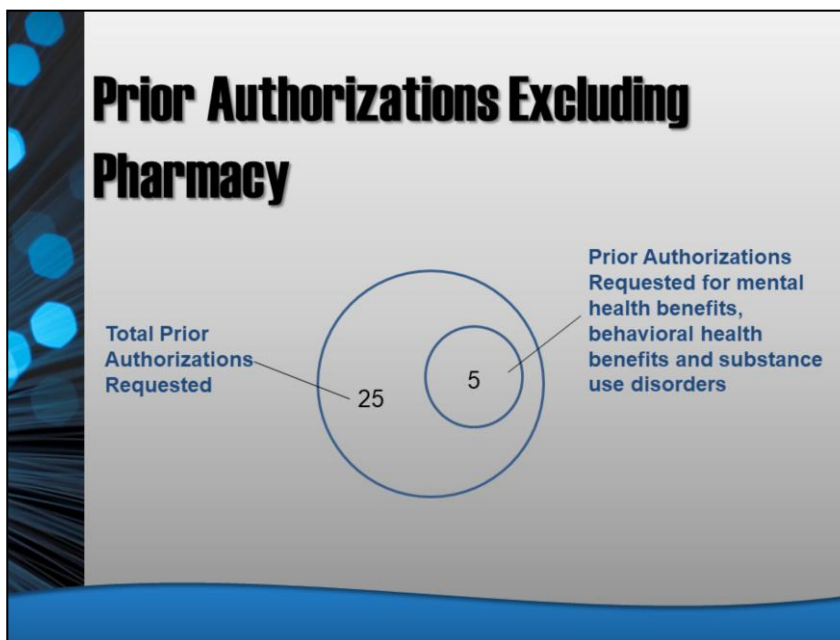
FAQ: Prior Authorizations

Should prior authorizations requested, approved and denied for mental health benefits, behavioral health benefits, and substance use disorders be included in the total number of prior authorizations requested, approved and denied?

Yes, Prior authorizations requested, approved and denied for mental health benefits, behavioral health benefits, and substance use disorders should be a subset of total prior authorizations requested, approved and denied.

The next FAQ we're going to discuss was added to clarify reporting in the prior authorization data elements related to mental health benefits, behavioral health benefits, and substance use disorders.

Prior authorizations requested, approved and denied for mental health benefits, behavioral health benefits, and substance use disorders should be a subset of total prior authorizations requested, approved and denied.



This means if there were 25 prior authorization requests during the year and 5 were for mental health benefits, behavioral health benefits and substance use disorders., you would report 25 total prior authorization requests and 5 prior authorization requests for mental health benefits, behavioral health benefits and substance use disorders. The 5 requests would be included within the 25 total requests.



Prior Authorizations Excluding Pharmacy

Mental Health Benefits – Benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Behavioral Health Benefits – Benefits to assist those with mental health or substance abuse issues.

According to the Data Call and Definitions, Mental Health Benefits are those benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines),

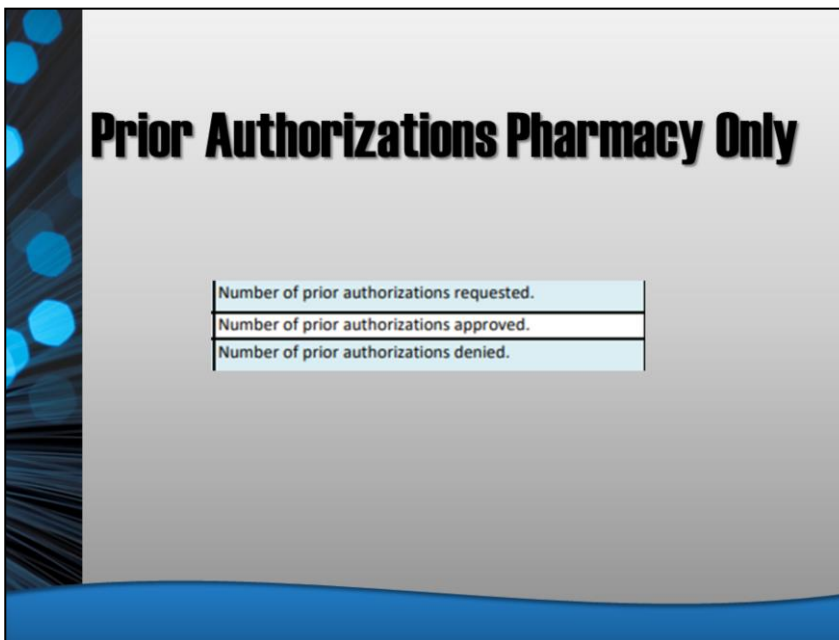
And Behavioral Health Benefits assist those with mental health or substance abuse issues.



Prior Authorizations Excluding Pharmacy

Substance Use Disorders Benefits – Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Substance Use Disorders Benefits are defined as Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).



The next reporting sections is Prior Authorizations for Pharmacy. You are asked to report pharmacy prior authorizations that were requested, approved and denied during the data year.

Claims Administration Excluding Pharmacy

Questions focus on:

- Claims received
- Claims denied
- Claims paid
- Insured responsibility

January 1, 2020 – December 31, 2020

Now we'll review the Claims Administration (Excluding Pharmacy) section. Data elements within this section focus on claims received, claims denied, claims paid and insured responsibility.

Remember that all data should reflect claims received, submitted, denied and paid, during the reporting year.

Also, each individual line of service within a claim should be counted as a separate claim.

There are several frequently asked questions related to claims reporting. We will review each of the relevant FAQs.

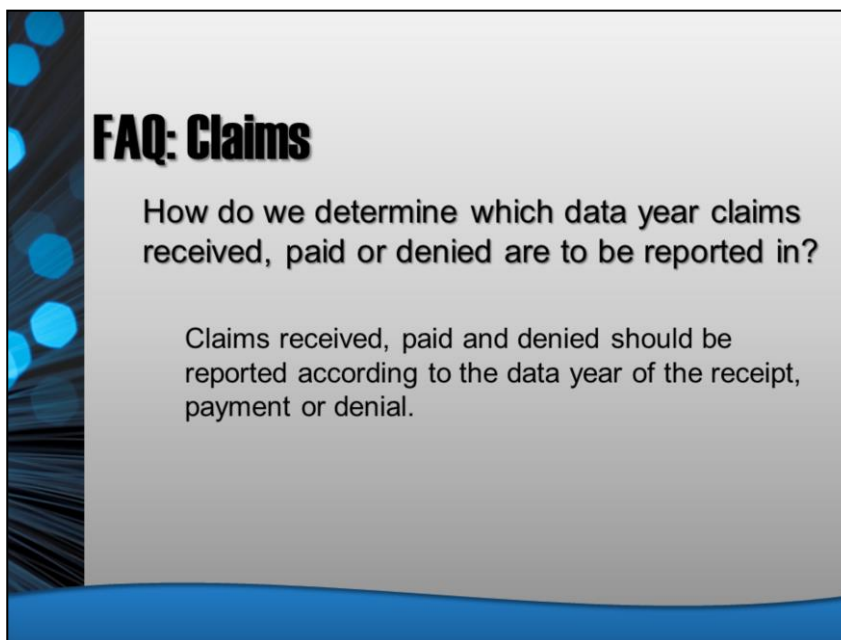


FAQ: Claims

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.

When reporting claims received it is recommended that you use the date the claim was “received” as the anchor date. Likewise, when reporting claims denied, it is recommended that you use the claim determination date as the anchor.

A slide titled "FAQ: Claims" with a decorative left border of blue circles and a blue wavy bottom. The text on the slide reads: "How do we determine which data year claims received, paid or denied are to be reported in?" and "Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial."

FAQ: Claims

How do we determine which data year claims received, paid or denied are to be reported in?

Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.

Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.

If a claim is received during the data year, it should be reported as received.

If a claim is paid during the data year, it should be reported as paid.

If a claim is denied during the data year, it should be reported as denied.

It is understood that a claim may have been opened in the prior data year and paid or denied during the current data year. In this case, the claim would only be reported as paid or denied during the current data year.

Claims Administration

Claim Received December 20, 2020

Claim paid January 5, 2021

Report as a claim received during the 2020 data year	Report as a paid claim in the 2021 data year
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For example, if the claim is received December 20, 2020, and the claim is paid on January 5, 2021, the claim would be reported as received in the 2020 data year and paid in the 2021 data year.

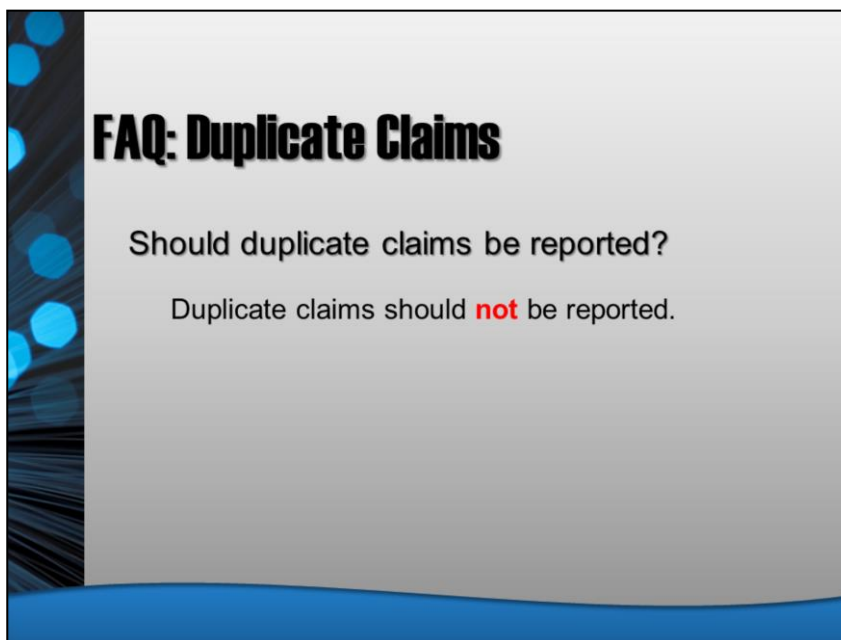
FAQ: Bundled Claims

How are line items on bundled claims reported?

Claims should be reported at the service line level.

The slide features a decorative left border with blue circles and a blue wavy footer.

The next FAQ clarifies that bundled claims should be reported at the service line level.

A graphic with a grey background and a blue wavy bottom. On the left, there is a vertical strip with a dark blue background and several bright blue circles of varying sizes. The text is centered on the grey background.

FAQ: Duplicate Claims

Should duplicate claims be reported?

Duplicate claims should **not** be reported.

Duplicate claims have resulted in several questions. This FAQ clarifies that duplicate claims should NOT be reported within the health MCAS.



FAQ: Dental and Vision Claims

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.

If Dental and Vision coverages are included within the medical policy, you should report the dental and vision claims. Dental and vision policies that are issued separate from the medical policy are not included within the health MCAS reporting.

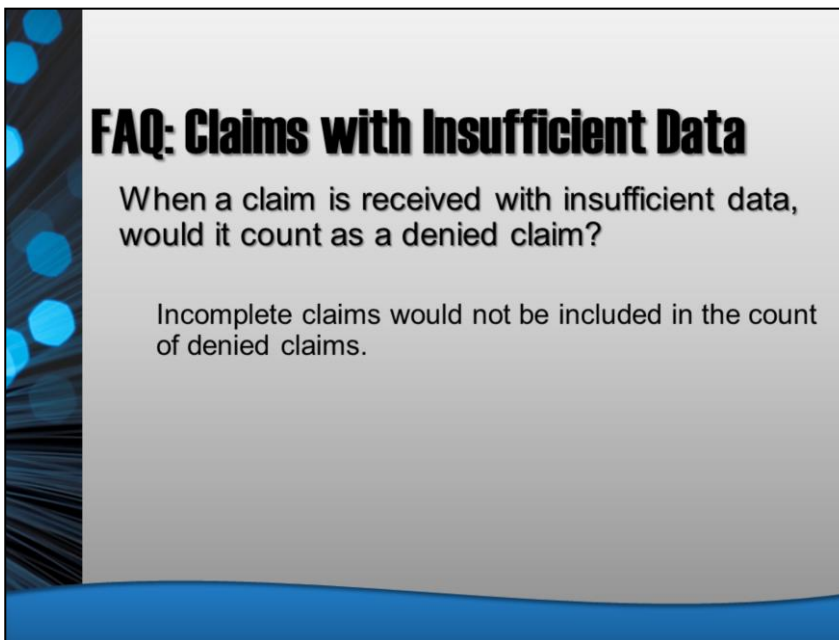


FAQ: Claim Payment Adjustments

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.

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 (or reopened), it would be considered as part of the original claim and would be aged from receipt of the original claim.

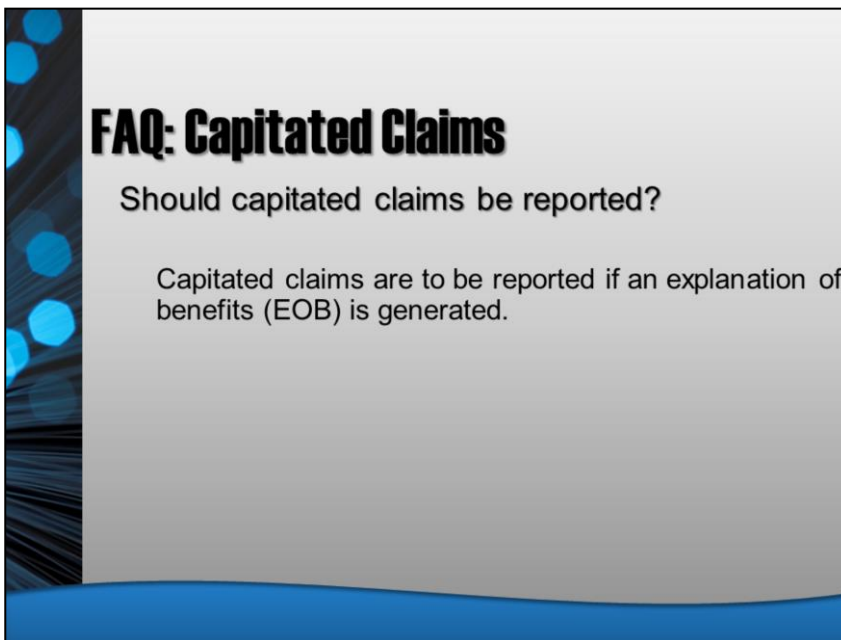


FAQ: Claims with Insufficient Data

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

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

Incomplete claims are not to be included in the claim reporting.

A graphic with a grey background and a blue wavy border at the bottom. On the left side, there is a vertical strip with a dark blue background and several bright blue circles of varying sizes. The text is centered on the grey background.

FAQ: Capitated Claims

Should capitated claims be reported?

Capitated claims are to be reported if an explanation of benefits (EOB) is generated.

If the company generates an explanation of benefits for a capitated claim, then it should be included in the health MCAS reporting.



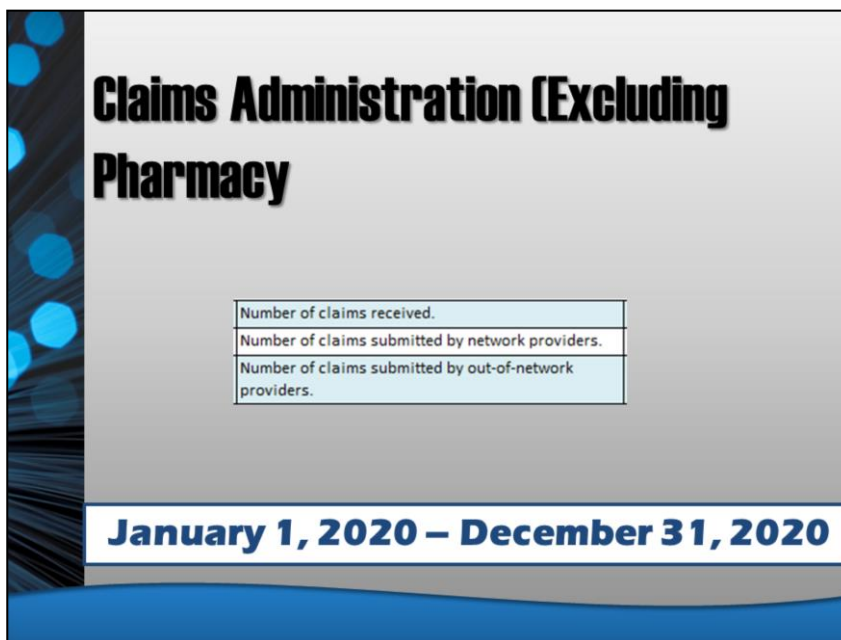
FAQ: Prepaid Capitated Services

If a claimed service is included in a prepaid capitated service, should this be reported as a denied claim or a paid claim?

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.

You should report claims that are included in a prepaid capitated service according to the determination shown on the explanation of benefits.

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.


The image shows the header section of a form. On the left, there is a vertical decorative bar with a dark background and several glowing blue circles. The main title "Claims Administration (Excluding Pharmacy)" is written in a large, bold, black font. Below the title is a table with three rows, each containing a text label for a data field. At the bottom of the header, there is a white horizontal bar with a blue border containing the date range "January 1, 2020 – December 31, 2020" in a bold blue font. The background of the header is a light gray gradient.

Number of claims received.
Number of claims submitted by network providers.
Number of claims submitted by out-of-network providers.

January 1, 2020 – December 31, 2020

Within the Claims Administration (Excluding Pharmacy) section, you are first asked to report the number of claims received, the number of claims received from network providers and the number of claims received from out-of-network providers.

The sum of submitted network and out-of-network claims should equal the total claims received.



Claims Administration (Excluding Pharmacy)

<p>Number of claim denials for in-network claims.</p> <p>In-network claims denied within 0-30 days.</p> <p>In-network Claims denied within 31-60 days.</p> <p>In-network Claims denied within 61-90 days.</p> <p>In-network Claims denied beyond 90 days.</p> <p>Number of in-network denied, rejected or returned - Claims Submission Coding Error(s).</p> <p>Number of in-network denied, rejected or returned - Prior Authorization Needed.</p> <p>Number of in-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.</p> <p>Number of in-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits).</p> <p>Number of in-network denied, rejected or returned - Not Medically Necessary (Behavioral Health Benefits Only).</p>	<p>Number of claim denials for out-of-network claims.</p> <p>Out-of-network claims denied within 0-30 days.</p> <p>Out-of-network Claims denied within 31-60 days.</p> <p>Out-of-network Claims denied within 61-90 days.</p> <p>Out-of-network Claims denied beyond 90 days.</p> <p>Number of out-of-network denied, rejected or returned - Claims Submission Coding Error(s).</p> <p>Number of out-of-network denied, rejected or returned - Prior Authorization Needed.</p> <p>Number of out-of-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.</p> <p>Number of out-of-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits).</p> <p>Number of out-of-network denied, rejected or returned - Not Medically Necessary (Behavioral Health Benefits Only).</p>
---	---

January 1, 2020 – December 31, 2020

The next grouping of data elements records the number of in-network and out-of-network claims that were denied.


In addition to reporting the total number of denials, you are to report the denials according to the length of time it took the carrier to make the denial determination.

The breakouts are:

- 0-30 days
- 31-60 days
- 61-90 days
- And beyond 90 days

You are also asked to report in-network and out-of-network claims that are denied, rejected or returned according to the reasons for the denial, rejection or return. The reporting categories are:

- Claim submission coding errors
- Prior authorization needed
- Non-covered benefit or benefit limitation
- Not medically necessary (Excluding Behavioral Health Benefits)
- And Not medically necessary (Behavioral Health Benefits Only)



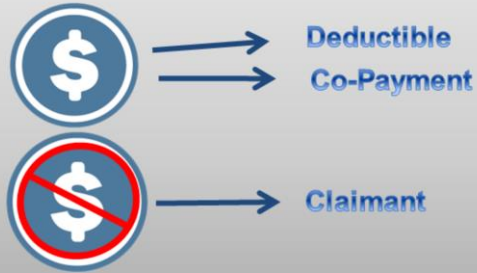
FAQ: Claim Denial Categories

Should the number of total claim denials be equal to the sum of the five claim denial reporting categories?

No. The five claim denial reporting categories added for the 2018 data year are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.

The five claim denial reporting categories added for the 2018 data year are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.

Claims Clarification



- Claims pending additional information and subsequently paid are NOT included in the count of denied claims.
- Claims considered as eligible (or applied to a deductible or co-payment), but without a payment, are NOT to be considered as denied claims.

Keep in mind...

- Claims that are pended for additional information and subsequently paid are not to be included in the count of denied claims.
- Also, a claim that is considered as eligible (or applied to a deductible or co-payment), but is without a payment, is not to be considered as a denied claim.

This means, if the claimed amount goes toward a Deductible or a Co-Payment, and no funds go to the claimant, the claim should not be considered a denied claim.

Claims Administration (Excluding Pharmacy)

Number of paid claims for in-network services.
In-network claims paid within 0-30 days.
In-network claims paid within 31-60 days.
In-network claims paid within 61-90 days.
In-network claims paid beyond 90 days.
Number of paid claims for out-of-network services.
Out-of-network claims paid within 0-30 days.
Out-of-network claims paid within 31-60 days.
Out-of-network claims paid within 61-90 days.
Out-of-network claims paid beyond 90 days.

The next grouping of data elements record the number of in-network and out-of-network claims that were paid.

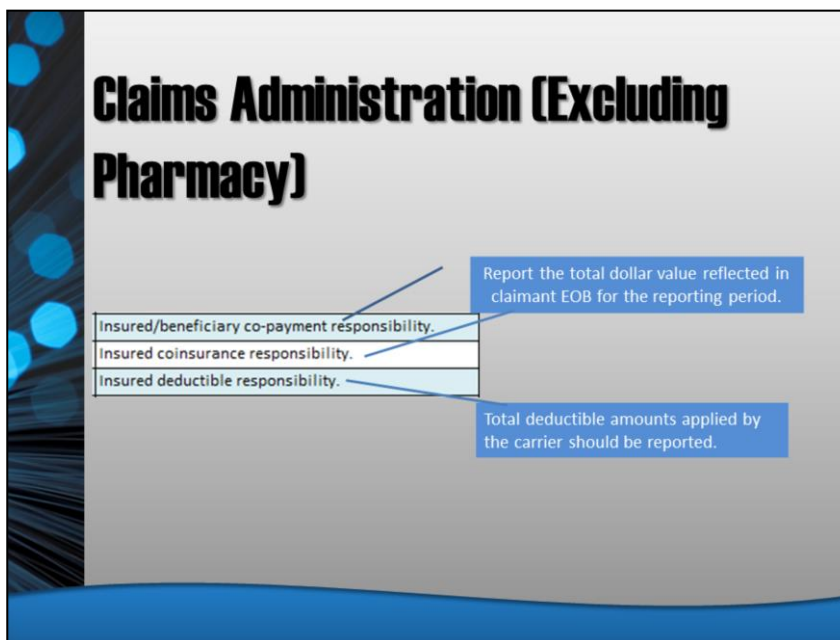
As with the denied claims, the claims paid are broken out according to the length of time it took the carrier to pay the claim.

Claims Administration (Excluding Pharmacy)

Claims Paid.

- Not intended for a claim count
- Should be the total dollar value of payments by the carrier for benefits reflected in claimant EOBs for the requested period

Special attention should be given to the Claims Paid data element. This field is not intended for a count of claims, but instead, the total dollar value of payments by the carrier for benefits reflected in claimant Explanations of Benefits (EOBs) for the requested period should be reported.



The final claims data elements (excluding pharmacy) deal with copayment, coinsurance and deductible responsibility.

The total dollar value of all co-payments and co-insurance reflected in claimant Explanation of Benefits for the reporting period should be reported.

Likewise, the total deductible amounts applied by the carrier should be reported.

Claims Administration (Pharmacy Only)

Number of claims received.
Number of claim denials for in-network claims.
Number of claim denials for out-of-network claims.
Number of paid claims for in-network services.
Number of paid claims for out-of-network services.
Claims Paid.
Insured/beneficiary co-payment responsibility.
Insured coinsurance responsibility.
Insured deductible responsibility.

The Claims Administration (Pharmacy Only) section of the health MCAS contains a subset of the data elements reported for the Claims Administration (Excluding Pharmacy) section. So, we are not going to review these elements again.

Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)

Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)

Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)

Number of customer requests for internal reviews of grievances not involving adverse determinations.

The next four data elements deal with internal review of grievances, both those involving adverse determinations and those that do not involve adverse determinations.

These data elements include terminology that may need to be clarified.

Adverse Determinations

- Rescission
- Denial
- Reduction
- Termination of
- Failure to provide or make payment (in whole or in part)



These actions may be the result of:

- A determination of a member's or eligible dependent's eligibility to participate in a plan
- The application of any utilization review
- Determination of an item or service to be experimental or investigational or not medically necessary or appropriate

Adverse Determinations can be a rescission, denial, reduction , termination of, or failure to provide or make payment (in whole or in part).

The Adverse Determinations can be the result of:

- A determination of a member's or eligible dependent's eligibility to participate in a plan
- The application of any utilization review
- Or Determination of an item or service to be experimental or investigational or not medically necessary or appropriate

Grievance



A written or oral complaint involving an urgent care Request, submitted by or on behalf of a covered person regarding:

- Availability, delivery or quality of health care services (including a complaint regarding an adverse determination made pursuant to utilization review)
- Claims payment, handling or reimbursement for health care services
- Matters pertaining to the contractual relationship between a covered person and a health carrier.

A grievance is a written or oral complaint involving an urgent care request, submitted by or on behalf of a covered person regarding:

- Availability, delivery or quality of health care services (including a complaint regarding an adverse determination made pursuant to utilization review)
- Claims payment, handling or reimbursement for health care services
- Or, Matters pertaining to the contractual relationship between a covered person and a health carrier.



FAQ: Grievance - Multiple Services

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?

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.

If a grievance includes multiple services, some of the services may be upheld while others are overturned.

If the company tracks the grievances separately, then they should be reported 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.

Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)
Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of customer requests for internal reviews of grievances not involving adverse determinations.

You are to report the number of requests for internal review of grievances involving adverse determinations, how many of those were upheld, and how many of them were overturned.

You are also asked to report the number of requests for internal reviews of grievances NOT involving adverse determinations.


FAQ: Second Level Internal Reviews

Should second level internal review be reported in the MCAS?

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

Only first level internal reviews should be reported. However, one of the interrogatory questions asks if the company has an additional voluntary level of review for grievances.

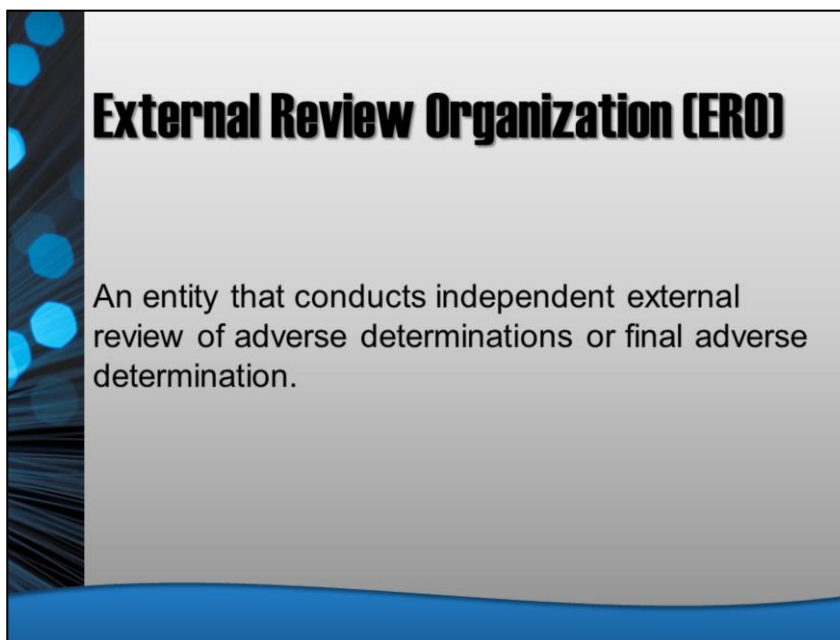
Second level reviews should be noted in response to this question.



Consumer Requested External Reviews (Including Pharmacy)

Number of customer requested appeals on final adverse determinations to an external review organization.
Number of final adverse determinations upheld upon request for external review.
Number of final adverse determinations overturned upon request for external review.

Finally, you are asked to report on consumer requested external reviews.

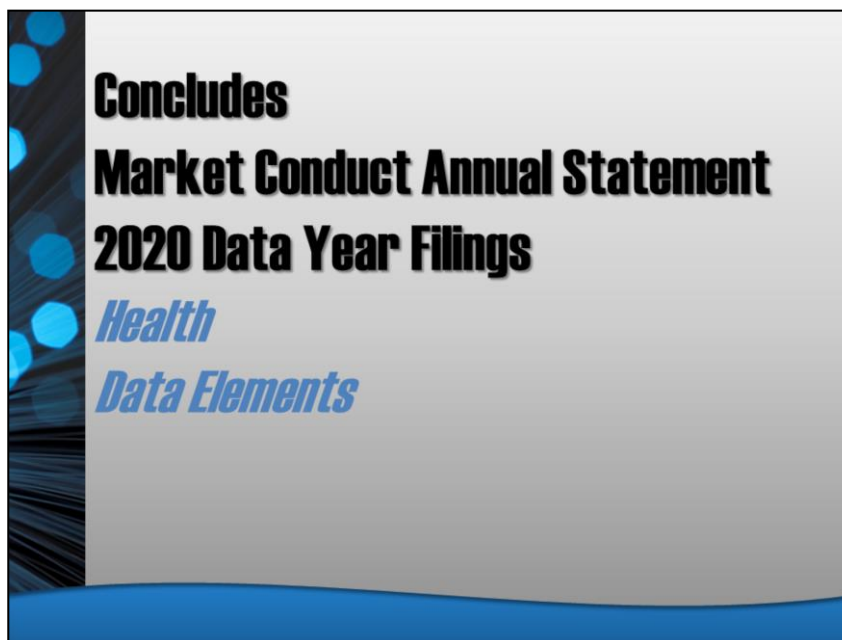


An External Review Organization or ERO is an entity that conducts independent external review of adverse determinations or final adverse determination.

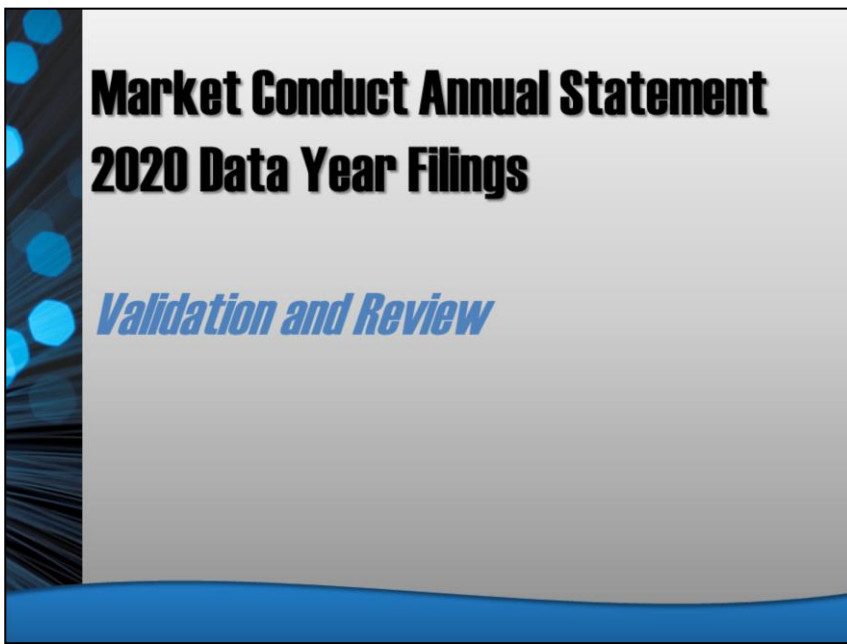
Consumer Requested External Reviews (Including Pharmacy)

Number of customer requested appeals on final adverse determinations to an external review organization.
Number of final adverse determinations upheld upon request for external review.
Number of final adverse determinations overturned upon request for external review.

You are asked to report the number of requested appeals on final adverse determinations to an external review organizations. Of those requests, you will report the number of adverse determinations upheld and overturned.



This concludes the data elements review portion of the tutorial. Now we'll discuss the MCAS data validations.



MCAS Validation and Review

MCAS Validations

- MCAS Validations are data checks programmed within the MCAS data submission application.

Errors - some validations are considered to be errors and must be corrected before submission of data is allowed.

Warnings - other validations are considered to be warnings. Filings containing Warnings can be successfully submitted.

MCAS Validations are data checks programmed within the MCAS data submission application.

- Some validations are considered to be Errors and must be corrected before submission of data is allowed.
- Other validations are considered to be Warnings. Filings containing Warnings can be successfully submitted.

MCAS Validation Warnings

MCAS Validations assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended.

MCAS Validations assist state insurance regulators and NAIC staff in reviewing submitted MCAS data.

MCAS Validations have multiple purposes.

- They assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended. For example: the validations can point out data issues that are a result of data entry errors or coding errors,
- And they assist state insurance regulators and NAIC staff in reviewing submitted MCAS data.



MCAS Validation Warnings

It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances.

It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances; for example, companies with small amounts of business to report, or runoff business to report may trigger validation warning failures that are not concerning.

		Total Errors: 0	Total Warnings: 2		
	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Health *	Filed	2	0		
Lender-Placed Insurance	In Progress	16	17		
Homeowners	In Progress	1	1		
Private Passengers Auto *	In Progress	1	2	PENDING	
Long Term Care *	In Progress	0	0		
Disability Income *	In Progress	0	0	APPROVED	

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Health *	Not Started	0	0		
Lender-Placed Insurance	Not Started	0	0		
Homeowners	Not Started	0	0		
Private Passengers Auto *	In Progress	0	0		PENDING

The MCAS system filing matrix provides the MCAS user with information regarding their filings. The filing matrix displays the number of warnings found in submitted or started filings. Before a company submits each filing containing warnings, they are prompted to add comments regarding any outstanding warnings in the submission.

The screenshot displays a filing matrix with two tables. The top table shows the following data:

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Health *	Filed	2	0		
Lender-Placed Insurance	In Progress	16	17		
Homeowners	In Progress	1	1		
Private Passengers Auto *	In Progress	1	2	PENDING	
Long Term Care *	In Progress	0	0		
Disability Income *	In Progress	0	0	APPROVED	

The bottom table shows the following data:

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Health *	Not Started	0	0		
Lender-Placed Insurance	Not Started	0	0		
Homeowners	Not Started	0	0		
Private Passengers Auto *	In Progress	0	0		PENDING

Once a company has filed the MCAS data, the filing matrix will display a status of “filed” for each state and line of business submitted. At this point in the process, NAIC staff will begin a review of the data, checking for data inconsistencies and anomalies.

Private Passenger Auto Interrogatories		Yes	No	
		Response	Explanation	
01	Were there policies in force during the reporting period that provided Collision coverage?	--	--	
02	Were there policies in force during the reporting period that provided Comprehensive coverage?	--	--	
03	Were there policies in force during the reporting period that provided Bodily Injury coverage?	--	--	
04	Were there policies in force during the reporting period that provided Property Damage coverage?	--	--	
05	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?	--	--	
06	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?	--	--	
07	Were there policies in force during the reporting period that provided Medical Payments coverage?	--	--	
08	Were there policies in force during the reporting period that provided Combined Single Limits coverage?	--	--	
09	Were there policies in force during the reporting period that provided Personal Injury Protection coverage?	--	--	
10	Was the company actively writing policies in the state at year end?	--	--	
11	Does the company write in the non-standard market?	--	--	
12	If Yes, what percentage of your business is non-standard?	--	--	
13	If Yes, how is non-standard defined?	--	--	
14/15	Has the company had a significant event/business strategy that would affect data for this reporting period?	--	--	
16/17	Has all or part of this block of business been sold, closed or moved to another company during the year?	--	--	
18	How does the company treat subsequent supplemental or additional payments on previously closed claims?	--	--	
19	Additional state specific Claims comments (optional):	--	--	Comments
20	Additional state specific Underwriting comments (optional):	--	--	

As NAIC analysts review company filings, they view comments found in the interrogatories,

By checking the "I attest" box below, I understand, agree and certify on behalf of the named company that:

1. I am authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. I am knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of my knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. I am aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. I affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary recreate the MCAS results as reported in this filing.

I Attest First name MI Last name Suffix Title Clear

I Attest First name MI Last name Suffix Title Clear

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attesters should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

Overall comments for the filing year 2020

Close Submit Attestation

and in the attestation to determine if the warnings have been sufficiently addressed.

If a filing contains “warning messages,” and there are no comments entered by the company, it is more likely that the company will be contacted for an explanation by NAIC staff.

Lender Placed Insurance (Auto and Home)

Both Single Interest and Dual Interest

Claims

Ratio 1. **Number of claims closed without payment to total number of claims closed**

$$\frac{(\# \text{ of claims closed without payment})}{(\# \text{ of claims closed with payment}) + (\# \text{ of claims closed without payment})}$$

Ratio 2. **Claims open at the end of the period to total claims during the period**

$$\frac{(\# \text{ of claims open at the beginning of period} + \# \text{ of claims opened during period} - \# \text{ of claims closed with payment} - \# \text{ of claims closed without payment})}{(\# \text{ of claims open at the beginning of period} + \# \text{ of claims opened during the period})}$$

Ratio 3. **Claims paid beyond 60 days to total claims closed with payment**

$$\frac{(\# \text{ of claims settled 61} - 90 \text{ days} + \# \text{ of claims settled 91} - 180 \text{ days} + \# \text{ of claims settled 181} - 365 \text{ days} + \# \text{ of claims settled beyond 365 days})}{\text{total } \# \text{ of claims closed with payment}}$$

Ratio 4. **Loss Ratio – Incurred claims to earned premium**

$$\frac{(\text{dollars of claims incurred during the period})}{(\text{dollar amount of premium earned during the period})}$$

Cancellations

Ratio 5. **Master policy cancellations to master policies in force at beginning of the period**

$$\frac{(\text{total } \# \text{ of master policy cancellations})}{(\text{total } \# \text{ of master policies in force at beginning of period})}$$

The company's standard ratio results are also reviewed. A listing of the scorecard ratios can be found on the MCAS web page.

During review of a company's ratio results, values that are significantly different than the expected value are identified, along with any significant changes in a company's ratio values year to year. Companies will be notified of these anomalies to allow verification of the submitted data.

Validation and Review

- Listed warnings
- Ratios
- Data comparisons
- General review



In addition to warnings and ratios, data relationships within the submission are reviewed. An example would be a comparison of policies in-force to the number of claims. Another example would be the comparison of policies in-force to written premiums. If an unusual data relationship is identified, the company will be asked to explain.

A final review is a general review of the data for potential data inaccuracies. An example of this might be the submission of a data element that contains a value much larger than expected; perhaps too many zeros were added, or two data elements were transposed. Again, if these anomalies are identified, the company will be asked to review the data.

2021 | 2020 | 2019 (Current Data Year) | 2018 | Contacts and Scorecards

Log In

Don't have an MCAS login?
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Help | [FAQ \(PDF\)](#) | [Contact](#)

GENERAL FILING INFORMATION

[Participation Requirements \(PDF\)](#)

TRAINING

[Online Data Element Tutorials](#)

RESOURCES

[Data Collection Worksheets \(Blanks\)](#)

- [Annuity \(PDF\)](#)
- [Disability Income \(PDF\)](#)
- [Health \(PDF\)](#)
- [Homeowners \(PDF\)](#)
- [Lender-Placed Home and Auto \(PDF\)](#)
- [Life \(PDF\)](#)
- [Long-Term Care \(PDF\)](#)
- [Private Passenger Auto \(PDF\)](#)

[Data Call and Definitions \(Instructions\)](#)

- [Disability Income \(PDF\)](#)
- [Health \(PDF\)](#)
- [Homeowners \(PDF\)](#)
- [Lender-Placed Home and Auto \(PDF\)](#)
- [Life & Annuity \(PDF\)](#)
- [Long-Term Care - Hybrid \(PDF\)](#)
- [Long-Term Care - Stand-Alone \(PDF\)](#)
- [Private Passenger Auto \(PDF\)](#)

[Summary of 2019 Changes \(PDF\)](#)

[2019 MCAS User Guide \(PDF\)](#)

KEY 2019 MCAS DATES

December 16, 2019	Call letters to companies
Mid-January 2020	Last day to submit 2018 corrections (See FAQ Document)
March 16, 2020	Filing may be submitted via the online MCAS filing tool
March - April, 2020	MCAS training webinars
June 30, 2020	MCAS submissions due for all lines of business except Disability Income and Health
August 31, 2020	MCAS submissions due for Disability Income and Health
September 1, 2020	MCAS industry scorecards posted to MCAS Web page for all lines of business except Disability Income and Health
November 1, 2020	MCAS industry scorecards posted to MCAS Web page for Disability Income and Health

NEW FOR 2019 DATA YEAR

- The disability income MCAS was adopted on August 7, 2018 at the NAIC Executive/Plenary session during the NAIC Summer National Meeting. Disability income MCAS data will be collected for the first time beginning with the 2019 data year.

WHAT DO DOCUMENTS FOUND ON THIS WEB PAGE TELL ME?

General Filing Information

- [Participation Requirements](#) - Detailed information to assist in determining if your company is required to submit MCAS data

Resources

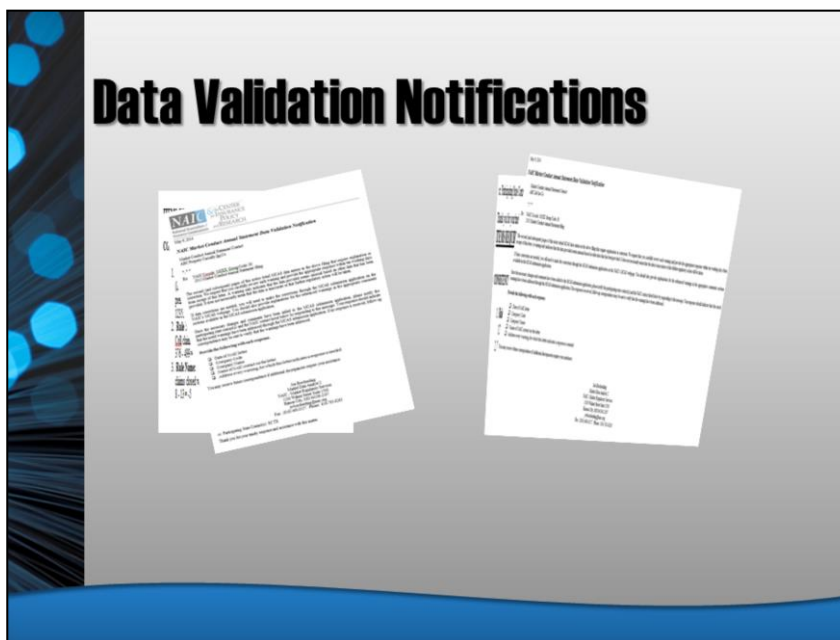
- [Data Collection Worksheets \(Blanks\)](#) - Table layout representation of the required data elements
- [Data Call and Definitions \(Instructions\)](#) - Listing of MCAS data elements and definitions to follow when preparing data for submission
- [MCAS User Guide](#) - Information about how to use the MCAS application and a listing of data validations used within the application
- [CSV Data Upload Instructions](#) - Layout guidelines for preparing a CSV file for uploading to the MCAS

The MCAS User Guide, (found on the MCAS webpage) lists the data validation messages that may be encountered while validating data. This includes both “Error” and “Warning” messages. Use the listing to prepare data and to determine comments that will be needed to explain “Warning” messages received during the data validation process.

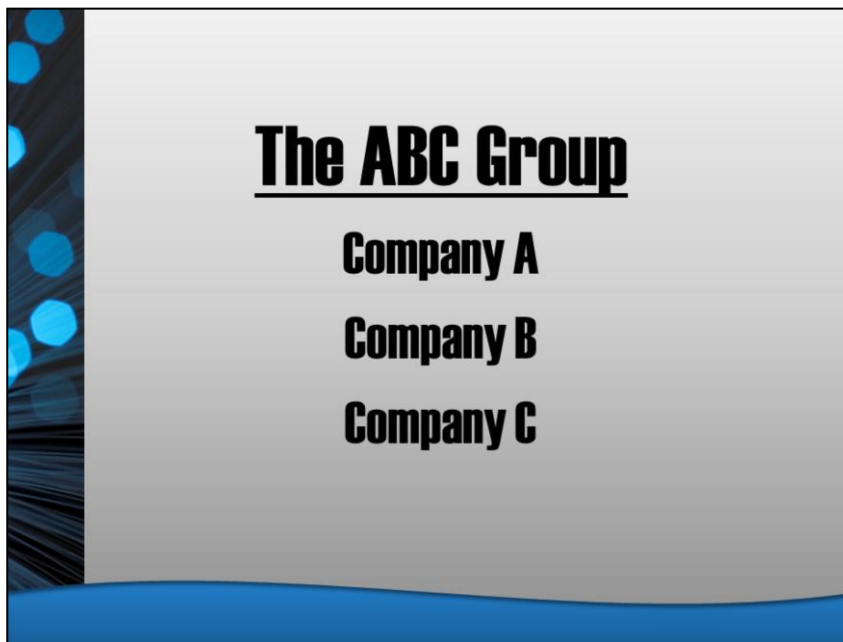
State Regulators have Oversight



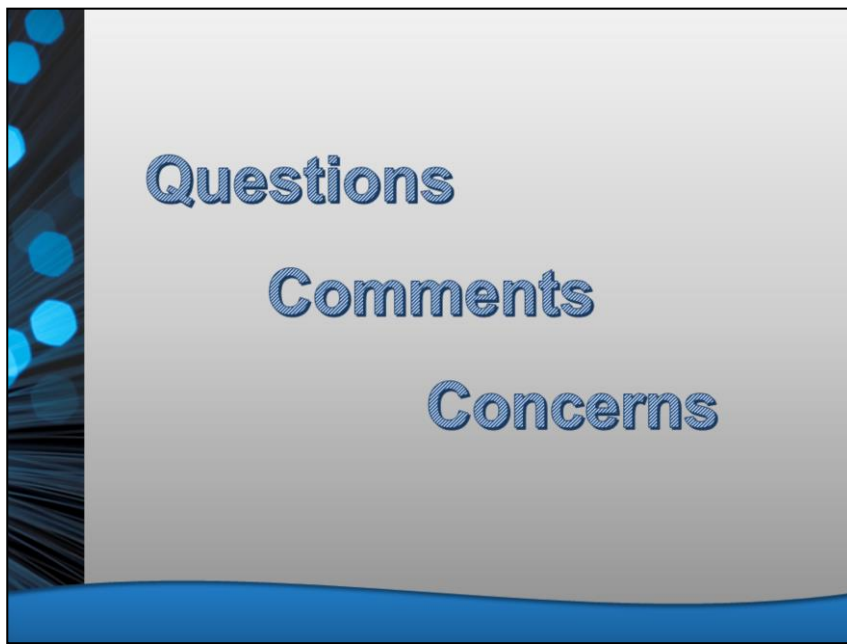
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within **multiple** states.



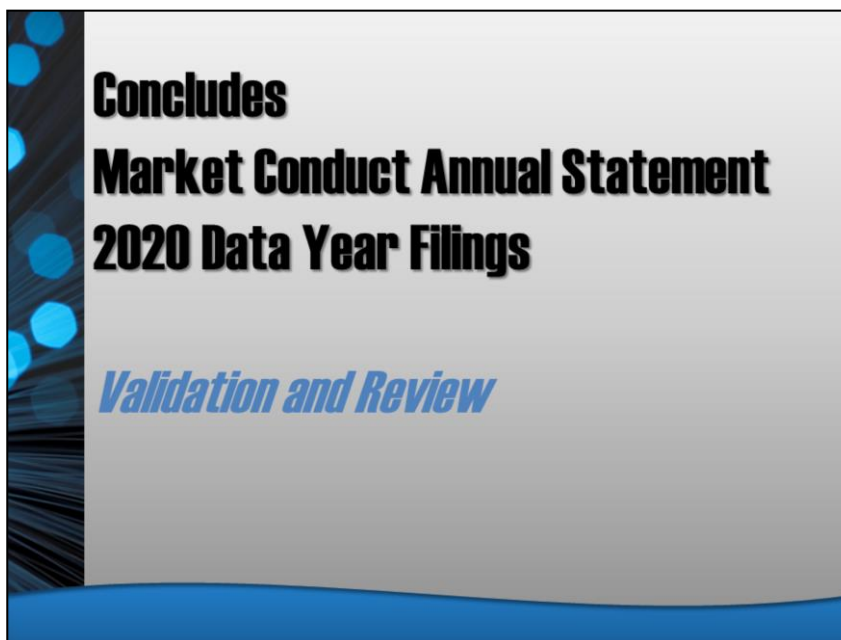
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence. If they have additional questions or concerns, they may also contact the company. However, keeping state regulators in the line of communication, should lessen the number of inquiries received for any particular data concern.



If company A is part of ABC group, and the same observations are made for other companies within the group, then separate correspondence will be sent to each company. It is important to respond to requests in a timely manner to avoid follow up from the NAIC or state regulators. In the company response to the NAIC, please include comments on what action the company will take.



If you receive correspondence from an NAIC analyst, we encourage you to reach out to the analyst with any questions, comments or concerns you may have regarding the correspondence, the validations, or other MCAS filing related issues.



Thank you for your time. This concludes the filing validation and review discussion. Additional questions may be sent to mcas@naic.org.