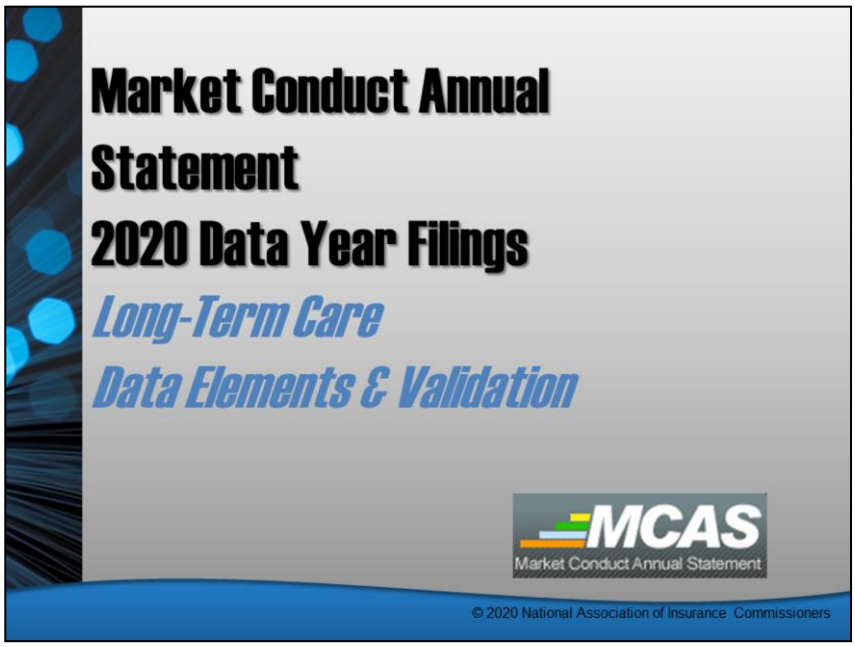
Market Conduct Annual Statement
2020 Data Year Filings
Long-Term Care
Data Elements & Validation
MCAS
Market Conduct Annual Statement
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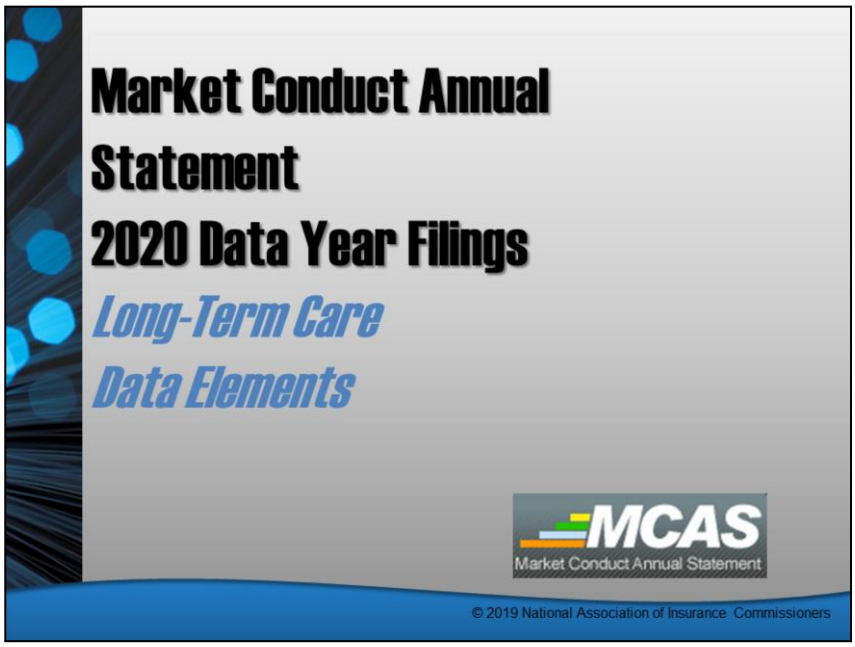
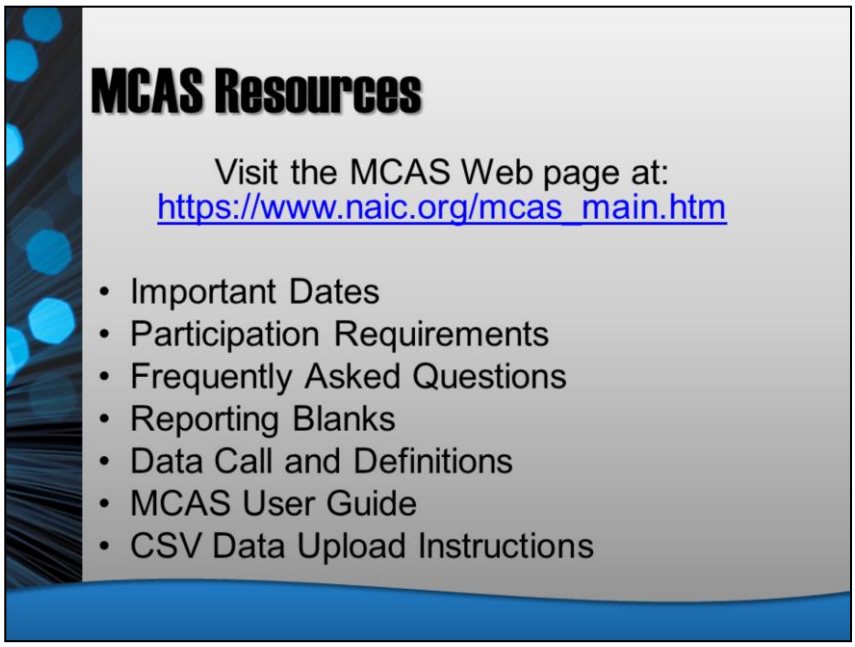


Hi, I'm Leana Massey, Market Regulation Trainer for the NAIC.

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

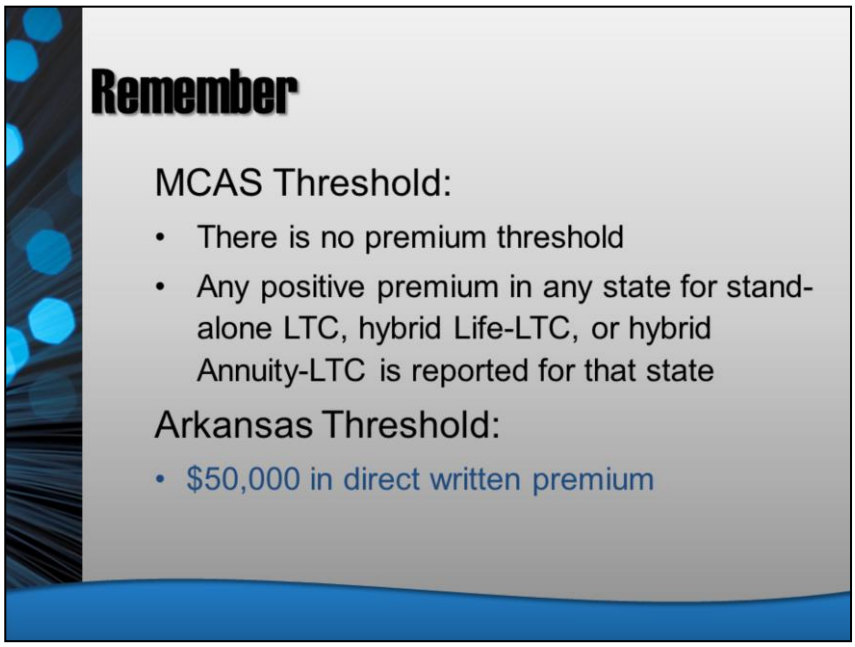


Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

The available resources include:

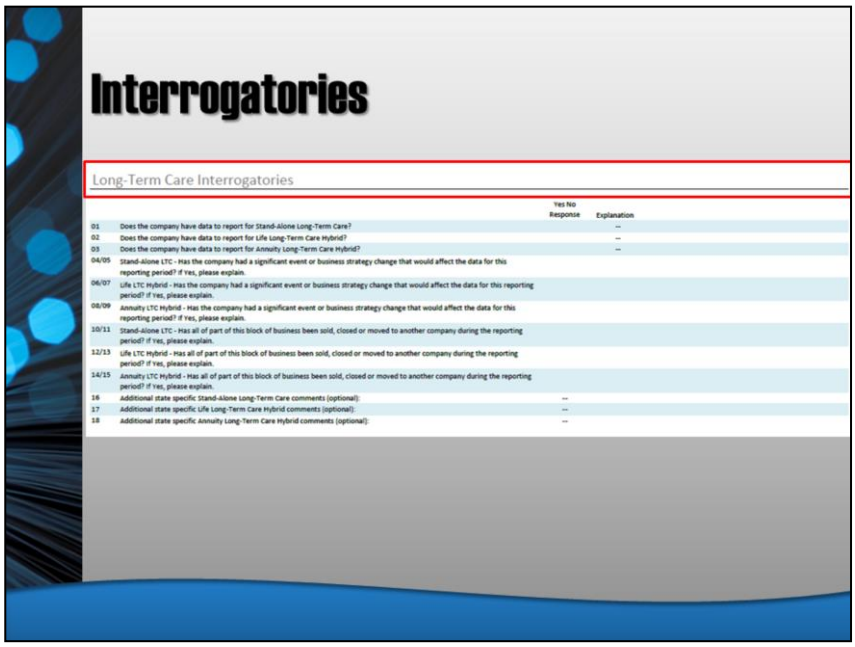
- A Listing of Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- Copy of the Call Letter
- MCAS User Guide
- And CSV Data Upload Instructions

Before we begin, please be sure to remember that the current year MCAS filing deadline is April 30th.

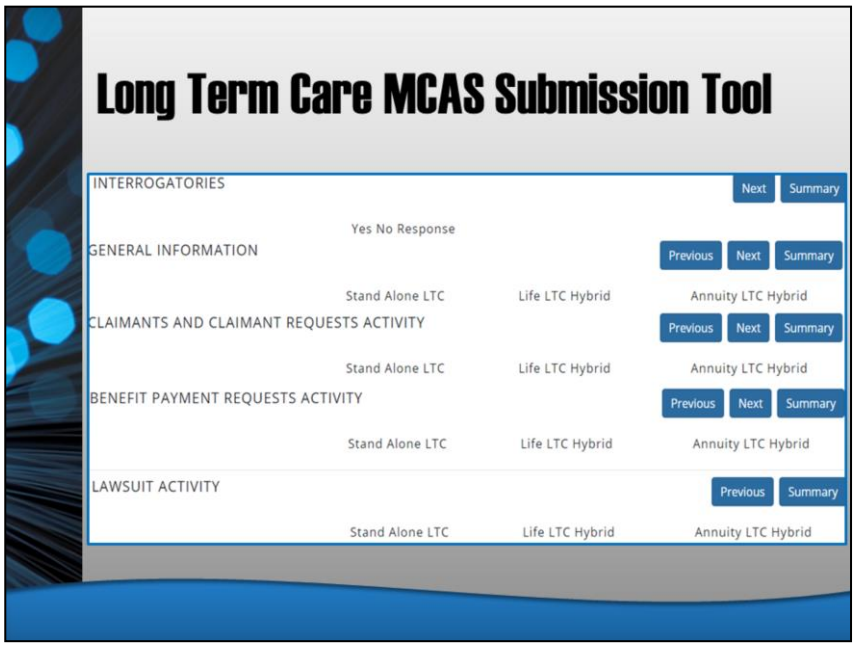


With only one exception, there is no premium threshold for this line of business. Companies with any in-force Long Term Care policies are required to report in all participating jurisdictions (for those jurisdictions in which they have in-force policies).

The Arkansas Long Term Care threshold is $50,000. A company is required to report Long Term Care MCAS data for Arkansas if they wrote at least $50,000 in stand-alone Long Term Care, hybrid Long Term Care-Life, or hybrid Annuity-Long Term Care premium. Reporting to the state should be made only for the line or lines of business that meets this threshold.

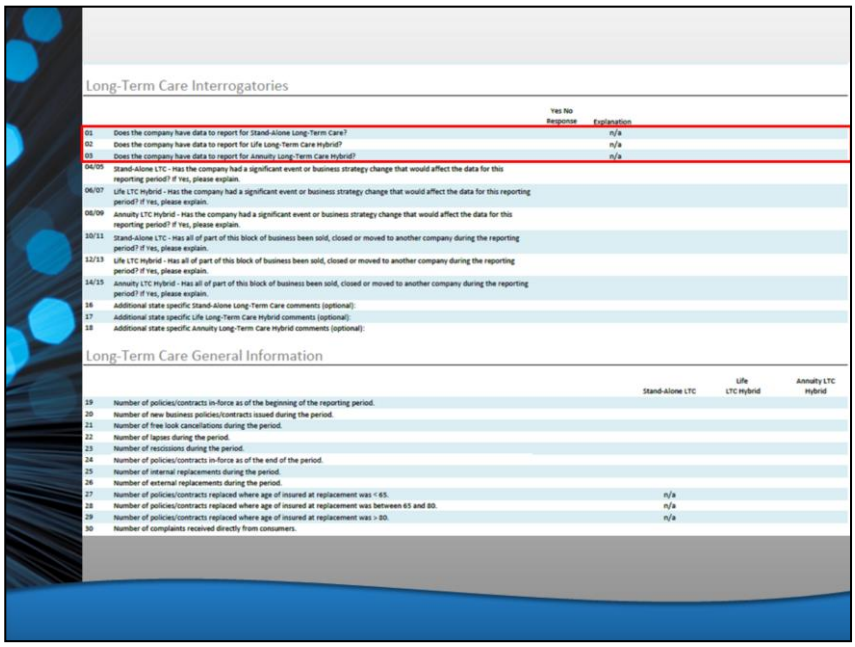


The first section of questions that you will see in the data entry screen is the interrogatories. The interrogatories provide one location for all comments and questions that require a text response.



You will notice on your data entry screen within the MCAS submission tool that there is one page for Interrogatory questions and four separate pages of data questions for the policy types. There are a total of 7 sections or schedules for the Long-Term Care MCAS, with the Interrogatories being the first, however, within the MCAS submission tool the data questions are separated into five total pages for a better user experience within the tool itself.

The five pages of data entry are Interrogatories, General Information, Claimants and Claimant Requests Activity, Benefit Payment Requests Activity and Lawsuit Activity. We will discuss the details of each section throughout this tutorial, but the way each page of information begins for the Long-Term Care MCAS appear here.



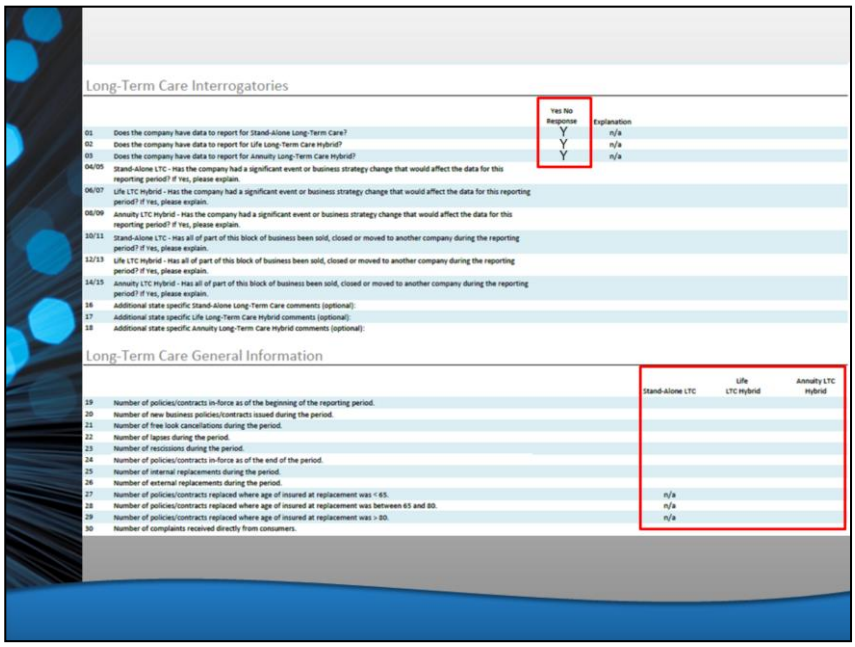
Long-Term Care Interrogatories

		Yes No Response	Explanation
01	Does the company have data to report for Stand-Alone Long-Term Care?		n/a
02	Does the company have data to report for Life Long-Term Care Hybrid?		n/a
03	Does the company have data to report for Annuity Long-Term Care Hybrid?		n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
16	Additional state specific Stand-Alone Long-Term Care comments (optional):		
17	Additional state specific Life Long-Term Care Hybrid comments (optional):		
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):		

Long-Term Care General Information

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.			
20	Number of new business policies/contracts issued during the period.			
21	Number of free look cancellations during the period.			
22	Number of lapses during the period.			
23	Number of rescissions during the period.			
24	Number of policies/contracts in-force as of the end of the period.			
25	Number of internal replacements during the period.			
26	Number of external replacements during the period.			
27	Number of policies/contracts replaced where age of insured at replacement was < 65.	n/a		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.	n/a		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.	n/a		
30	Number of complaints received directly from consumers.			

The first interrogatories ask insurers to indicate if they will be reporting data for each of the policy types for the line of business selected.



Long-Term Care Interrogatories

		Yes No Response	Explanation
01	Does the company have data to report for Stand-Alone Long-Term Care?	Y	n/a
02	Does the company have data to report for Life Long-Term Care Hybrid?	Y	n/a
03	Does the company have data to report for Annuity Long-Term Care Hybrid?	Y	n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
16	Additional state specific Stand-Alone Long-Term Care comments (optional):		
17	Additional state specific Life Long-Term Care Hybrid comments (optional):		
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):		

Long-Term Care General Information

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.			
20	Number of new business policies/contracts issued during the period.			
21	Number of free look cancellations during the period.			
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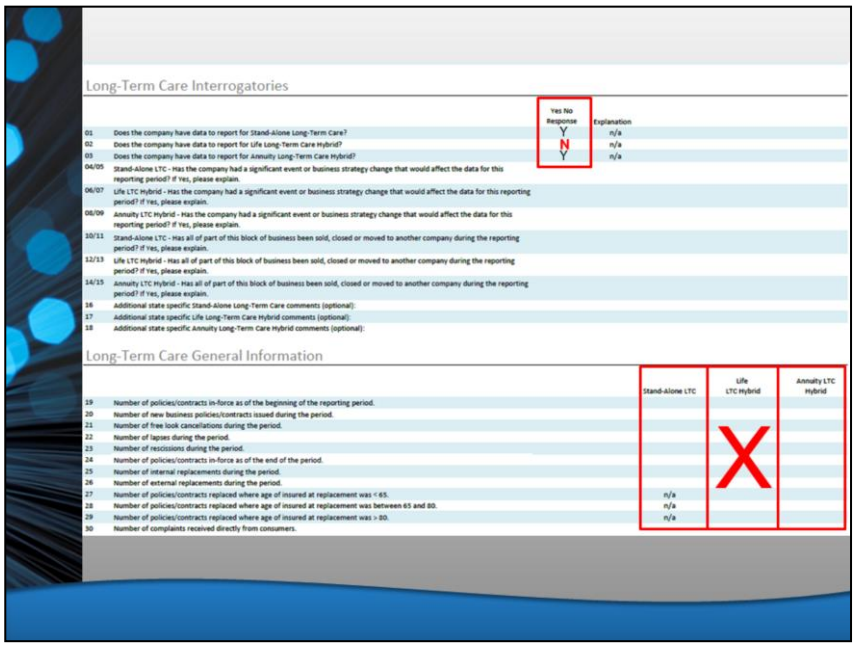
23	Number of rescissions during the period.			
24	Number of policies/contracts in-force as of the end of the period.			
25	Number of internal replacements during the period.			
26	Number of external replacements during the period.			
27	Number of policies/contracts replaced where age of insured at replacement was < 65.	n/a		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.	n/a		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.	n/a		
30	Number of complaints received directly from consumers.			

If you answer “YES” you must provide data to each of the data questions in the schedule.



Long-Term Care Interrogatories

		Yes No Response	Explanation
01	Does the company have data to report for Stand-Alone Long-Term Care?	Y	n/a
02	Does the company have data to report for Life Long-Term Care Hybrid?	N	n/a
03	Does the company have data to report for Annuity Long-Term Care Hybrid?	Y	n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If Yes, please explain.		
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
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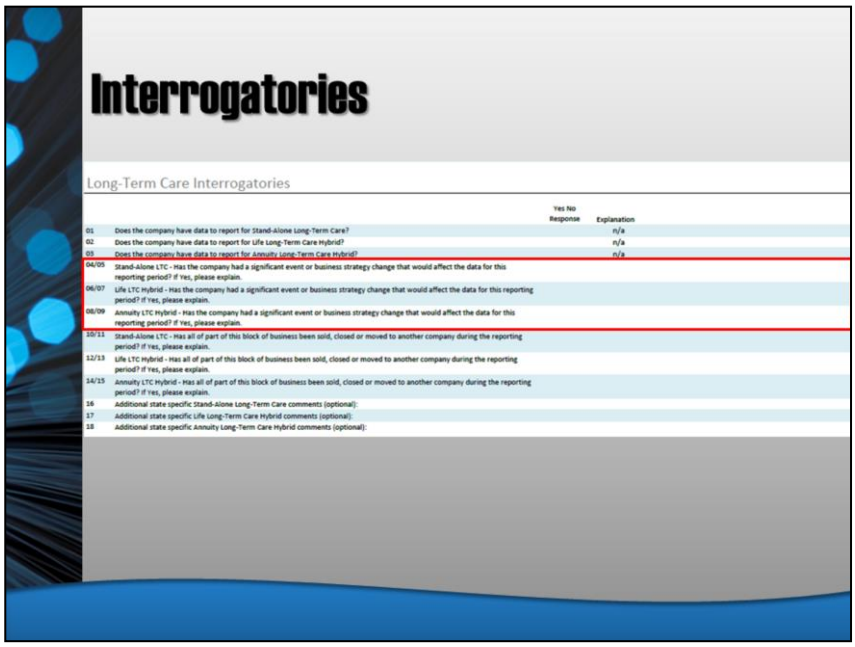
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If Yes, please explain.		
16	Additional state specific Stand-Alone Long-Term Care comments (optional):		
17	Additional state specific Life Long-Term Care Hybrid comments (optional):		
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):		

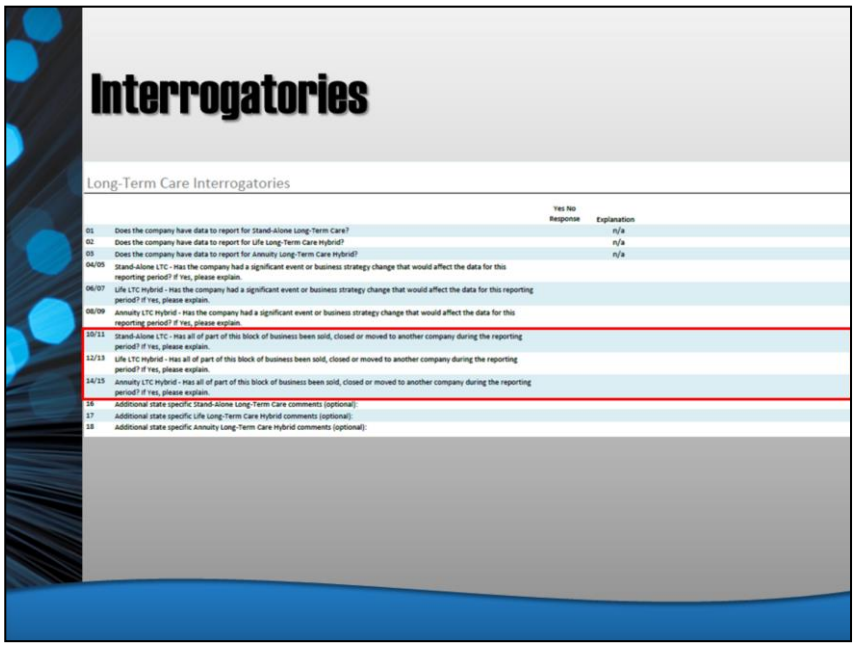
Long-Term Care General Information

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.		X	
20	Number of new business policies/contracts issued during the period.			
21	Number of free look cancellations during the period.			
22	Number of lapses during the period.			
23	Number of rescissions during the period.			
24	Number of policies/contracts in-force as of the end of the period.			
25	Number of internal replacements during the period.			
26	Number of external replacements during the period.			
27	Number of policies/contracts replaced where age of insured at replacement was < 65.	n/a		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.	n/a		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.	n/a		
30	Number of complaints received directly from consumers.			

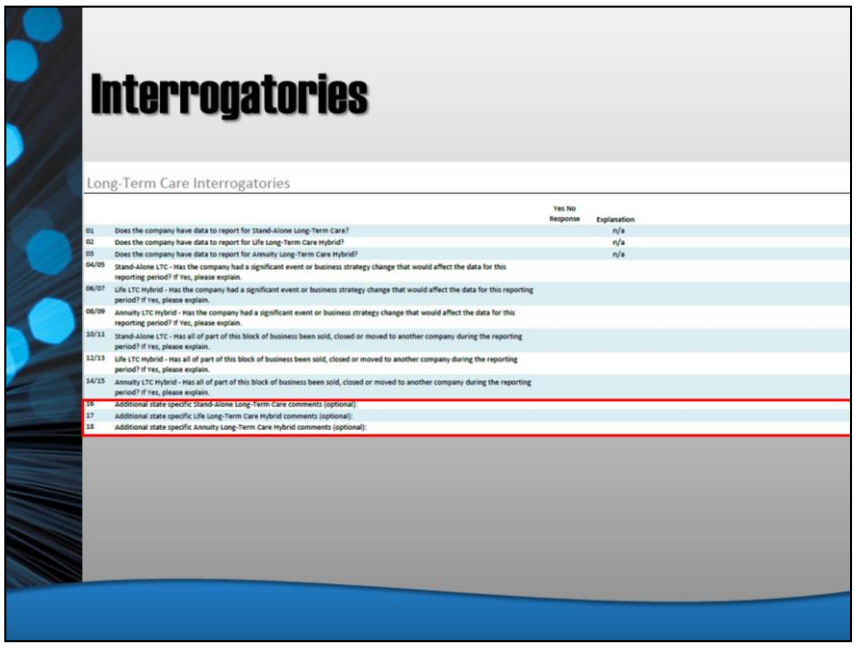
If you respond “NO”, you must leave all the response boxes blank for that line of business. You should only provide data for schedules that you are required to report on.



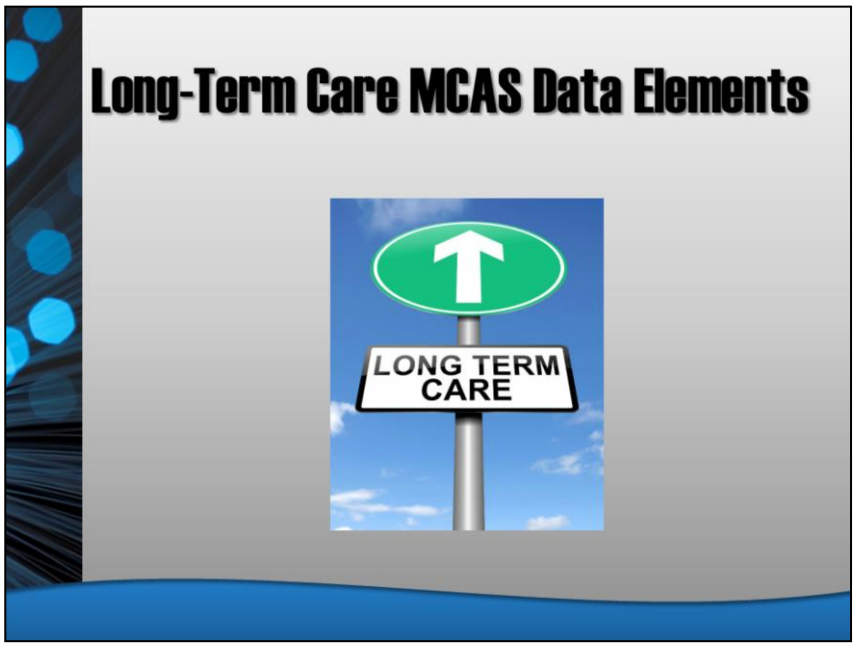
If you indicate that you will be reporting data for a policy type, you are asked if there has been a significant event or business strategy change that would affect the data for this reporting period. These could include assuming blocks of business, shifting market strategies, or underwriting changes.



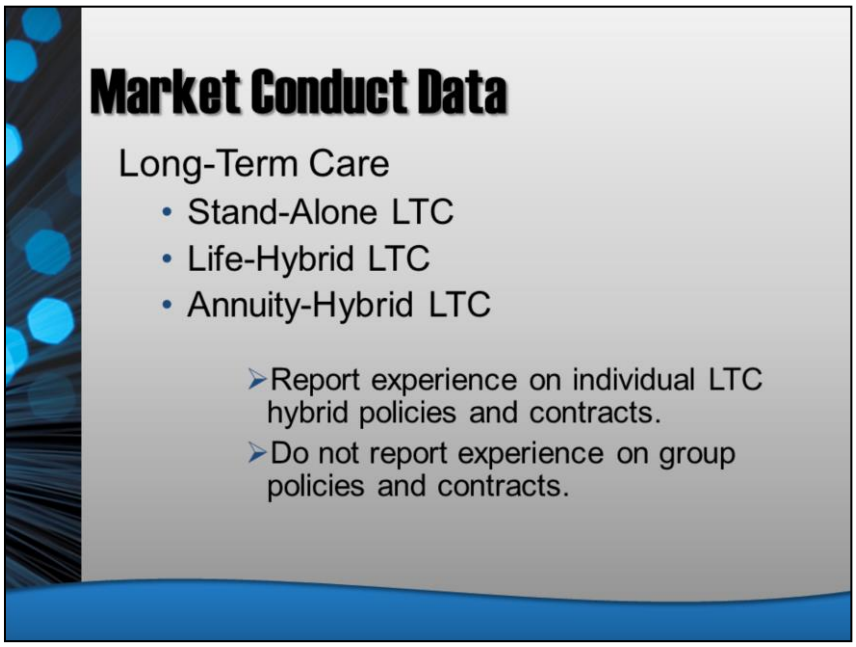
You are also asked if any part of the block of business has been sold, closed or moved to another company during the reporting period. These questions are your opportunity to explain any of your data that you anticipate may generate an inquiry from the state regulators. It is important that these questions be answered fully to allow regulators to have an understanding of your company's MCAS filing results.



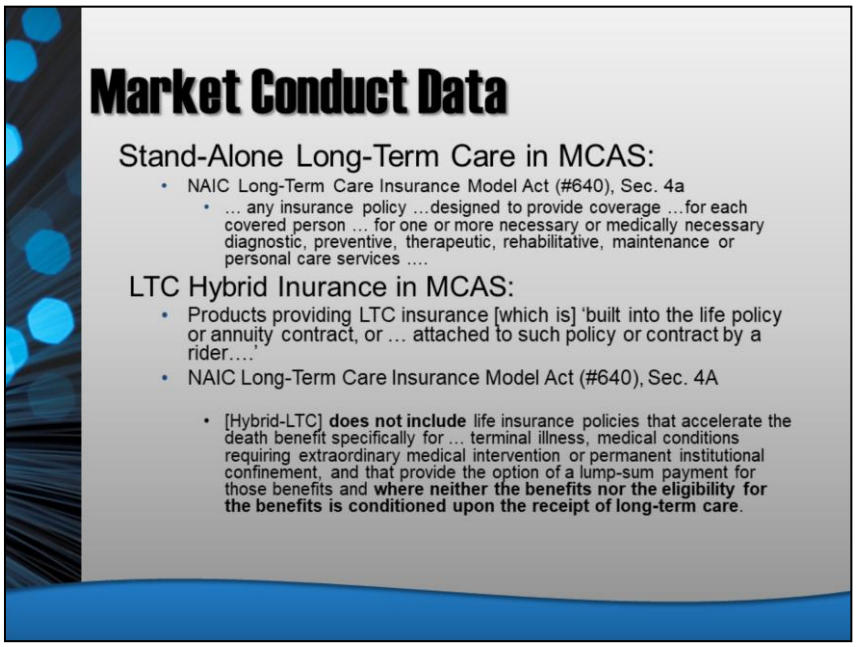
The interrogatories also provide space where you may enter any state specific comments for the policy types. Any areas of your data that may raise questions or generated a warning when your data was validated should be explained fully in these comment areas. At the end of this tutorial we will discuss the MCAS validations in more detail along with the importance of using the comments sections.



The LTC MCAS requests market conduct data on three types of policies that offer long-term care coverage.



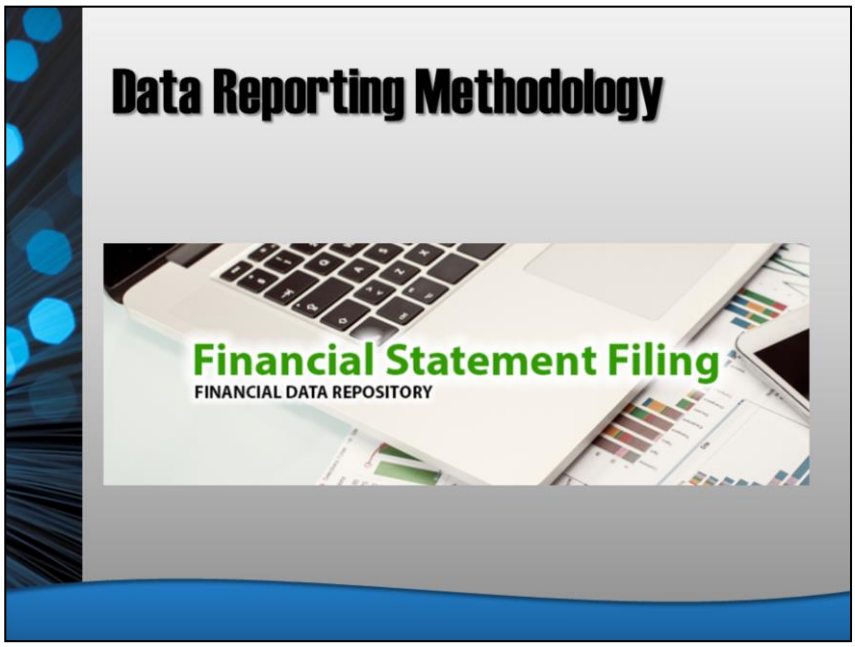
Stand-Alone LTC policies, Life LTC Hybrid policies and Annuity LTC Hybrid policies. Please note, that MCAS is only collecting data on individual policies, not LTC offered through group coverage.



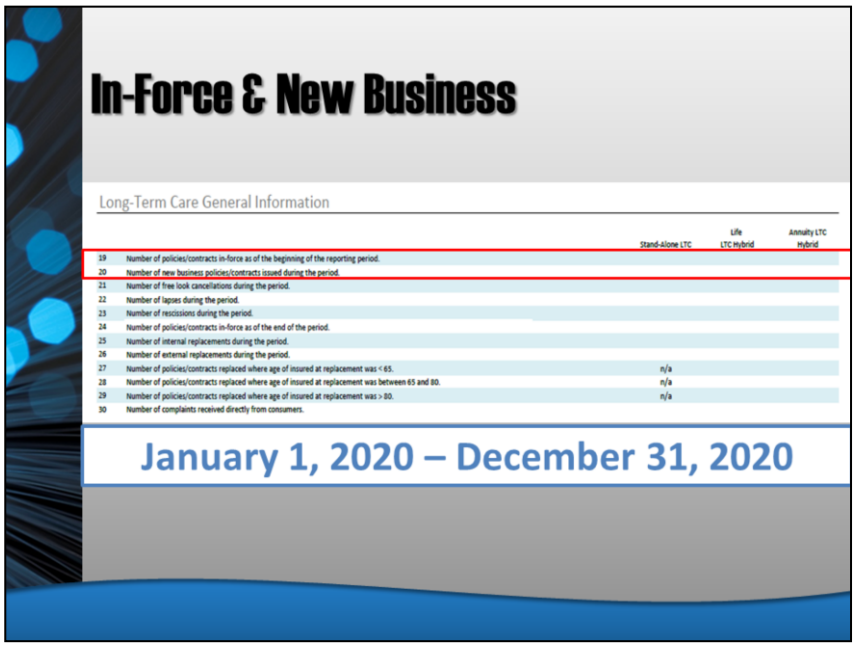
The definitions of Stand-Alone and Hybrid-LTC insurance can be found in the MCAS Data Call and Definitions. The Data Call and Definitions reference Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640). Stand-Alone LTC, per the Model Act, is "any insurance policy…designed to provide coverage …for each covered person … for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services …." LTC-Hybrid products, per the MCAS Hybrid-LTC Data Call and Definitions are products in which LTC coverage is built into the life policy or annuity contract, or attached to them by a rider.

The definitions for hybrid LTC also references Sec 4A of the LTC Model Act. Per the Model, Hybrid-LTC riders and policies would only qualify for reporting if the trigger for coverage is solely conditioned on the receipt of eligible long-term care. So, if a life policy provides accelerated death benefits, but those benefits can be received for other conditions in addition to LTC needs, it would not be included in MCAS.

As the data elements for hybrid products and stand-alone products are basically the same, with one exception, we will discuss them all together. However, they must be reported separately.



Before we move on to the main data elements, it's important to point out that if there is any question regarding data reporting methodology, you should follow the same methodology used to report on the Financial Annual Statement.

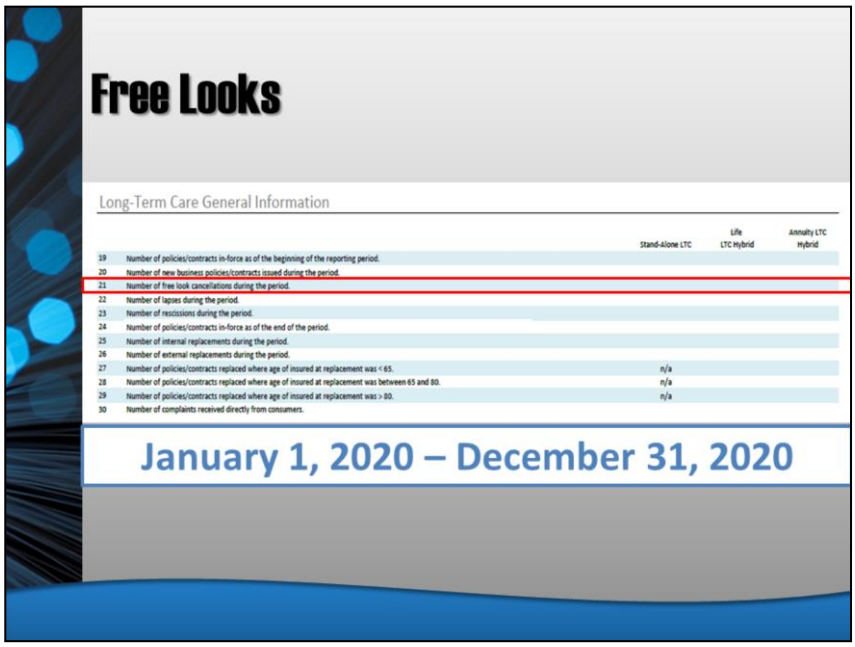


Now we're ready to discuss the Long-Term Care MCAS questions. The first questions are about policies issued during the period:

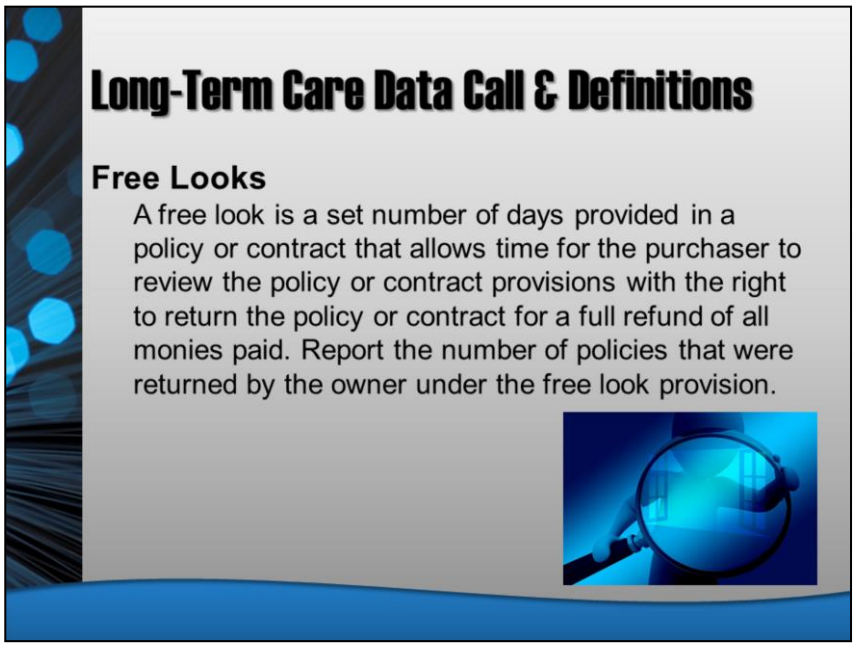
Both the Stand-Alone and Hybrid LTC schedules ask for the:

- total number of policies/contracts in-force at the beginning of the reporting period, and
- the total number of new business policies/contracts issued by the company during the period

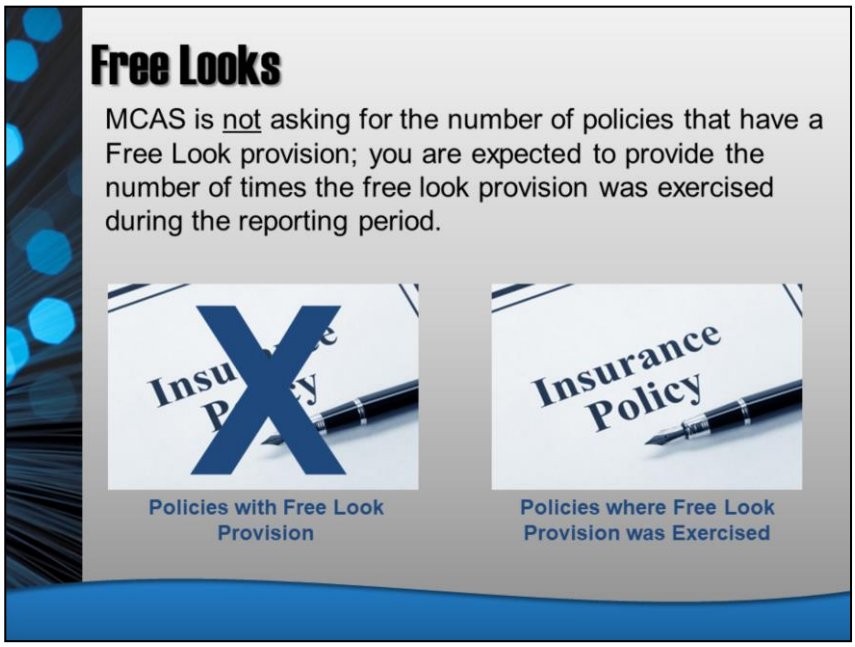
As mentioned before, the reporting period only includes those policies issued between January 1 and December 31. If a policy was applied for on December 31 of the reporting period, but not finally issued until the middle of January, do not count it.



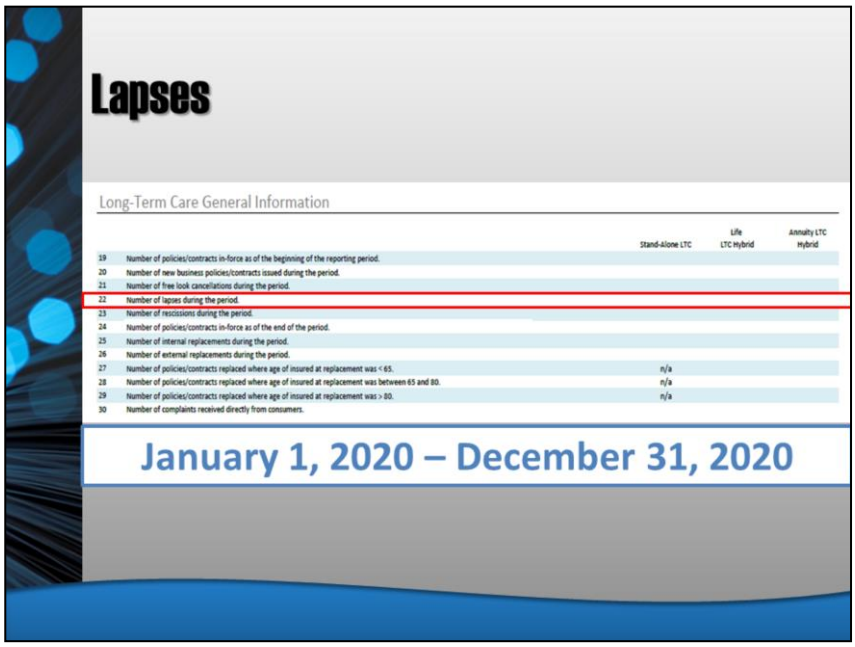
Next you are asked to report the number of free look cancellations during the period. Note that, regardless of when the policy was issued, you should include only those free looks that occurred during the reporting period.



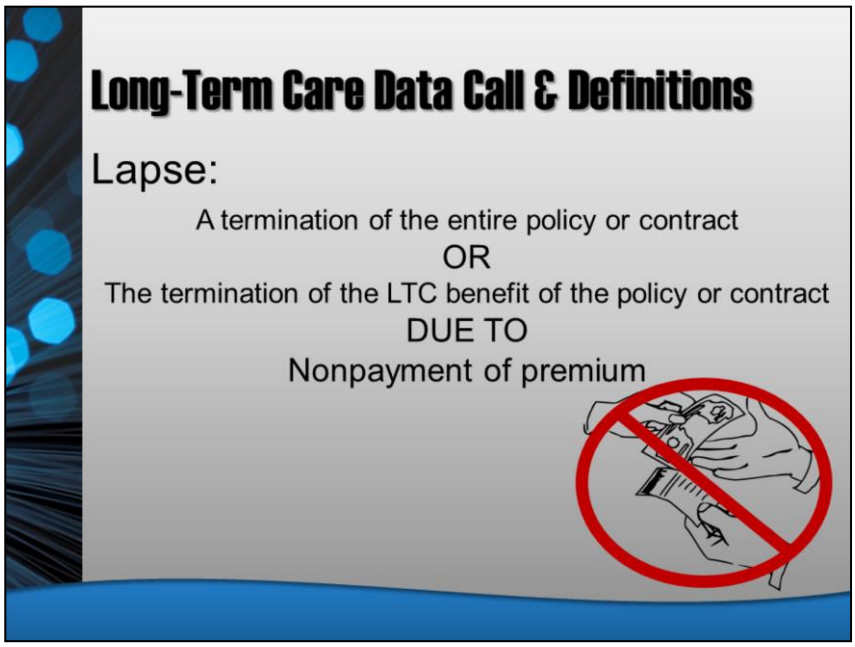
A free look is a set number of days provided in a policy or contract that allows time for the purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.



MCAS is **not** asking for the number of policies that have a Free Look provision; you are expected to provide the number of times the free look provision was exercised during the reporting period.

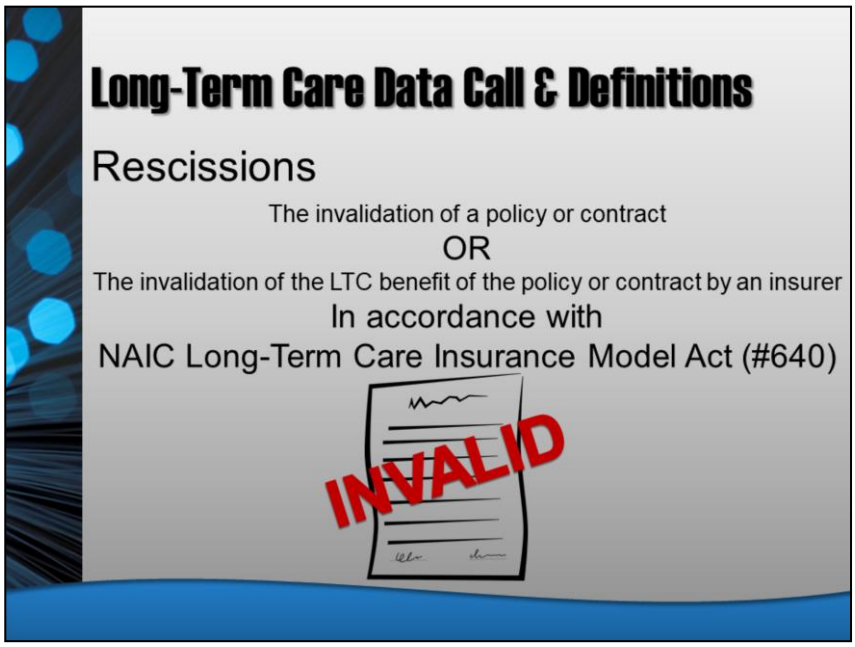


The next data element asks that you report the number of lapses during the period.

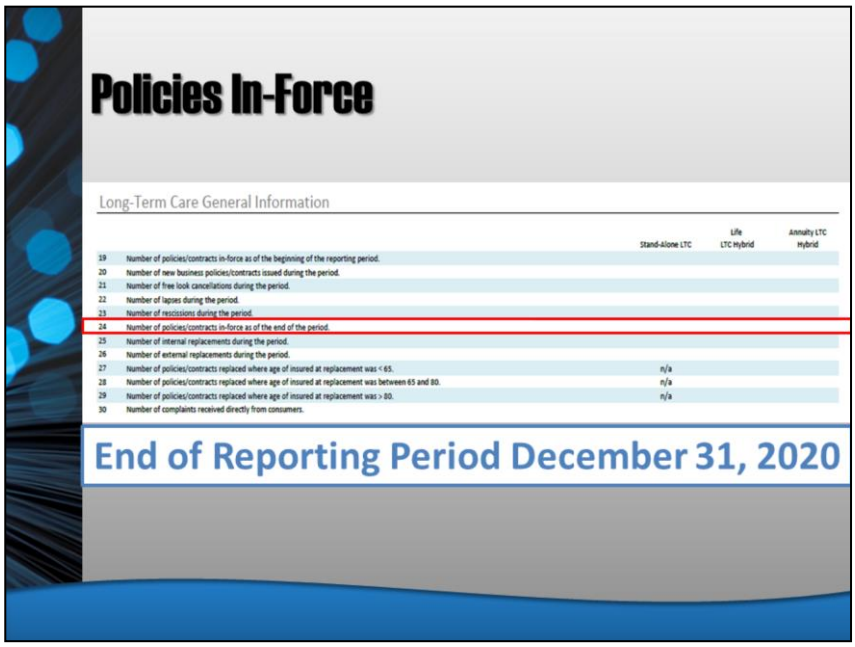


A lapse is the termination of the entire policy or contract or the termination of the LTC benefit of the policy or contract due to nonpayment of premium.

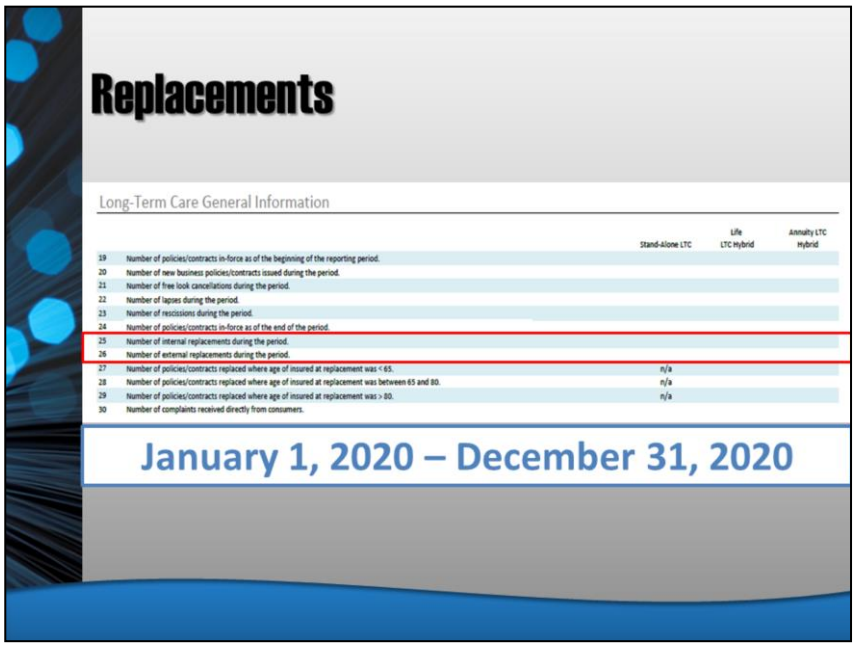
Then you are asked to report the number of rescissions during the period.



A rescission is the invalidation of a policy or contract or invalidation of the LTC coverage portion of a policy or contract by an insurer, in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640).



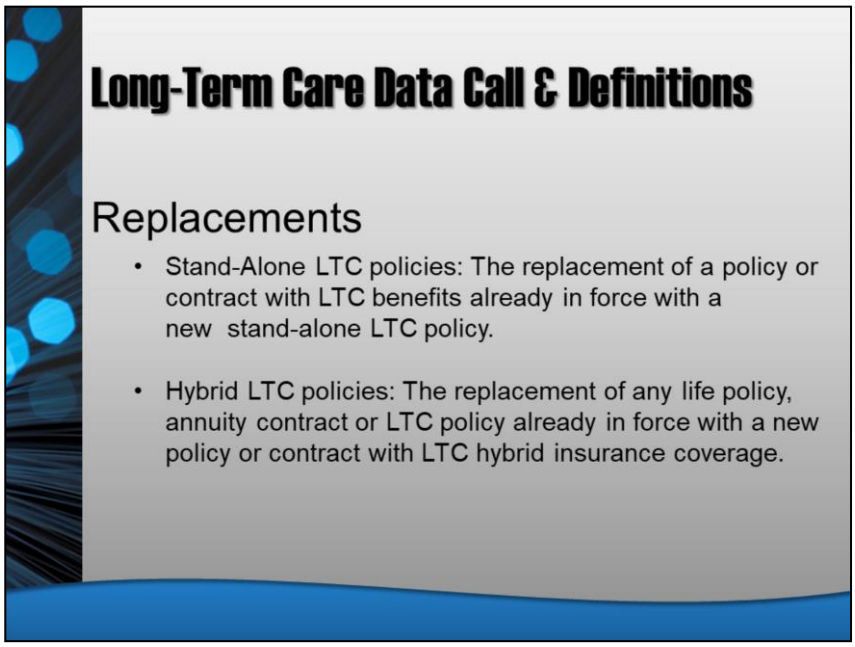
Next, you are asked to report the number of policies in-force at the end of the period. The number of policies in-force, is simply the number of in-force policies and contracts on the last day of the **reporting** period (which is December 31).



There is a series of questions addressing “replacement” activity during the reporting period. As we mentioned, the reporting period for the data year is January 1 through December 31. So, you would provide the number of replacements **issued** between January 1 and December 31.

For all products (Stand-Alone LTC, Life LTC Hybrid and Annuity LTC Hybrid) you are asked to provide the:

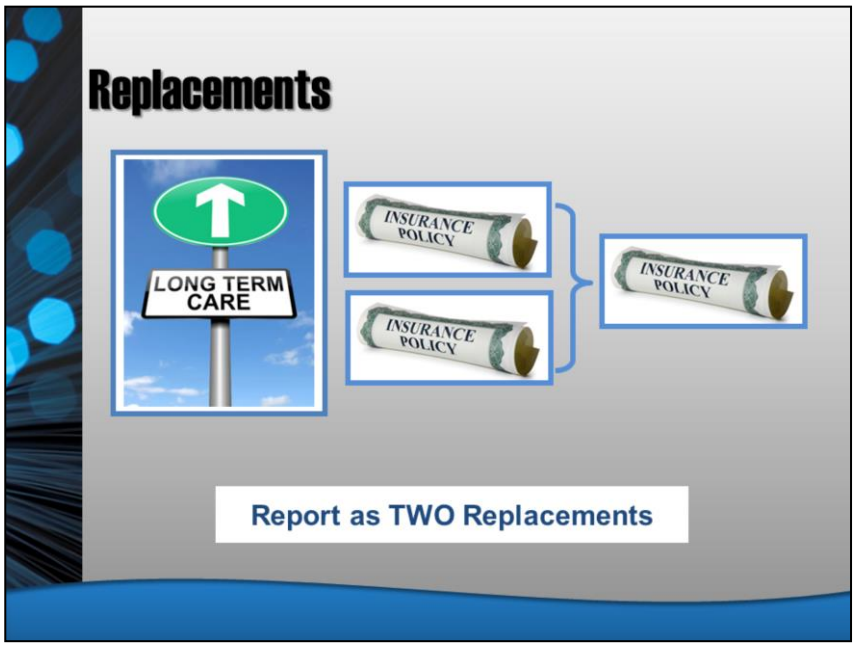
- Number of internal replacements issued during the period, and the
- Number of external replacements issued during the period.



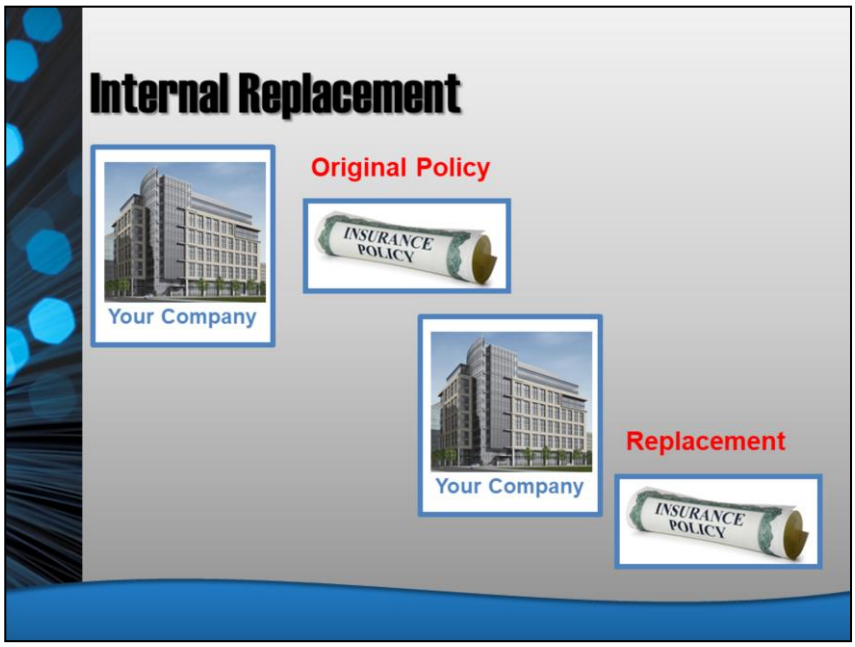
The definition of a replacement policy as stated in the Long-Term Care Data Call & Definitions for Stand-Alone LTC policies is the replacement of a policy or contract with LTC benefits already in force with a new LTC policy. (Please note that new LTC policy means a stand-alone LTC policy.)

The definition for Hybrid LTC policies is the replacement of any life policy, annuity contract (that is, any life or annuity policy whether or not it already has LTC coverage) or LTC policy already in force with a new policy or contract with LTC hybrid insurance coverage.

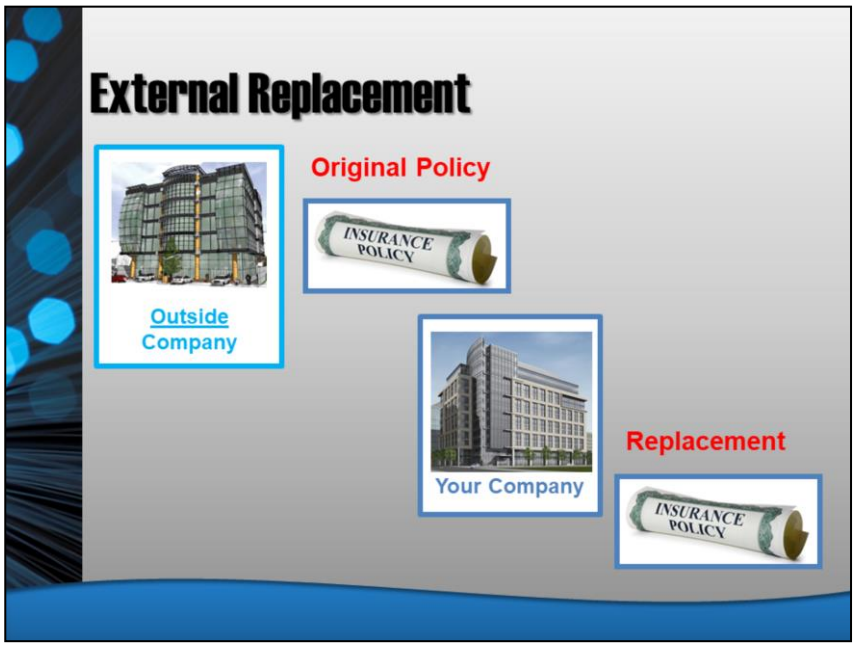
Remember that you should report the replacement according to what type of product the new policy is.



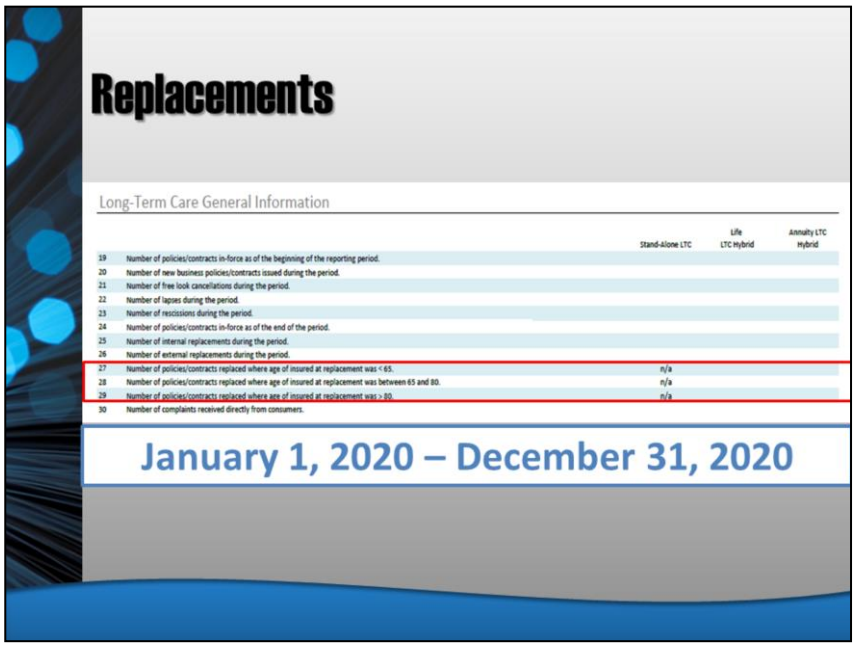
Note that if a person replaces two policies with one policy, this should be counted as two replacements.



An internal replacement is when the policy to be replaced was also issued by your company,



and an external replacement is when the policy to be replaced was issued by another company. The replacements reported **do not** include policies written by your company that are replaced by policies issued by another company.

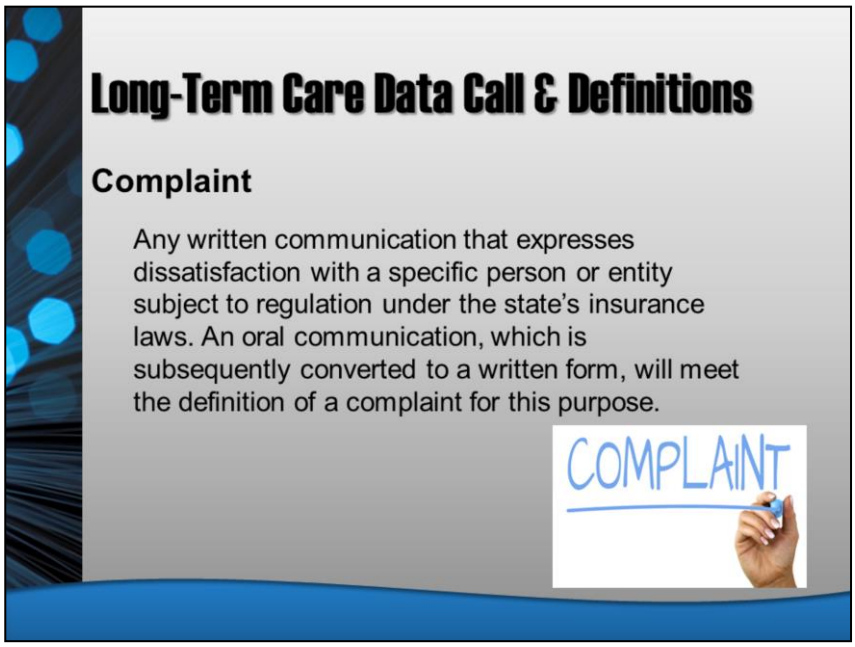


In addition, *ONLY* for the Life LTC Hybrid and Annuity LTC Hybrid products you are asked to provide

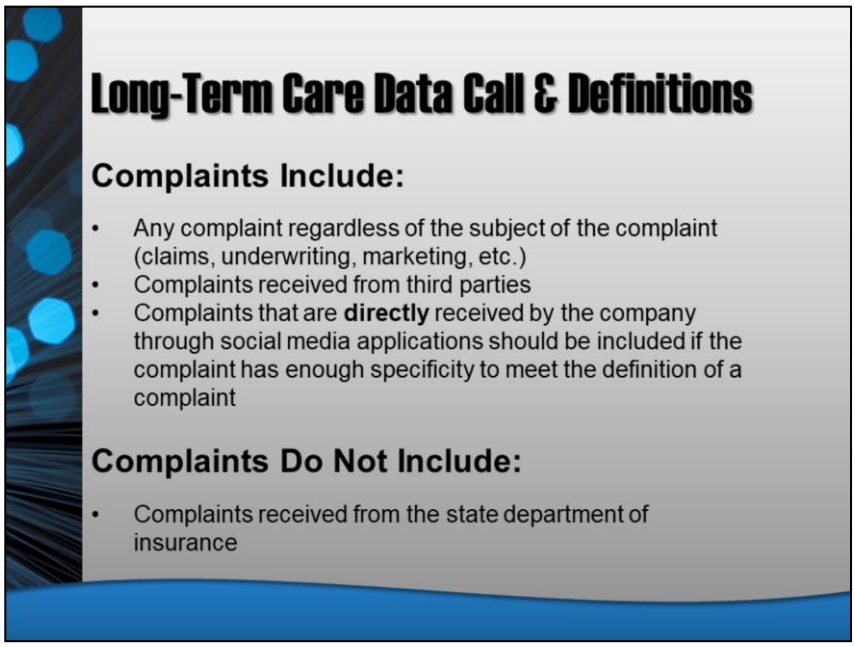
- The number of policies replaced where the age of insured at replacement was < 65 years old,
- The number of policies replaced where the age of insured at replacement was between 65 years old and 80 years old, and the
- Number of policies replaced where the age of insured at replacement was > 80 years old.

Please note that if more than one person is insured on the policy, you would use the age of the oldest insured.

The next question asks for the number of complaints received directly from consumers. Please note that complaints should be counted separately for Stand-Alone LTC, Life-Hybrid LTC, and Annuity-Hybrid LTC.

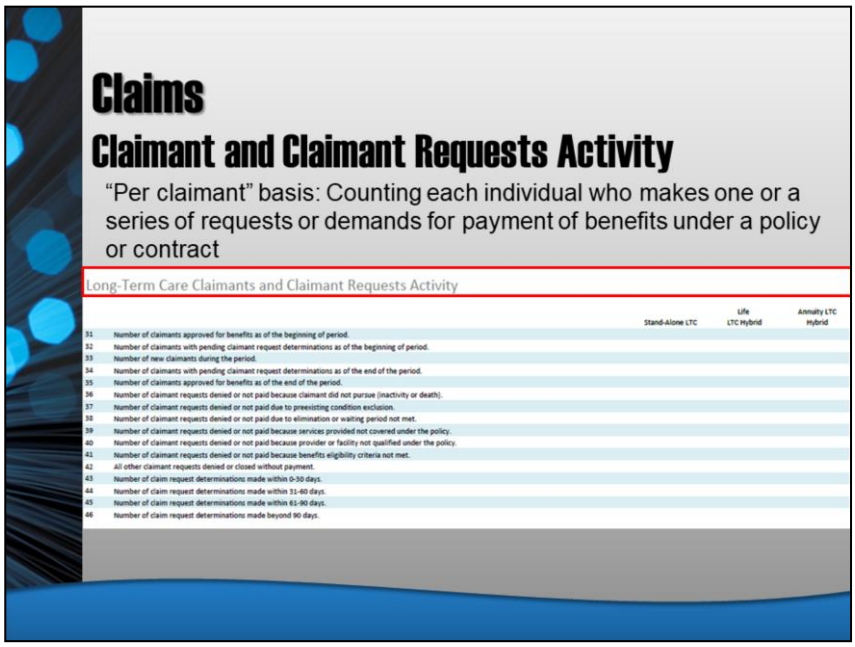


A complaint is defined as “Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.“

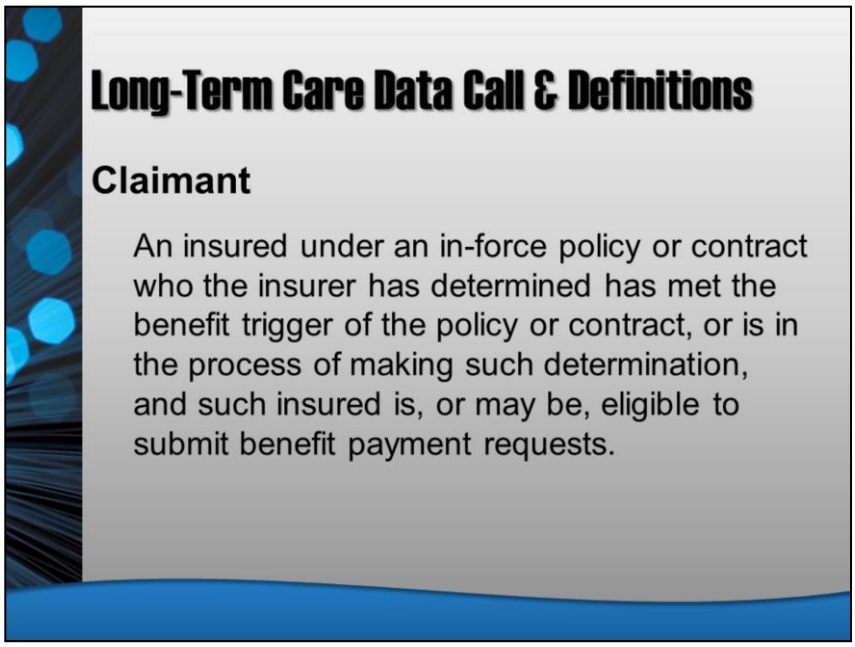


Complaints should be included in the complaint count regardless of the subject of the complaint. So, whether it is regarding claims, underwriting, marketing, or another area, it should be included. Complaints received from third parties also should be included. Complaints that are **directly** received by the company through social media applications should be included if the complaint has enough specificity to meet the definition of a complaint. Please note that this does not include complaints that have been received via the department of insurance.

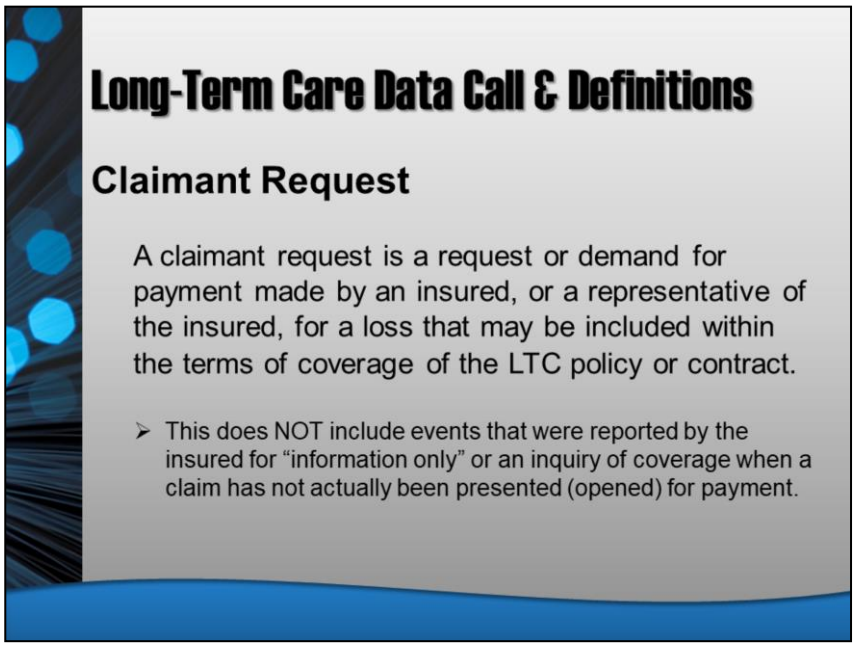
The next two sections in MCAS deal with the claims activity. Please note that there are different sections for reporting claimant and claimant requests vs benefit payment requests. These differences are explained in further detail for each section. It is important to remember to report the experience for those policies or contracts with LTC hybrid benefits and report experience only for the LTC benefit portion of the policy or contract. For example, if the insured on a life LTC hybrid policy dies, you would not report this as a claim on the LTC MCAS. You only report experience the LTC benefit portion of the LTC hybrid product.



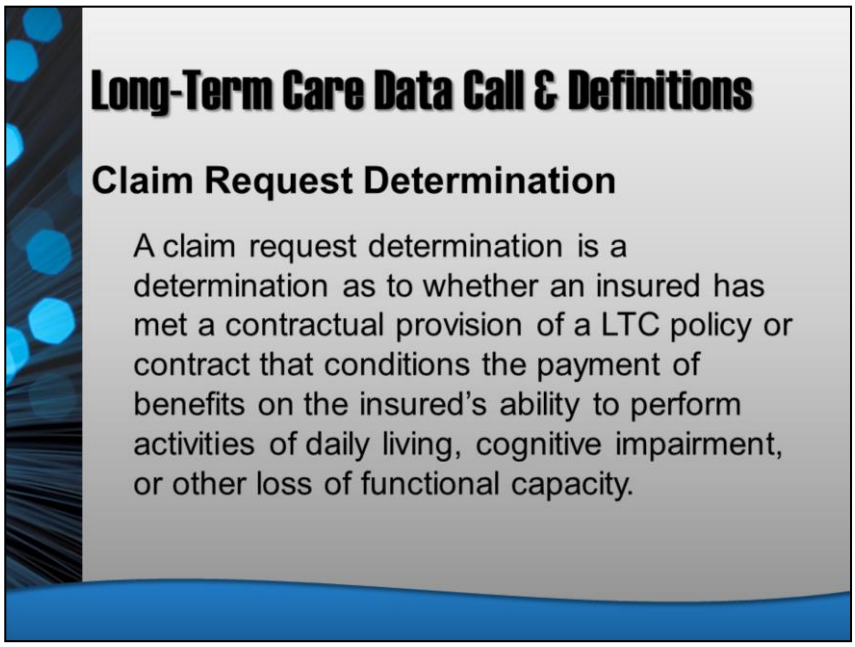
The first few questions deal with claimant requests and claimant request determinations. Reporting for this section is to be done on a "per claimant" basis which means that we are counting **each** individual who makes one or more requests for coverage under a policy or contract. It is ***NOT*** the actual benefit payment request. Those are reported in the Benefits section.



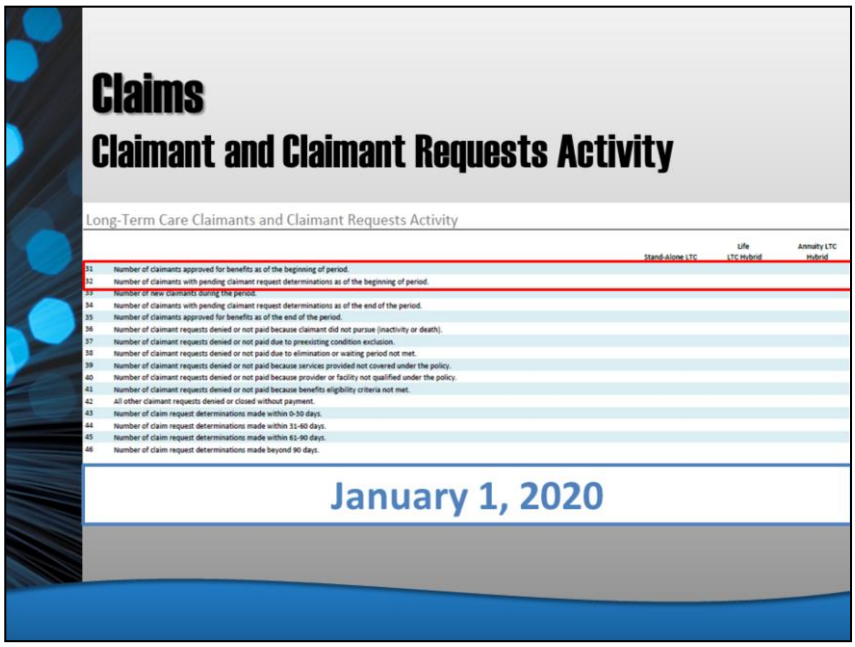
It may help to review the definition of claimant that is used in the MCAS LTC Data Call and Definitions. A claimant is an insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests.



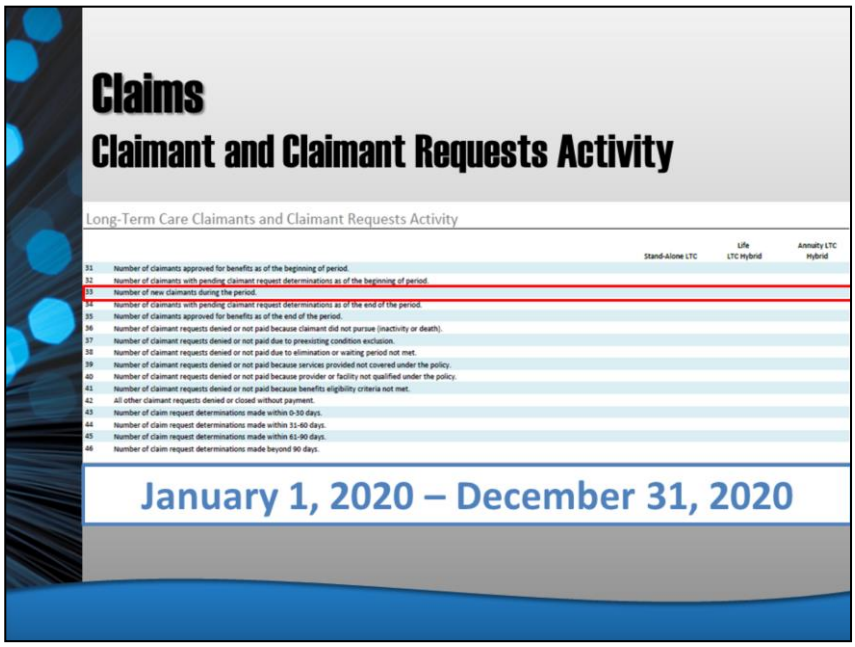
A claimant request is a request or demand for payment made by an insured, or a representative of the insured, for a loss that ***may*** be included within the terms of coverage of the LTC policy or contract. It does not, however, include events that were reported by the insured for "information only" or an inquiry of coverage when a claim has not actually been presented (opened) for payment.



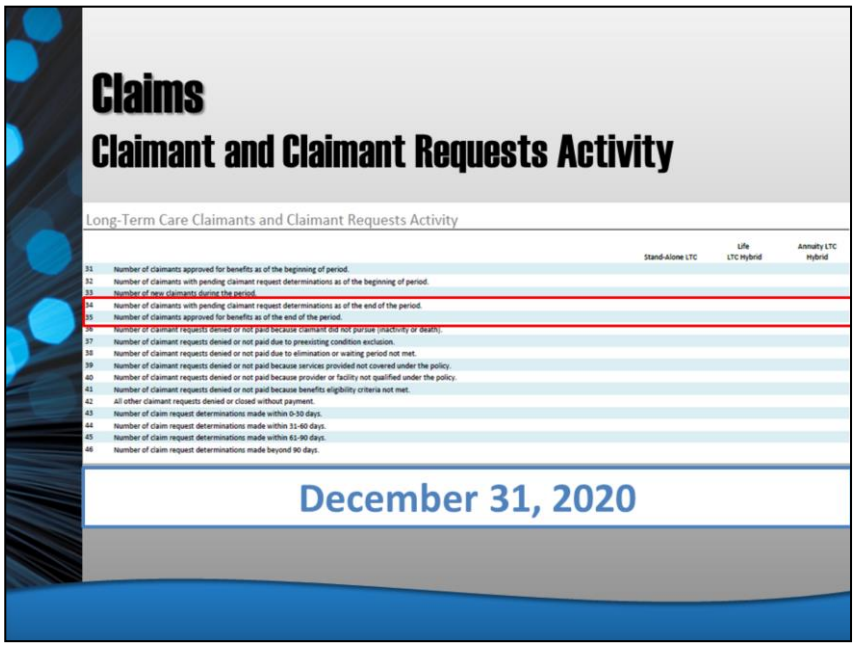
A claim request determination is a determination, by your company, as to whether an insured has met a contractual provision of a LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity.



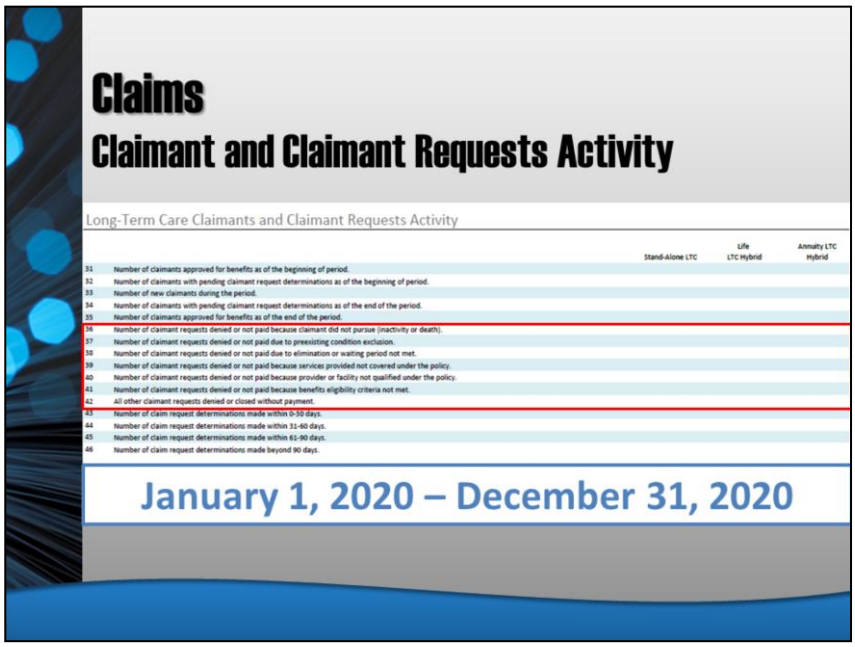
Now that we have defined these terms, there are varying types of data that we ask for regarding them. The first two questions are regarding what activity is pending as of the beginning of the reporting period (January 1st). The first question asks for the number of claimants approved for benefits as of the beginning of the period. The second asks for the number of claimants with pending claimant request determinations as of the beginning of the period.



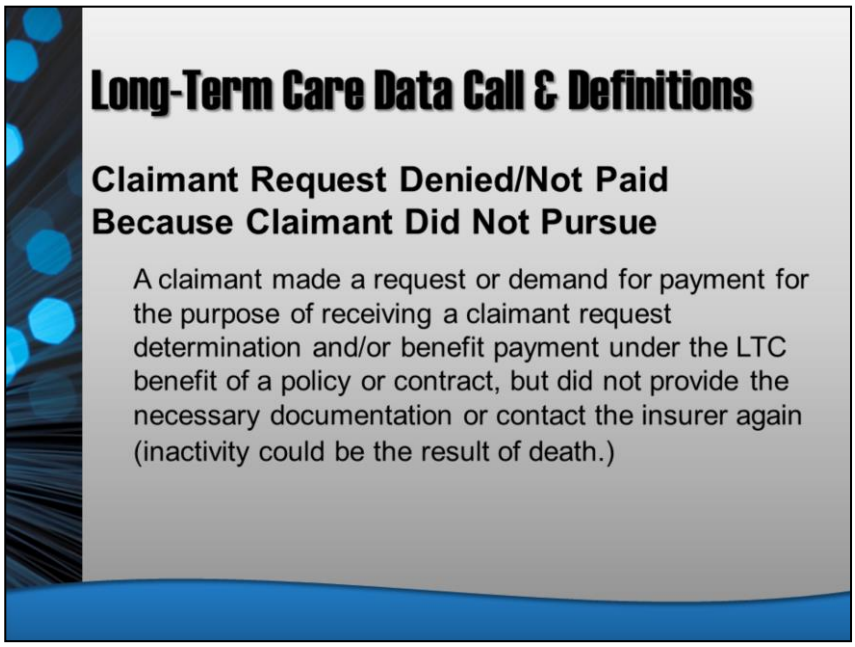
Next, we ask how many new claimants there are during the period. Please note that if a claim is re-opened, report the claim as new.



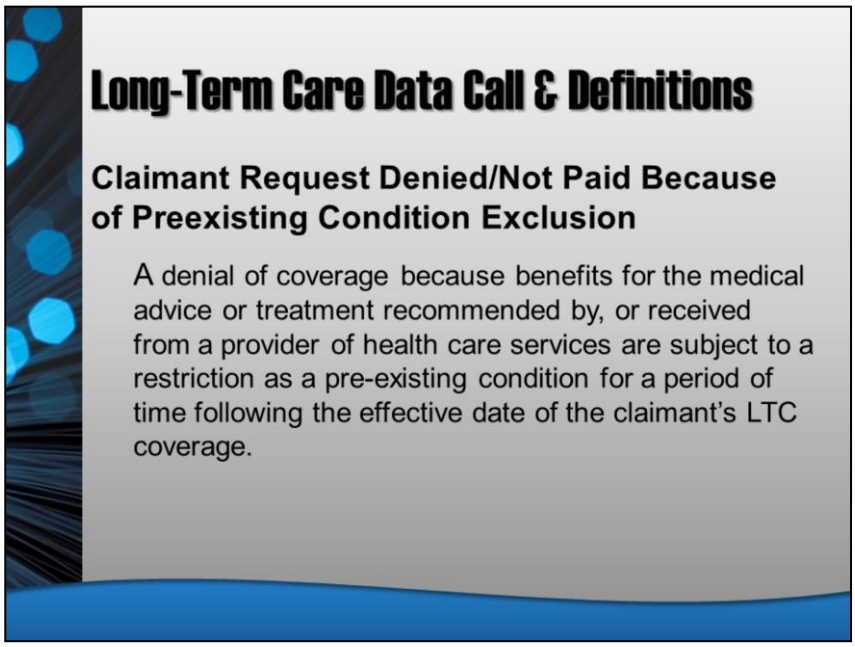
The next two questions are very similar to the first two in this section. However, these are regarding what activity is pending as of the **end** of the reporting period (December 31st). The first question asks for the number of claimants approved for benefits as of the end of the period. The second asks for the number of claimants with pending claimant request determinations as of the end of the period.



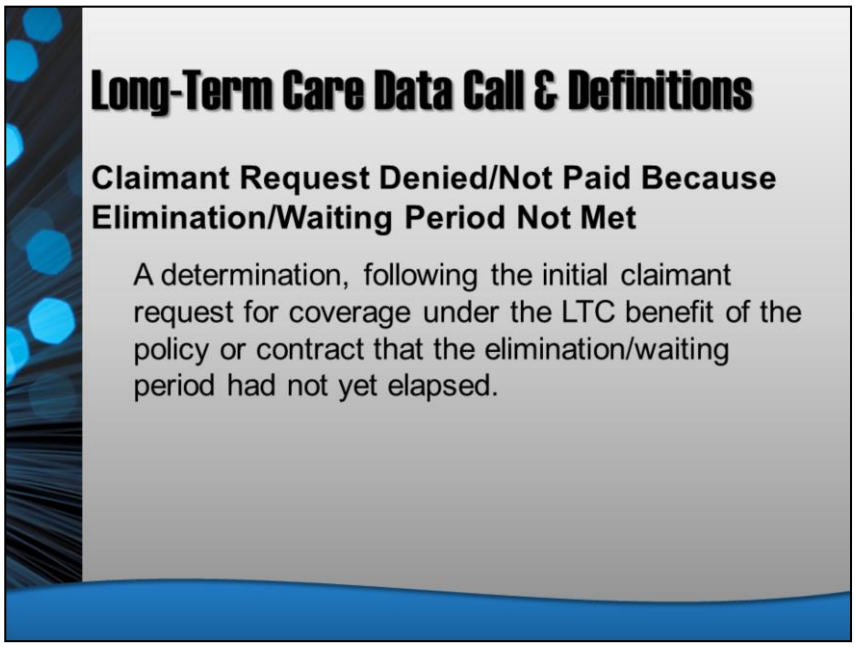
The next section of questions, in MCAS, deal with reasons that claimant requests could be denied. There are six reasons to choose from, and one “all other” category. We will quickly cover the reasons in the next few slides. Please note that if a denial could be reported under more than one of the categories, you should report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant’s request was denied, the denial should ***NOT*** be counted more than once.



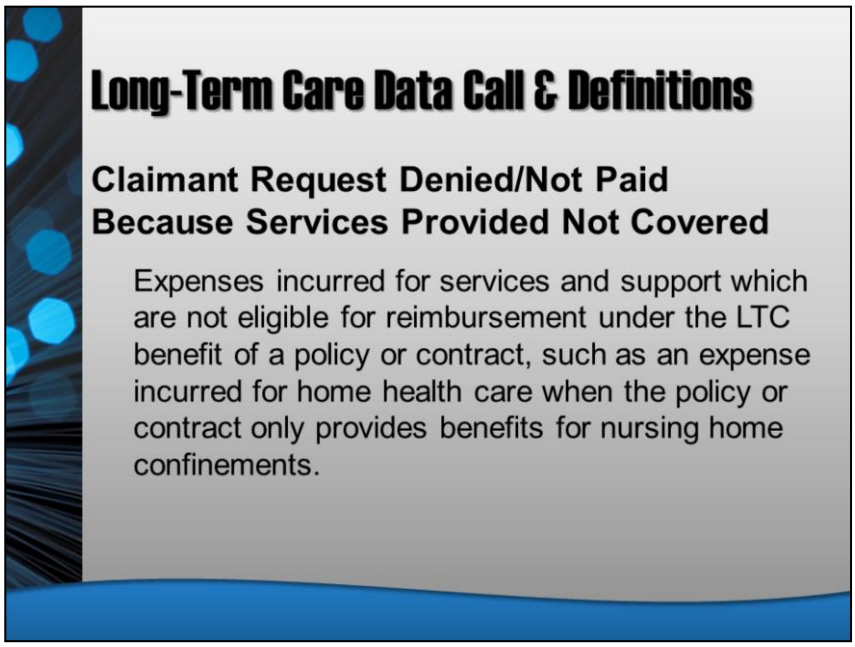
Claimant Request Denied/Not Paid Because Claimant Did Not Pursue—this would be if a claimant made a request or demand for payment for the purpose of receiving a claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again.



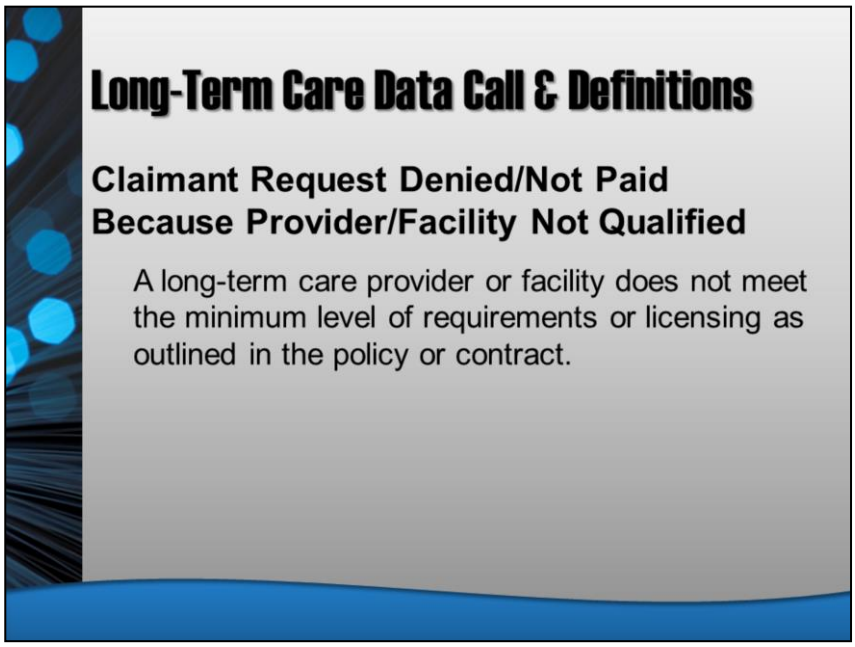
Claimant Request Denied/Not Paid Because of Preexisting Condition Exclusion—this is a denial of coverage if the benefits are subject to a restriction as a pre-existing condition.



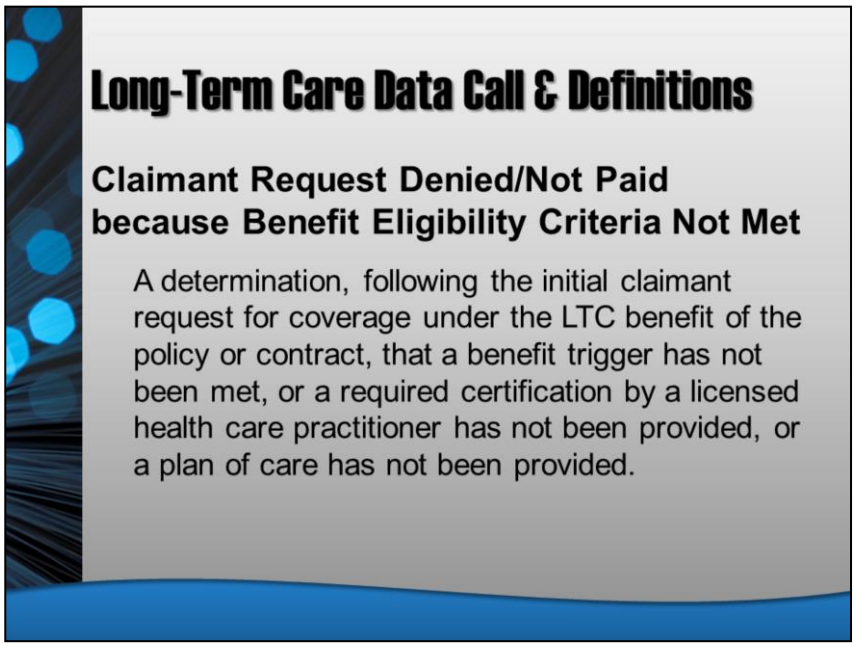
Claimant Request Denied/Not Paid Because Elimination/Waiting Period Not Met—this would be used if the elimination or waiting period had not yet elapsed.



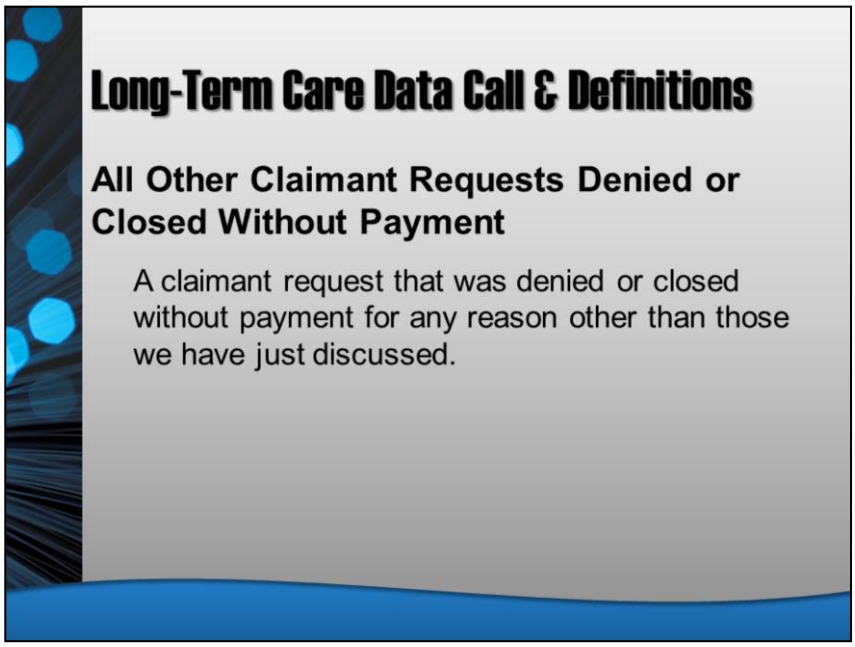
Claimant Request Denied/Not Paid Because Services Provided Not Covered—this would be chosen if the expenses incurred for services and support are not eligible for reimbursement under the LTC benefit of a policy or contract.



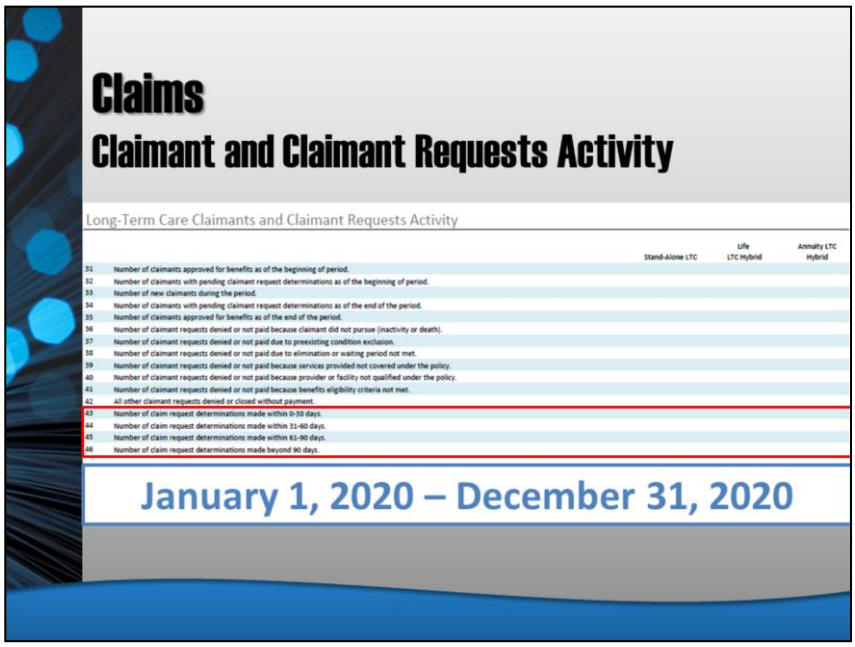
Claimant Request Denied/Not Paid Because Provider/Facility Not Qualified—this is for denials because the long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract.



Claimant Request Denied/Not Paid because Benefit Eligibility Criteria Not Met—This is used if it is determined that the initial claimant request for coverage fails to meet any of the eligibility criteria or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided.

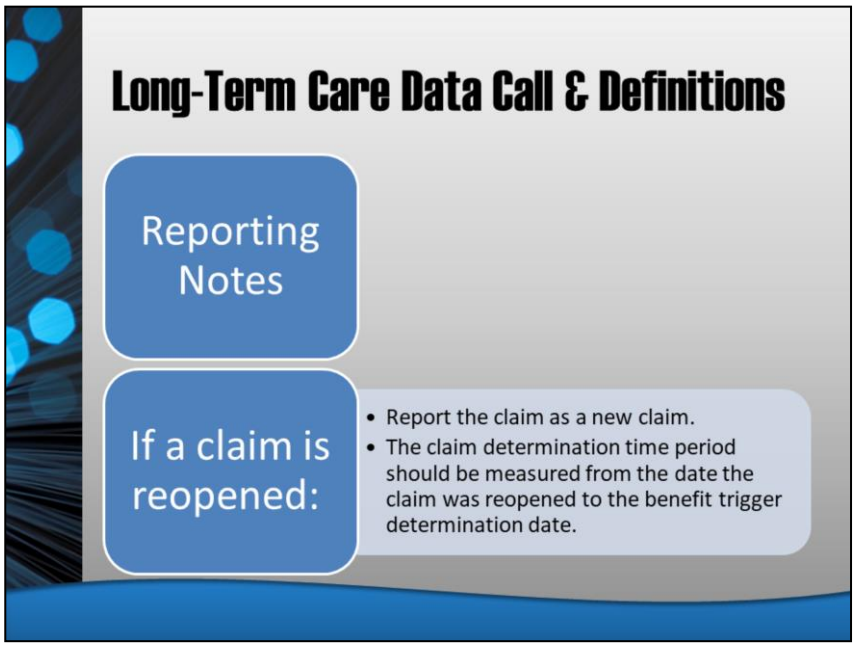


All Other Claimant Requests Denied or Closed Without Payment—this is a claimant request that was denied or closed without payment for any reason other than those specifically listed.

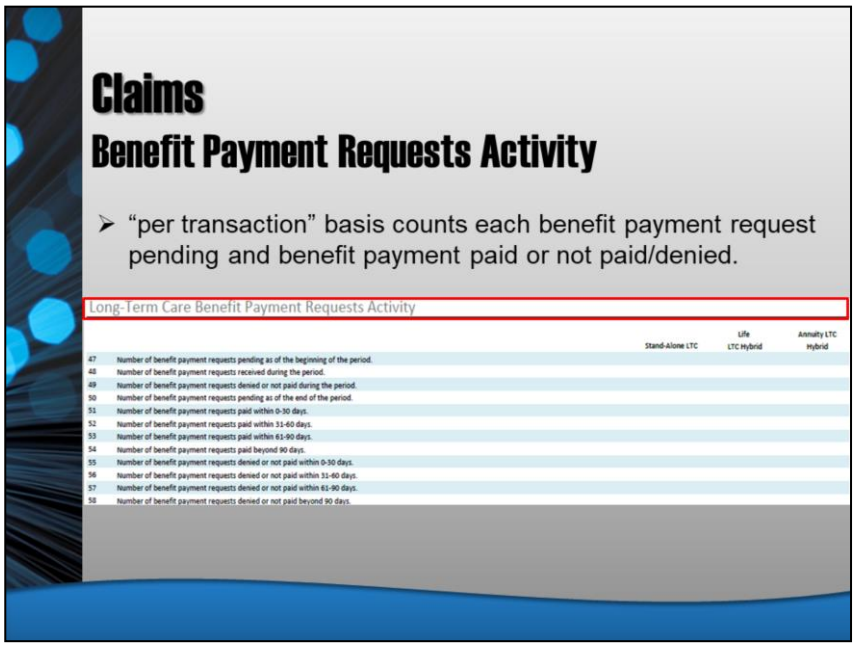


The next questions refer to the length of time that it took for a claim request determination to be made. To review, a claim request determination is a determination as to whether an insured has met a contractual provision of an LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity.

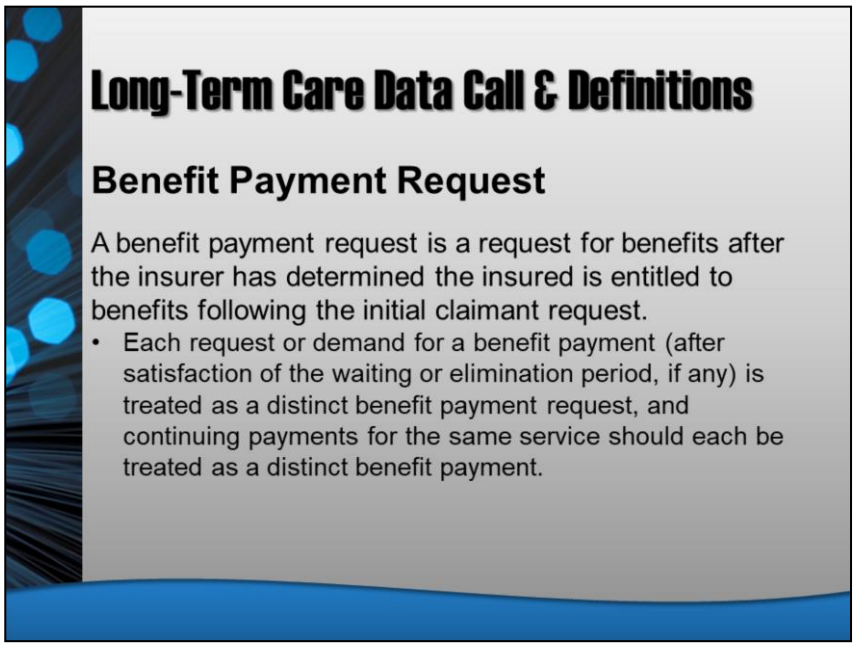
For purposes of the MCAS, the term applies to the initial claimant request, and captures the period of time from the notice of claim to the claimant request determination date. For claimant requests that are denied or not paid, you should report the period of time from the date of notice of claim to the date the claimant was ***notified*** of the determination to deny or not pay the claim. These are broken out into time frames from 0-30 days, from 31-60 days, from 61-90 days and those beyond 90 days.



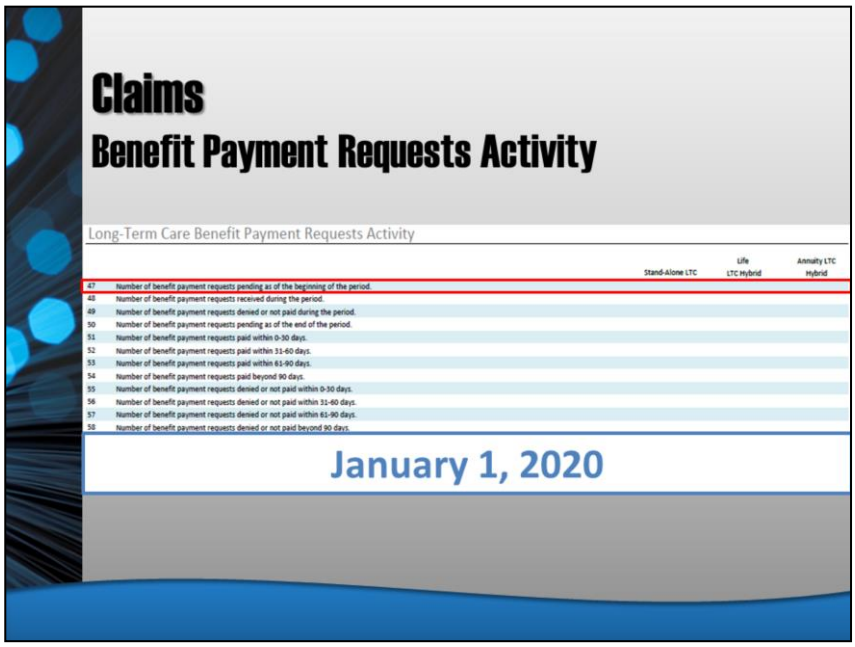
If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.



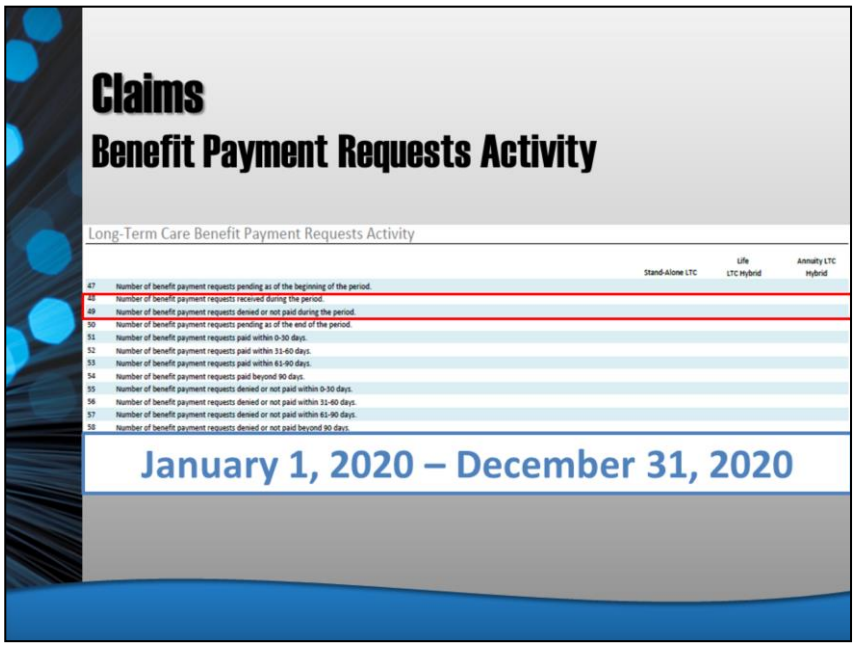
The next section in MCAS deals with benefit payment requests activity. This is to be done on a "per transaction" basis (that is, you count each benefit payment request pending and benefit payment paid or not paid (or denied.)



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. These are broken out into groupings of information requested.

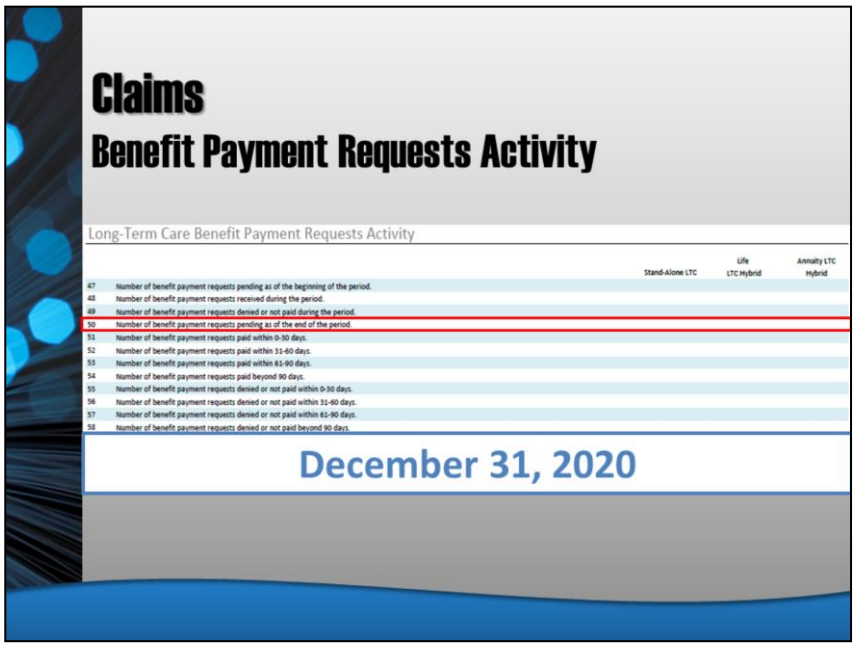


Benefit payment requests pending as of the beginning of the reporting period – those requests that are pending as of January 1st.

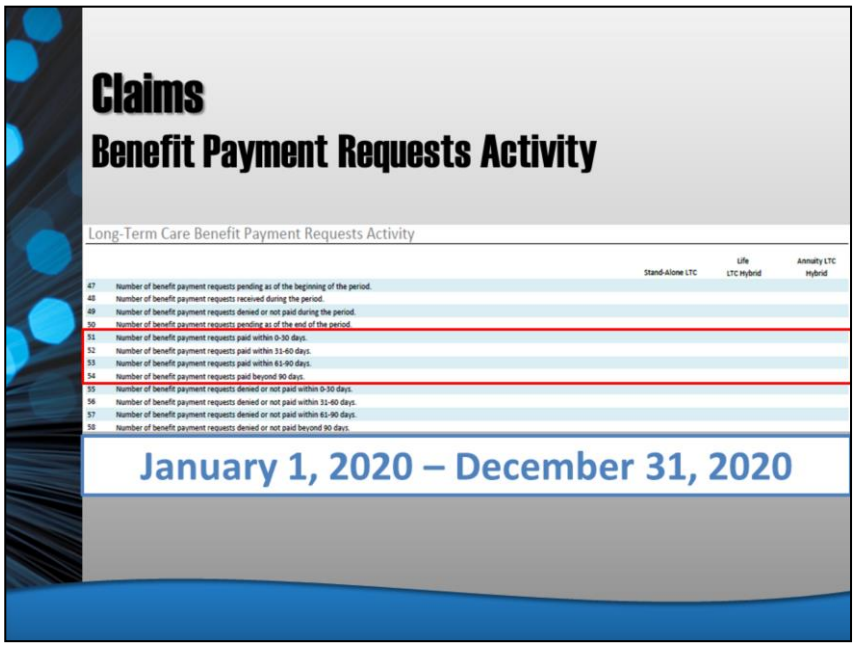


Benefit payment requests received during the period – those requests that were received at any point during the reporting period.

Benefit payment requests that were denied or not paid during the reporting period for any reason.

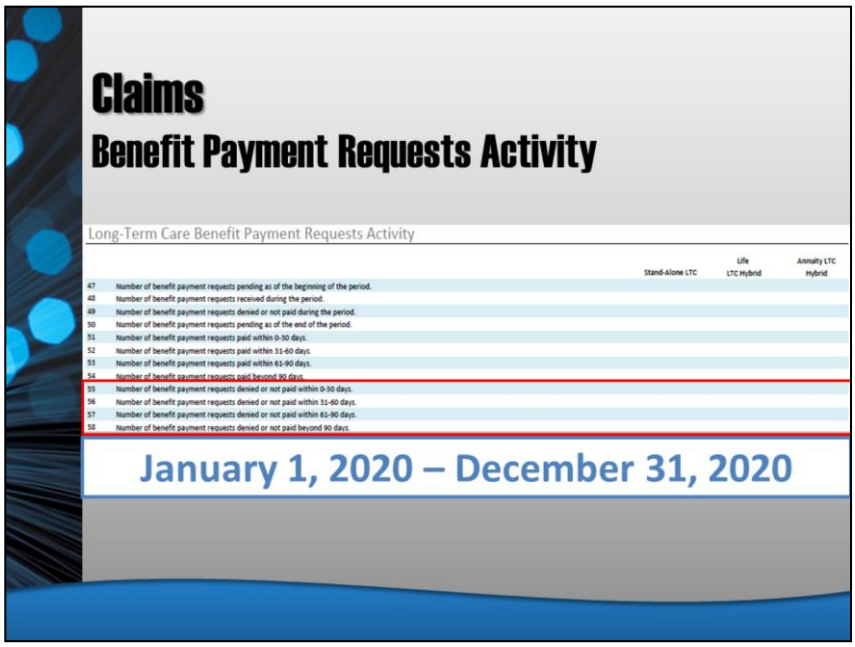


and benefit payment requests that are still pending as of the end of the reporting period – those requests that are still pending on December 31st.



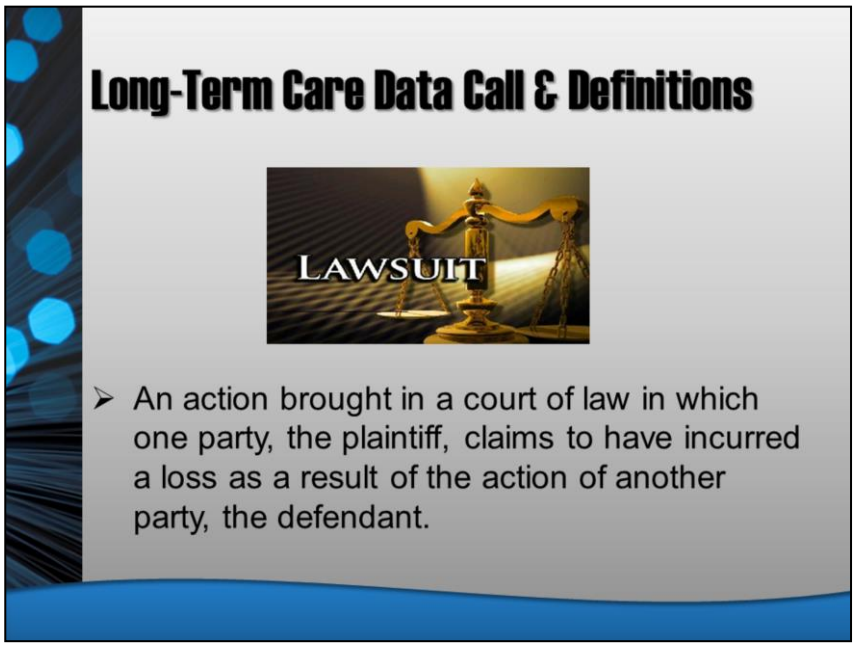
Lastly, this section asks for the time frames during which benefit payment requests were paid or denied (or not paid.)

Benefit payment requests that were **paid** during the period are broken out into time frames from 0-30 days, from 31-60 days, from 61-90 days and those beyond 90 days.

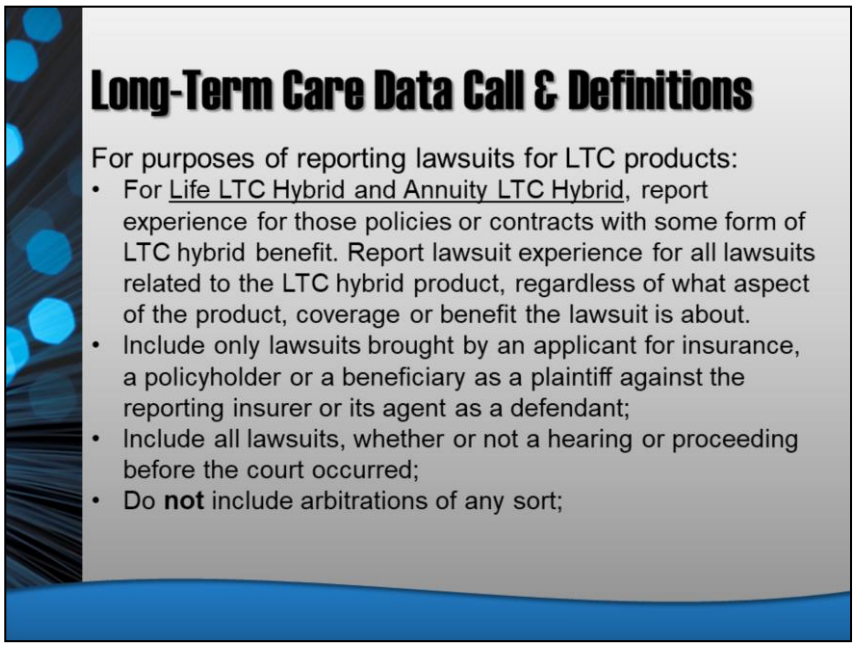


Those benefit payment requests that were denied or not paid are also broken out into time frames from 0-30 days, from 31-60 days, from 61-90 days and those beyond 90 days.

The final section of the LTC MCAS relates to Lawsuit Activity. There are some specifics you will need to know regarding the way lawsuits are defined.



A **lawsuit** is an action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.



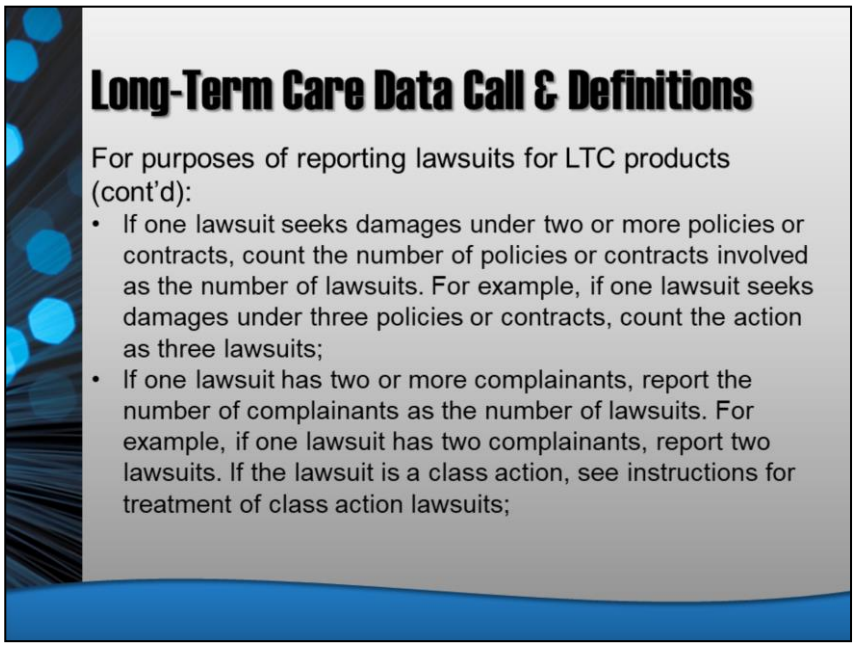
For purposes of reporting lawsuits for LTC products:

For Life LTC Hybrid and Annuity LTC Hybrid, you report lawsuit experience for all lawsuits related to the LTC-hybrid product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.

You would only include lawsuits brought by an applicant for insurance, a policyholder or a beneficiary.

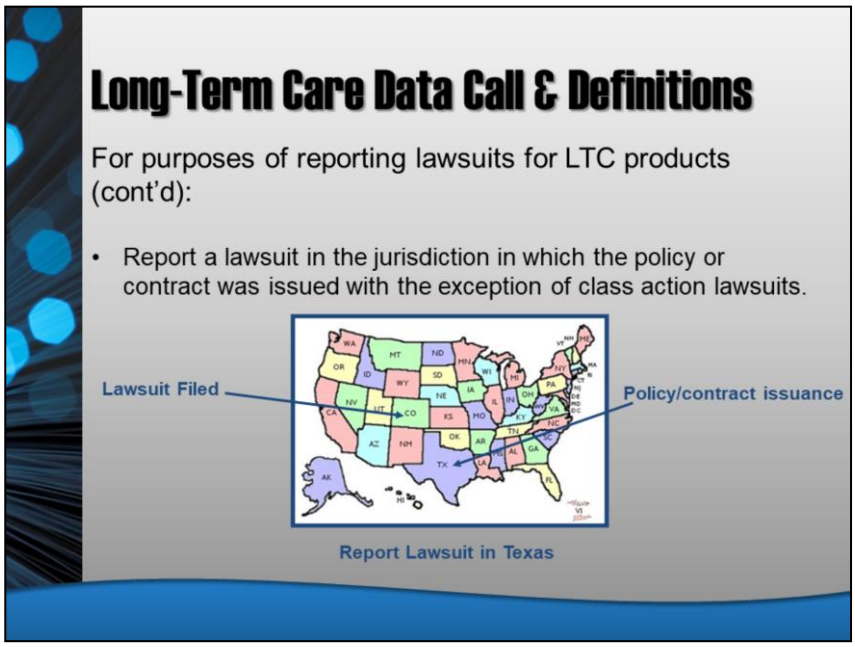
And you would include all lawsuits, whether or not a hearing or proceeding before the court occurred.

But you would not include arbitrations.

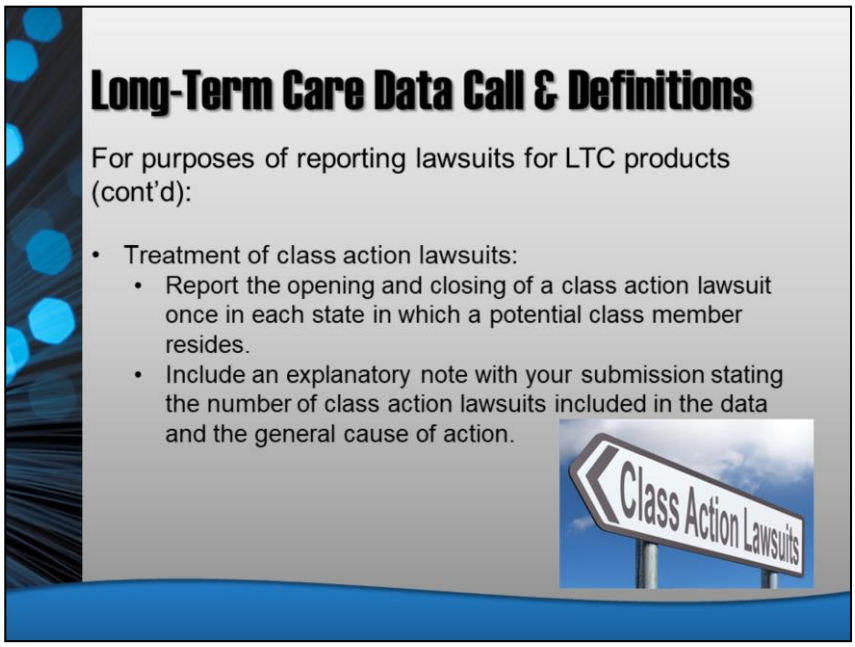


If one lawsuit seeks damages under two or more policies or contracts, you would count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits.

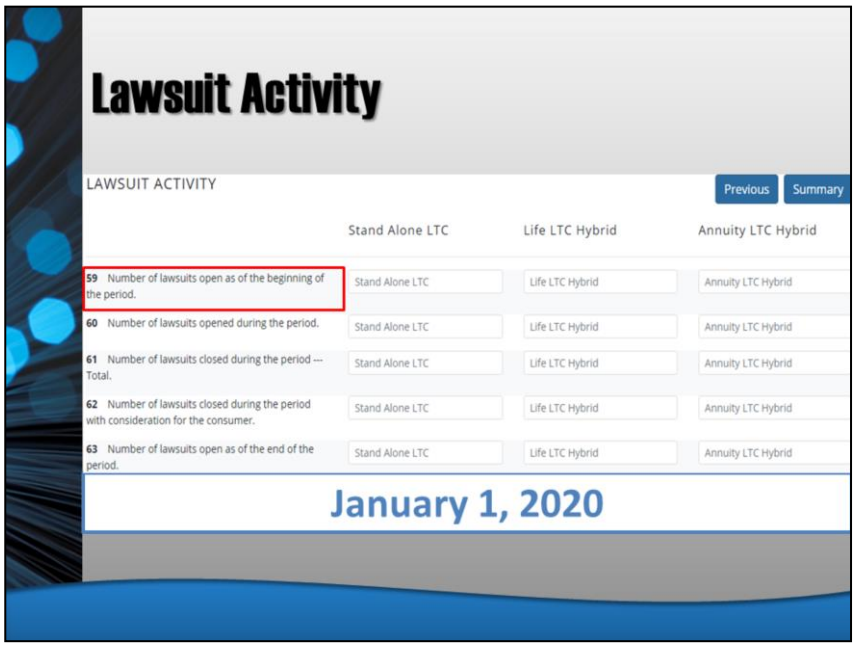
And, if one lawsuit has two or more complainants, you would report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits.



Finally, you should report a lawsuit in the jurisdiction in which the policy or contract was issued.

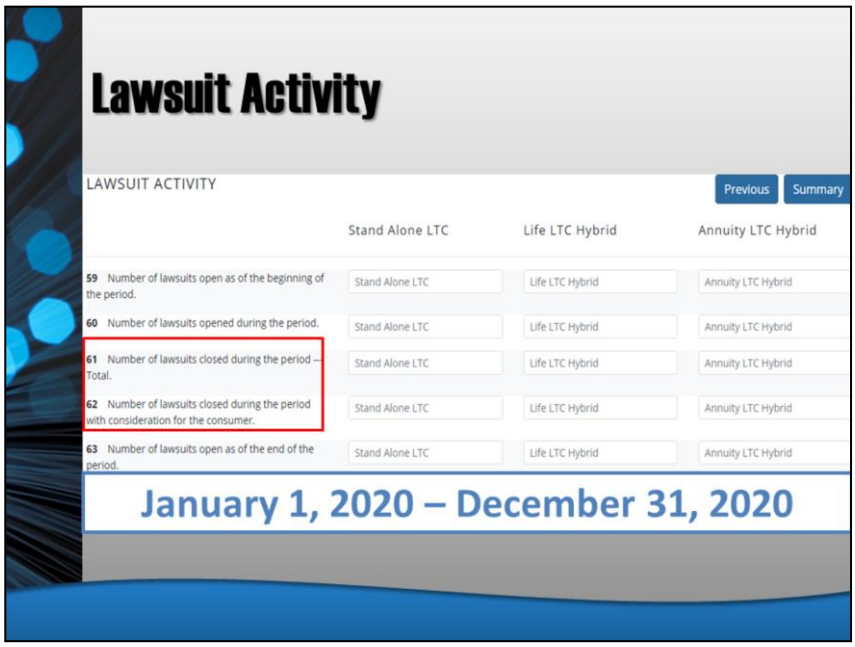


Regarding the treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.



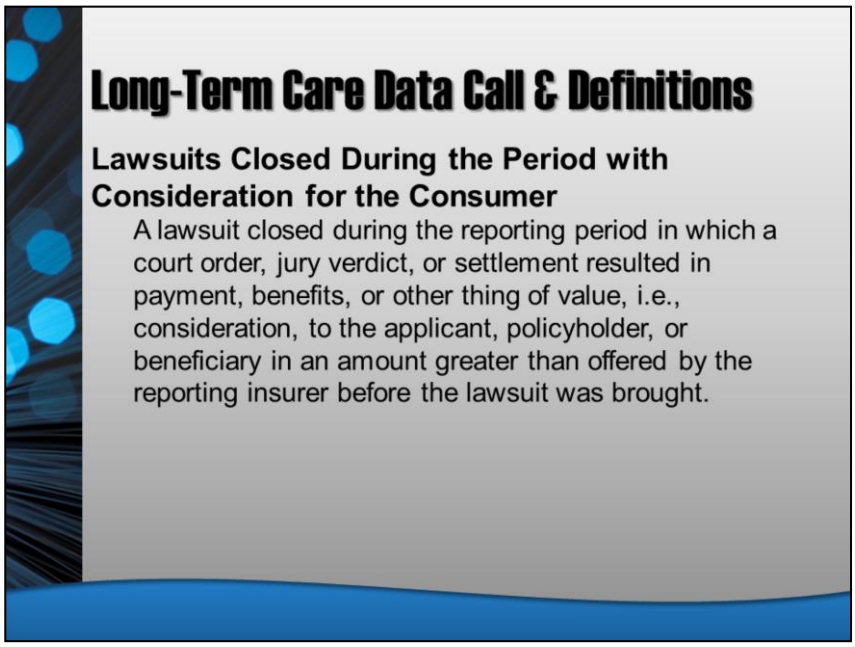
The information requested regarding lawsuits includes the number of lawsuits open at the beginning of the reporting period (January 1st),

The number of lawsuits opened during the reporting period,



The total number of lawsuits closed during the reporting period (That is, all lawsuits).

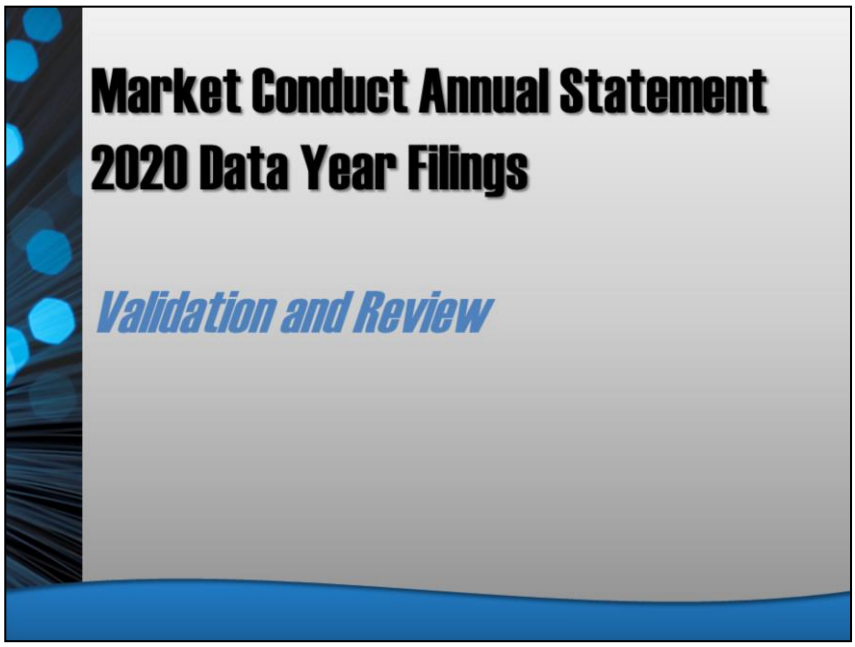
The number of lawsuits closed during the period with consideration for the consumer



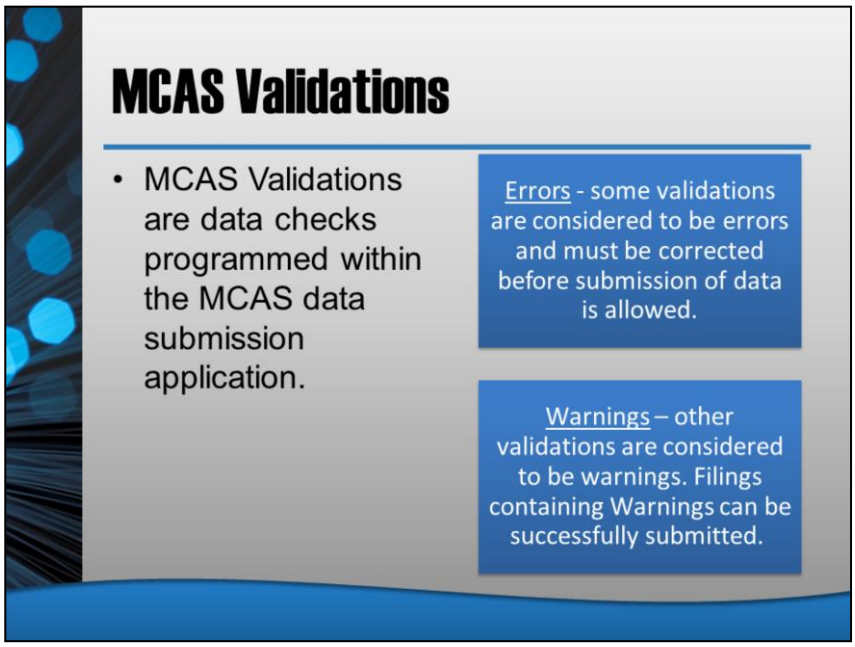
The definition of **Lawsuits Closed During the Period with Consideration for the Consumer** is defined as a lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

And lastly, the number of lawsuits open at the end of the reporting period (December 31st).

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

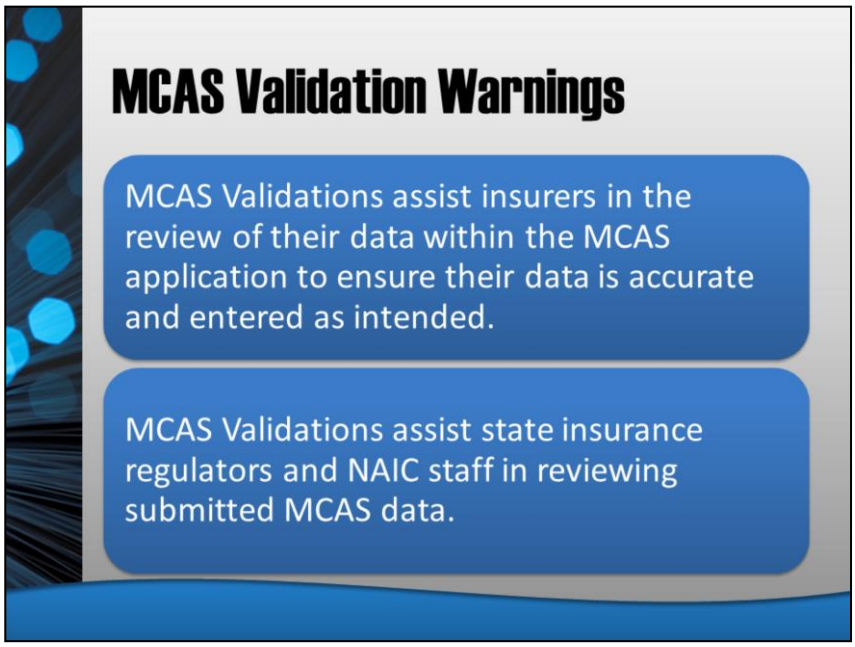


MCAS Validation and Review



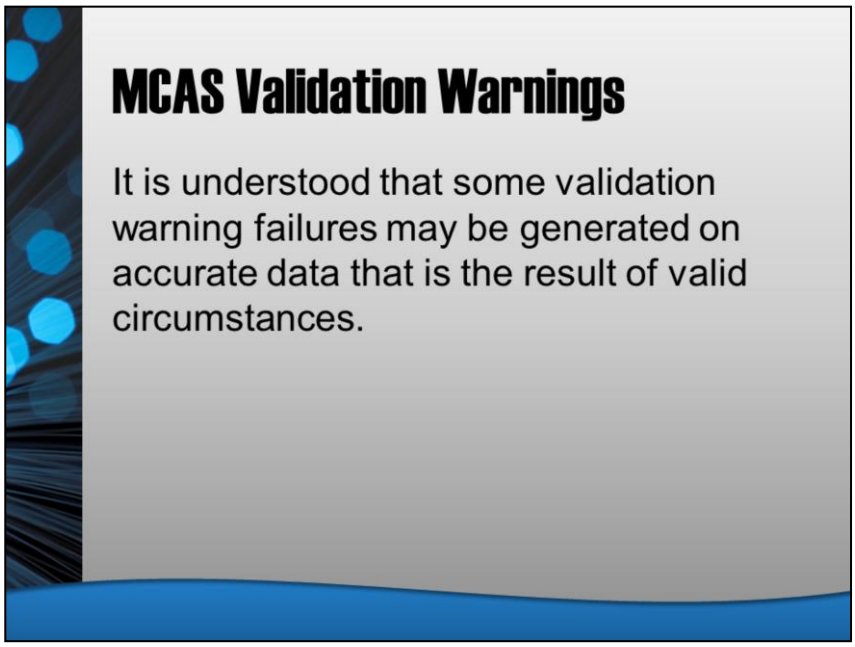
MCAS Validations are data checks programmed within the MCAS data submission application.

- 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.

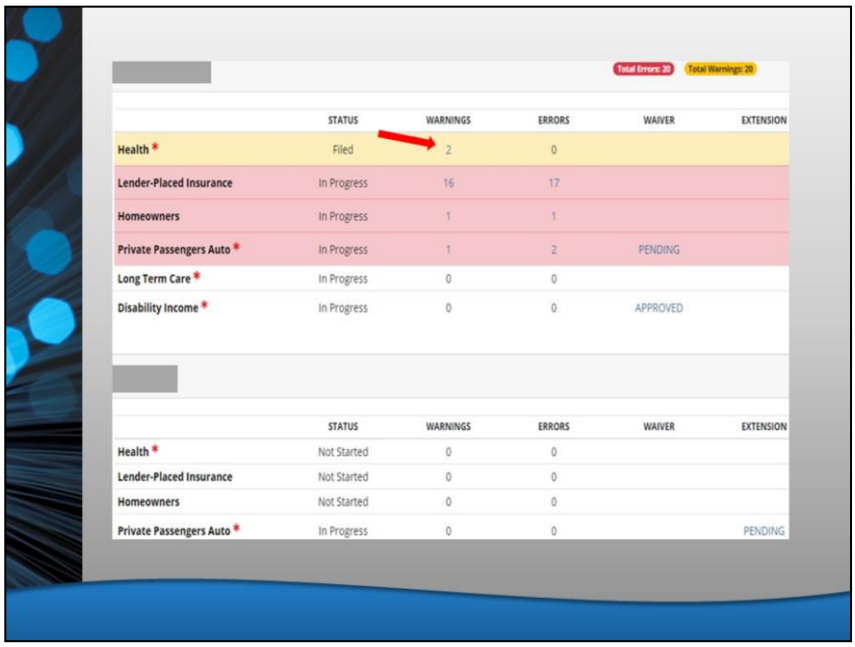


MCAS Validations have multiple purposes.

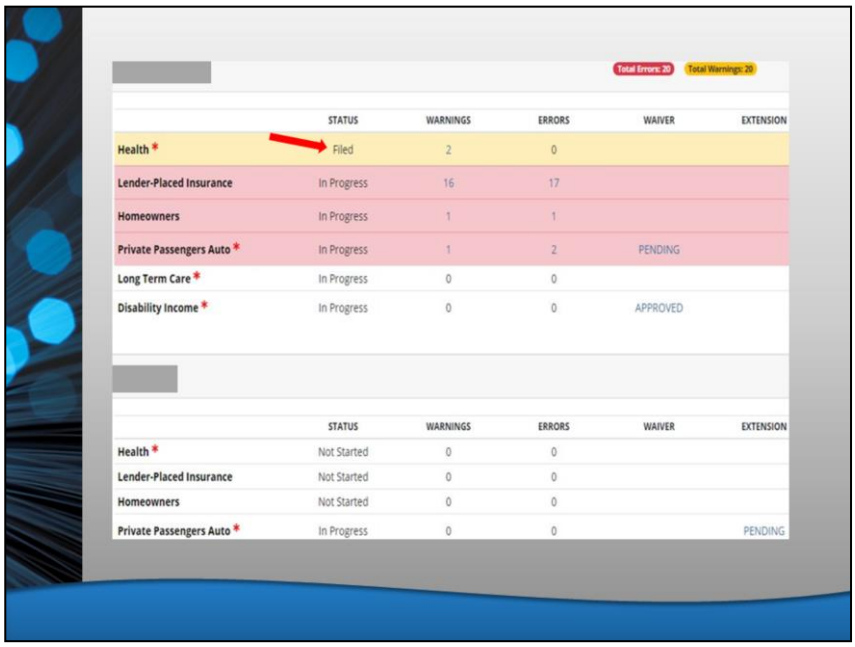
- They assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended. For example: the validations can point out data issues that are a result of data entry errors or coding errors,
- And they assist state insurance regulators and NAIC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



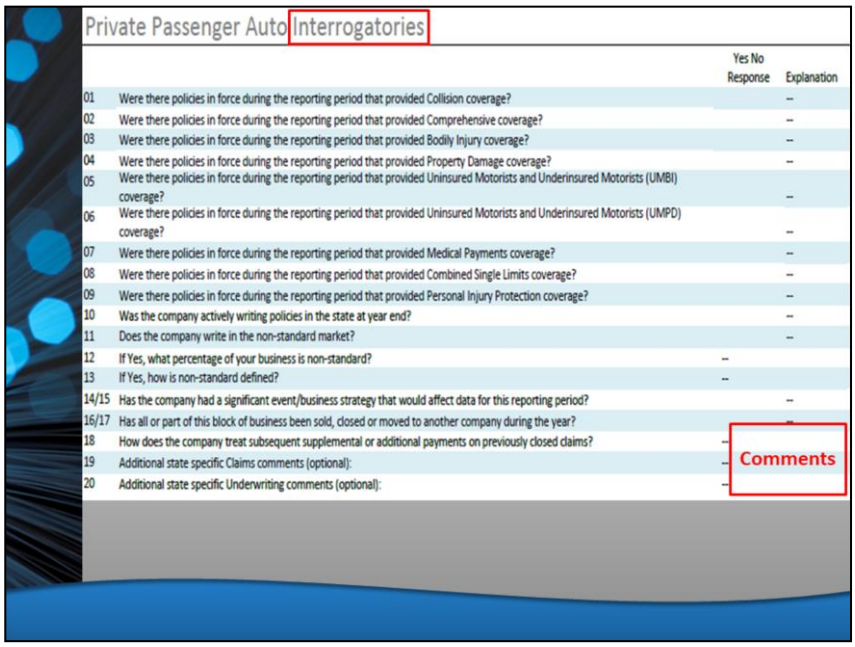
It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances; for example, companies with small amounts of business to report, or runoff business to report may trigger validation warning failures that are not concerning.



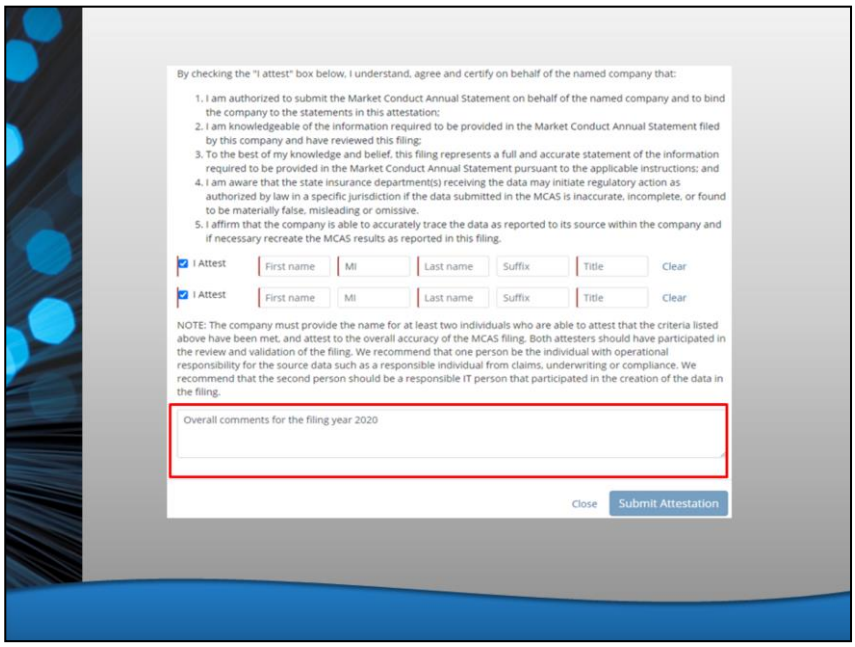
The MCAS system filing matrix provides the MCAS user with information regarding their filings. The filing matrix displays the number of warnings found in submitted or started filings. Before a company submits each filing containing warnings, they are prompted to add comments regarding any outstanding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



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.

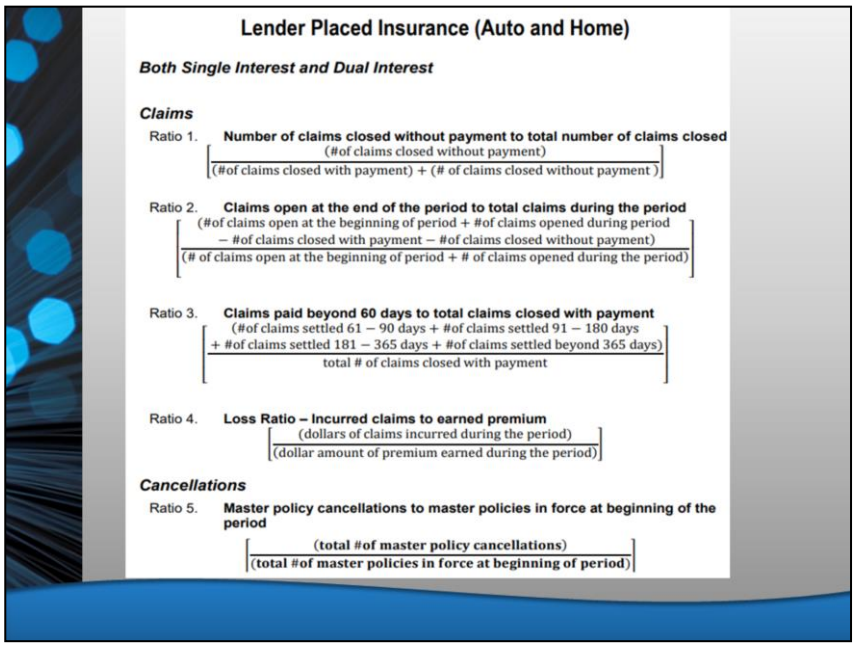


As NAIC analysts review company filings, they view comments found in the interrogatories,



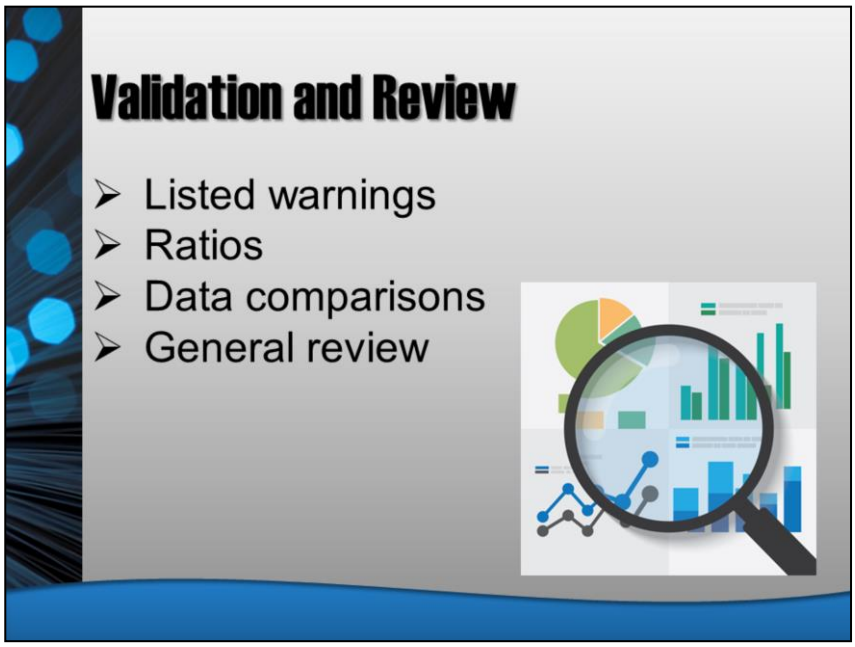
and in the attestation to determine if the warnings have been sufficiently addressed.

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.



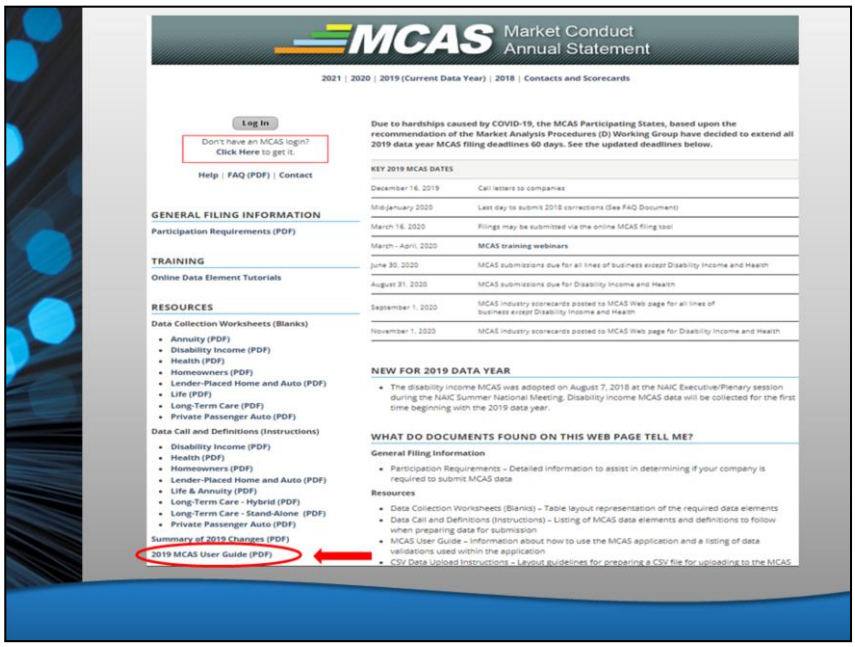
The company's standard ratio results are also reviewed. A listing of the scorecard ratios can be found on the MCAS web page.

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.



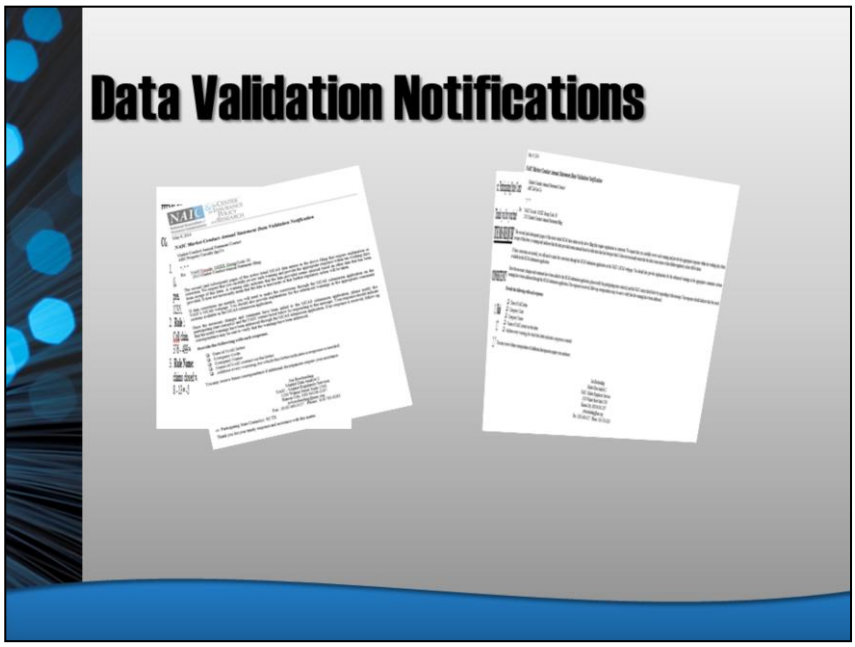
In addition to warnings and ratios, data relationships within the submission are reviewed. An example would be a comparison of policies in-force to the number of claims. Another example would be the comparison of polices in-force to written premiums. If an unusual data relationship is identified, the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

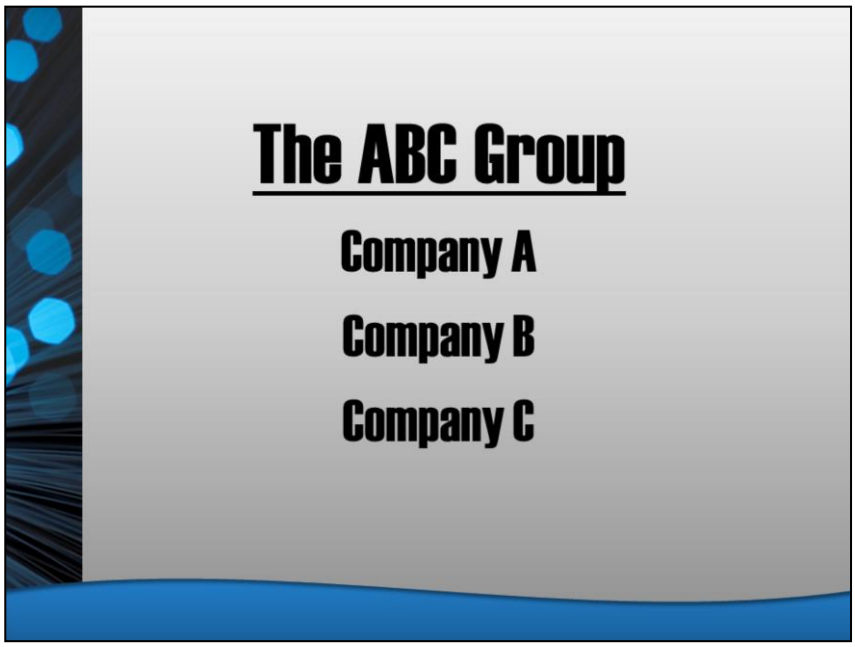


The MCAS User Guide, (found on the MCAS webpage) lists the data validation messages that may be encountered while validating data. This includes both “Error” and “Warning” messages. Use the listing to prepare data and to determine comments that will be needed to explain “Warning” messages received during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

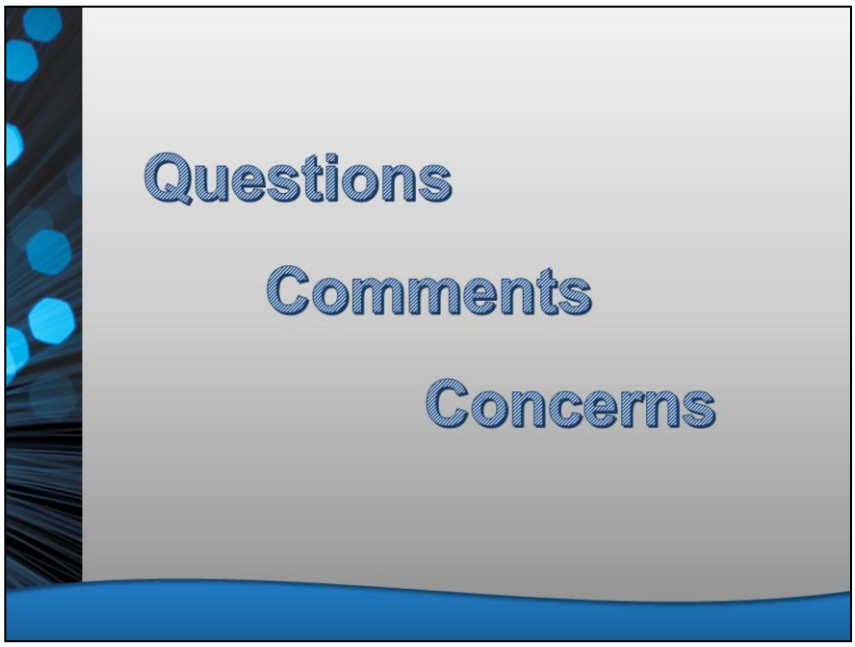
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within **multiple** states.



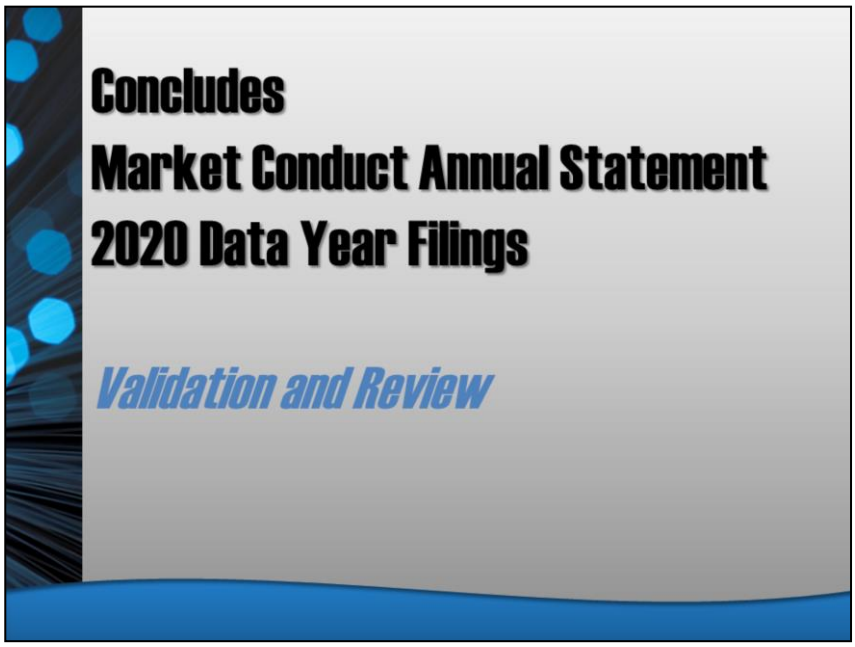
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence. 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.