Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

Line of Business: Other Health Insurance

Reporting Period: January 1, 2024 through December 31, 2024

Filing Deadline: May 31, 2025

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1 - Interrogatories

1-01	Are you currently marketing these products in this jurisdiction?	Yes/No
1-02	Do the products you are reporting on in response to this blank include closed or frozen blocks of business?	Yes/No
1-03	If yes, list the closed or frozen blocks of business?	Comment
1-04	Number of Other Health products offered to residents in this state	Number
1-05	For products reported to this MCAS jurisdiction, list the states where your Other Health products are filed (provide SERFF tracking number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing.	Comment
1-06	For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?	Yes/No
1-07	If yes, list the associations/trusts.	Comment
1-08	If yes, do you have a contractual relationship with any association/trust?	Yes/No
1-09	If yes, please identify which associations/trusts.	Comment
1-10	If yes, does the contract allow any association/trust to market the product?	Yes/No
1-11	If yes, please identify which associations/trusts.	Comment
1-12	If yes, does the contract allow any association/trust to collect policy or contract premiums?	Yes/No
1-13	If yes, does the contract allow any association/trust to collect and pay commissions?	Yes/No
1-14	If yes, please identify which associations/trusts.	Comment
1-15	If yes, does the contract allow any association/trust to adjudicate claims?	Yes/No
1-16	if yes, please identify which associations/trusts.	Comment

1-17	Has the company filed the associations by-laws and articles of incorporation in their state of domicile?	Yes/No
1-18	Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?	Yes/No
1-19	If yes please provide the state, and the SERFF tracking number, if applicable	Comment
1-20	Has the company filed the association by-laws and articles of incorporation in the filing state?	Yes/No
1-21	Has the company filed the certificate of insurance in the filing state, if applicable?	Yes/No
1-22	Does the company contract with third-party administrators for administrative services related to Other Health products?	Yes/No
1-23	If yes, does the company issue Other Health products through administrators/TPAs?	Yes/No
1-24	If yes, how many administrators/TPAs?	Number
1-25	If yes, list the TPAs and provide their respective National Producer Number (NPN), if required by the state.	Comment
1-26	If yes, does your company contract claims services related to Other Health products?	Yes/No
1-27	If yes, does your company contract complaints-related services related to Other Health products?	Yes/No
1-28	If yes, does your company contract medical underwriting services related to Other Health products?	Yes/No
1-29	If yes, does your company contract pricing services related to Other Health products?	Yes/No
1-30	If yes, does your company contract producer appointment services related to Other Health products?	Yes/No
1-31	If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?	Yes/No
1-32	If yes, does your company contract policyholder services related to Other Health products?	Yes/No
1-33	If yes, does your company contract premium collection services related to Other Health products?	Yes/No
1-34	Does your company audit third parties to whom you have delegated responsibilities?	Yes/No
1-35	If yes, please provide frequency of audits.	Comment
1-36	Does your company distribute its product through independent agents?	Yes/No
1-37	Does your company distribute its products through captive agents?	Yes/No
1-38	Does your company distribute its products through its employees?	Yes/No
1-39	Does the company use pre-existing condition exclusions?	Yes/No
1-40	If yes, identify which products.	Comment
1-41	Does the company contract with producers to collect premium or bind coverage on behalf of the company?	Yes/No

1-42	For fees that are included in reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.	Comment
1-43	For fees not included in the reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.	Comment
1-44	Additional state specific comments (optional)	Comment

Products

Product Identifiers	Explanation of Product Identifiers
Individual H-AO	**Accident Only. Purchased by an individual**
Individual ADD	**Accidental Death and Dismemberment. Purchased by an individual**
Individual SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased by an individual**
Individual H-H/OI	**Hospital/Other Indemnity. Purchased by an individual**
Individual H-HSME	**Hospital/Surgical/Medical Expense. Purchased by an individual**
Association H-AO	**Accident Only. Purchased through an association/trust**
Association ADD	**Accidental Death and Dismemberment. Purchased through an association/trust**
Association SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased through an association/trust**
Association H-H/OI	**Hospital/Other Indemnity. Purchased through an association/trust**
Association H-HSME	**Hospital/Surgical/Medical Expense. Purchased through an association/trust**
Employer Group H-AO	**Accident Only. Purchased through an employer group**
Employer Group ADD	**Accidental Death and Dismemberment. Purchased through an employer group**
Employer Group SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased through an employer group**
Employer Group H-H/OI	**Hospital/Other Indemnity. Purchased through an employer group**
Employer Group H-HSME	**Hospital/Surgical/Medical Expense. Purchased through an employer group**

Schedule 2 – Policy/Certificate Administration

2-45	Direct written premium
2-46	Earned premiums for reporting year
2-47	Number of policies/certificates in force at the beginning of the period
2-48	Number of covered lives on policies/certificates in force at the beginning of the period
2-49	Number of new policy/certificate applications/enrollments received during the period
2-50	Number of new policy/certificates issued during the period
2-51	Number of new policies/certificates denied during the period
2-52	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-53	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
2-54	Number of policies/certificates cancelled during the free look period
2-55	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-56	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period
2-57	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
2-58	Number of rescissions during the period
2-59	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder
2-60	Number of covered lives impacted on terminations and cancellations due to non-payment
2-61	Number of covered lives impacted by rescissions
2-62	Number of policies/certificates in force at the end of the period
2-63	Number of covered lives on policies/certificates in force at the end of the period

Schedule 3 – Claims Administration (Including Pharmacy)

3-64	Number of claims pending at the beginning of the period
3-65	Number of claims received (include non-clean claims)
3-66	Total number of claims denied, rejected or returned
3-67	Number denied, rejected, or returned as non-covered or maximum benefit exceeded
3-68	Number denied, rejected, or returned as subject to pre-existing condition exclusion
3-69	Number denied, rejected, or returned due to failure to provide adequate documentation
3-70	Number denied, rejected, or returned due to being within the waiting period (do not answer for ADD products)
3-71	Number denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
3-72	Number of claims pending at the end of the period
3-73	Median number of days from receipt of claim to decision for denied claims
3-74	Average number of days from receipt of claim to decision for denied claims
3-75	Median number of days from receipt of claim to decision for approved claims
3-76	Average number of days from receipt of claim to decision for approved claims
3-77	Number of claims paid
3-78	Aggregate dollar amount of paid claims during the period
3-79	Number of claims where the claims payment was reduced by premium owed
3-80	Dollar amount of claims payments applied to unpaid premiums.

Schedule 4 – Consumer Complaints and Lawsuits

4-81	Number of complaints received by Company (other than through the DOI)
4-82	Number of complaints received through DOI
4-83	Number of complaints resulting in claims reprocessing
4-84	Number of lawsuits open at the beginning of the period
4-85	Number of lawsuits opened during the period
4-86	Number of lawsuits closed during the period
4-87	Number of lawsuits closed during the period with consideration for the consumer
4-88	Number of lawsuits open at the end of the period

Schedule 5 – Marketing and Sales

5-89	Number of individual applications/enrollments pending at the beginning of the period
5-90	Number of individual applications/enrollments denied during the period for any reason
5-91	Number of individual applications/enrollments denied during the period - health status or condition
5-92	Number of individual applications/enrollments approved during the period
5-93	Number of individual applications/enrollments pending at the end of the period
5-94	Number of applications/enrollments received via phone (audio only) (only answer for individual products)
5-95	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) (only answer for individual products)
5-96	Number of applications/enrollments received online (electronically) (only answer for individual products)
5-97	Number of applications/enrollments received by mail during the period (only answer for individual products)
5-98	Number of applications/enrollments received by any other method during the period (only answer for individual products)
5-99	Commissions paid during reporting period (dollar amount of commissions incurred during the period)
5-100	Unearned commissions returned to company on policies/certificates sold during the period

Schedule 6– Other Health Insurance Attestation

6-101	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-102	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-103	Overall Comments for the Period

Participation Requirements: All companies licensed and reporting at least $50,000 of other health insurance premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Report by Residency: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situsued.

General Definitions:

Other Health - Health insurance forms that are not subject to the Affordable Care Act (ACA). For this MCAS blank, they are Health-Accident Only; Health - Accidental Death and Dismemberment; Health-Specified Disease-Limited Benefit/Critical Illness; Health - Hospital/Other Indemnity; and Health - Hospital/Surgical/Medical Expense

Health-Accident Only - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability (not disability income), or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident

Health-Accidental Death and Dismemberment - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

Health-Specified Disease-Limited Benefit/Critical Illness - An insurance contract that pays benefits for the diagnosis and/or treatment of a specifically named disease, diseases, or critical illness. Benefits can be paid as expense incurred, per diem, or a principle sum.

Health-Hospital/Other Indemnity - An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred.

Health-Hospital/Surgical/Medical Expense - An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.

Association/Trust – For purposes of this MCAS blank, a non-employer group that offers benefits to its members (does not include banks or credit unions).

Individual Product - Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance.

Group Product / Coverage - Policies issued to a trust, association, employer, or administrator for the purpose of marketing, selling, and issuing certificates to eligible members or employees, regardless of whether or not the policy forms have been filed with any State's department of insurance and regardless of where the association, trust, employer, or administrator is situsued.

National Producer Number (NPN) - This is a specific number provided by National Insurance Producers Registry (NIPR) to individuals and most business entities that are listed in the NIPR's Producer Database (PDB).

Policies/Certificates - Refers to the coverage documents provided to individuals, families, or eligible members (i.e., state residents) who are enrolled in coverage (not the association/trust)

Policyholder/Certificate holder – Refers to the individual or member who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association/trust)

Policyholder Service - A company's activities relating to servicing its policyholders which incudes, but is not limited to, notice/billing, disclosures, premium refunds and coverage questions.

Schedule 2 Definitions (Policy/Certificate Administration):

Rescission – A rescission is a cancellation or discontinuance of coverage based on a misrepresentation that is retroactive to the issue date. (Does not include cancellations for non-payment.)

Free Look – A set number of days provided in an insurance policy/certificate that allows time for the purchaser to review the contract provisions with the right to return the policy/certificate for a full refund of all premium paid. Report the number of policies/certificates that were returned by the insured under the free look provision during the period, regardless of the original issuance date.

Schedule 3 Definitions (Claims Administration):

Claim – Provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Duplicate claims should not be reported.

For the purposes of this Market Conduct Annual Statement, a "Claim" includes any such request or demand, even those with incomplete or inadequate documentation and those made by an individual not eligible or covered under the policy against which the claim is made.

Communications with an insurer that are not explicit claims as per the definition above should not be reported on this MCAS. Such communications could include general queries regarding policy provisions, potential coverage, events reported for "information only", or other communications for which a clear request or demand for payment has not been made.

If a claim is reopened, treat the reopened claim as a new and distinct claim apart from the original claim. For reopened claims, the claim determination time period is measured from the date the claim was re-opened to the date a benefit determination is made.

Claims Received - provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

Claims Denied - provide the total number of claims denied during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed; includes rejected and returned claims, whether in whole or in part

Claims Paid - provide the total number of claims paid during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

Waiting Period: Period of time a covered person who is entitled to receive benefits must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

Schedules 4 Definitions (Consumer Complaints and Lawsuits):

Complaint - any written communication that expresses dissatisfaction with a specific person or entity. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose. A complaint should be reported to the state where the policyholder resides.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.).
- Complaints received from third parties.

Lawsuit—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 Other Health Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;

- 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.

Lawsuits Closed During the Period with Consideration for the Consumer—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.

Schedule 5 Definitions (Marketing and Sales)

Commissions - The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. NOTE: For products ***not*** related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting. Do not include any fees or other compensation paid for outsourced services.

Schedule 6– Other Health Insurance Attestation

By completing the attestation information, those named understand, agree, and certify on behalf of the named company that:

1. They are 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. They are 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 their 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. They are 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. They 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.

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 attestors 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.