Frequently Asked Question

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

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Who has to complete the MCAS?

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

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

- Life/Annuity: The company is licensed and reports at least $50,000 of individual life insurance premium (excluding credit life) for the data year or at least $50,000 of individual annuity consideration for the data year in that participating state. If the company meets the threshold for either individual life insurance or individual annuities in a state, but does not meet the threshold for the other line of business, reporting to the state should be made only for the one line of business that meets the threshold.
- Long-Term Care: The company is licensed and reports any individual long-term care insurance premium (stand-alone, life-LTC hybrid, annuity-LTC hybrid) for the data year for that participating state. All companies with any in-force individual LTC policies, individual Life-LTC hybrid products, or individual Annuity-LTC hybrid products are required to report data in MCAS.
- Other Health: All companies licensed and reporting at least $50,000 of Other Health written premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions.
- Property/Casualty: The company is licensed and reports at least $50,000 in private passenger automobile insurance premium for the data year; or $50,000 in homeowners insurance premium for the data year; or both for that participating state. If the company meets the threshold for either private passenger automobile or homeowners insurance in a state, but not the other, reporting to the state should be made only for the one line of business that meets the threshold.
- Private Flood Insurance: All companies licensed and reporting at least $50,000 of Private Flood written premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions.
- Travel: All companies licensed and reporting Travel written premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (Note: for Arkansas, there is a premium threshold of $50,000 for Travel. Reporting to the state should be made only for the line(s) of business that meets the threshold.)
- The company is automatically exempt from filing in a particular participating state if:
    - The company is not licensed to do business in that state; or
    - The company reported less than the state threshold in premium or consideration in individual life, individual annuity, individual long-term care (stand-alone or hybrid), private passenger auto, homeowners and health insurance.

See Participation Requirements and General Information

How are Required to File flags within the MCAS submission application populated?

In the past, various premium references from within the NAIC Financial Annual Statement filings were used to determine the expectations for MCAS filings and to populate the MCAS Required to File flags found within the MCAS submission application.
However, due to inconsistencies in reporting and differences between financial statement instructions and MCAS reporting guidelines, the past method did not prove to always be accurate. Some examples of the reporting differences are:

	Required to file	
PPA premiums	FAS	MCAS
Antiques	Yes	No
Collectibles	Yes	No
Trailers	Yes	No

For the 2023 data year, there is a new supplement for insurers to provide better information related to the jurisdictions and lines of business MCAS reportable premium exists.
Insurers are expected to review the MCAS data call and definition documentation found on the MCAS webpage along with their premium information to establish responses to the new MCAS supplement to the financial statement.
The premium amount is determined from the financial annual statement that a company files with the NAIC. These are the financial annual statement references used:

- Annuity – Ordinary considerations, State Page, line 2
- Disability Income Insurance – Schedule T, Part 2, Disability Income (Group and Individual)
- Health – Individual Comprehensive, Small Group Employer Comprehensive, Large Group Employer Comprehensive, and Student Health Plans reported on the Supplemental Health Care Exhibit Part 1, Health Premiums Earned
- Homeowners – Direct Premiums Written, State Page, line 4
- Lender-Placed Insurance – Credit Insurance Experience Exhibit – Part 4; Creditor Placed Home Hazard (single and dual) plus Creditor Placed Wind Only (single and dual) plus Creditor Placed Home Flood Only (first dollar and excess), line 01.1 OR Creditor Placed Auto (single and dual), line 01.1
- Life – Ordinary premiums, State Page, line 1
- LTC – Long-Term Care Experience Reporting Form 5, line 1 plus line 3 plus line 5 (stand alone and hybrid)
- Private Flood – Direct Premiums Written, State Page, line 2.5
- Private Passenger Auto – Direct Premiums Written, State Page, lines 19.1, 19.2 and 21.1
- Other Health – Currently no Financial Annual Statement references

- Short-term Limited Duration – Accident and Health Policy Experience Exhibit, Direct Premiums Written, line 2.3
- Travel – Currently no Financial Annual Statement references

For your reference, a copy of the new financial statement supplement is shown below:

LINE_CODE	LINE_NUMBER	ROW_NAMELABEL
1	01	01_Disabil Disability income MCAS LOB
2	02	02_Health Health MCAS LOB
3	03	03_HomeoHomeowners MCAS LOB
4	04	04_Indvan Individual annuity MCAS LOB
5	05	05_IndvLi Individual life MCAS LOB
6	06	06_LenderLender-placed home and auto MCAS LOB
7	07	07_LongteLong-term care MCAS LOB
8	08	08_OthheaOther health MCAS LOB
9	09	09_PrivatePrivate flood MCAS LOB
10	10	10_Privat Private passenger auto MCAS LOB
11	11	11_ShortteShort-term limited duration health plans MCAS LOB
12	12	12_Travel Travel MCAS LOB

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

Companies that filed a financial annual statement as a Property, Life or Health company and licensed to write business in participating MCAS jurisdictions received a call letter indicating that they may be required to file the MCAS.

See Participation Requirements and General Information

If we have less than the premium threshold for a given state and line of business but the filing matrix indicates that the company is required to file. What do we need to do to remove the asterisk (*) that indicates required to file on the filing matrix?

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

See Participation Requirements and General Information

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

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

There may be premiums applicable to MCAS that are not accounted for when the required to file field is indicated. If you have data to report that meets the filing thresholds but do not have a required to file asterisk, you must report this data. For example, when reporting for homeowners, if you have premiums applicable to MCAS reporting on your state page in Line 1 (Fire) or Line 17 (Other Liability), combining these with the premiums reported on Line 4 (Homeowners) may put the company over the premium threshold, even though you don't have a required to file asterisk for that state.

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

What changes will there be this year? (Updated 10/24/2023)

For a full description of the changes for the line(s) of business your company writes, please see the "Summary of 2023 Changes" document found on the MCAS Web page.

When is the MCAS filing due date? (Updated 10/24/2023)

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

Data Year	Other Health	STLDI	Health	Travel	All Others
2023	June 30, 2024	May 31, 2024	May 31, 2024	April 30, 2024	April 30, 2024
2024	June 30, 2025	May 31, 2025	May 31, 2025	April 30, 2025	April 30, 2025

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

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

See Participation Requirements and General Information

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

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

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

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

See Participation Requirements and General Information

How do I request a waiver or an extension?

Requesting a waiver or an extension, you must log into the online MCAS submission tool. Within the tool on the Filing Matrix screen, there are waiver and extension buttons on the left-hand side. You must select a line of business, the extension request period, and then the option to select all applicable states will appear. You will be able to make your request to one or more states. Requests should be made as early as possible. Do not wait until the data is due.

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

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

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

See Participation Requirements and General Information

How many extensions can be requested?

You may make up to 4 extension requests. The first request must be the initial request for 14 days past the deadline date. If more time is needed, additional requests may be submitted in the following order: the second request for 28 days after the deadline, the third request for 42 days past the deadline, and the final request for 56 days past the deadline.

The requests must be made in the order listed above. A further extension may not be requested until the previous request has been approved. For example, a company may not make its first request for 28, 42, or 56 days past the deadline. Likewise, the second request may not be made for 42 or 56 days past the deadline.

Which jurisdictions participate in the MCAS?

Fifty jurisdictions are currently participating in MCAS. For a complete listing, please refer to the Authority References.

General Data Questions

If an individual has more than one policy and files claims for multiple policies, does this count as one claim or multiple claims? 11

If a renewal offer is made to the insured, but the insured does not make the first premium payment, is this considered a cancellation by the insured or a non-renewal by the insured? 11

If a company cancels a policy because the insured moves to another state where the company is not licensed to provide insurance, would this be considered a cancellation initiated by the insured or the company? 11

If an individual has more than one policy and files claims for multiple policies, does this count as one claim or multiple claims?

Reporting should be counted by policy and would result in multiple claims in this situation.

If a renewal offer is made to the insured, but the insured does not make the first premium payment, is this considered a cancellation by the insured or a non-renewal by the insured?

This is considered a non-renewal by the insured and would not be reported on the MCAS blank.

If a company cancels a policy because the insured moves to another state where the company is not licensed to provide insurance, would this be considered a cancellation initiated by the insured or the company?

This is a cancellation by the company. The insured must request the cancellation for it to be considered at the insured's request.

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What is the role of the Market Conduct Contact? (Updated 04/27/2023)

The Market Conduct Contact is provided by the company on the Jurat page of the quarterly and annual financial statements. The Market Conduct Contact is the person that state insurance regulators contact for all market conduct matters with the company; therefore, the Market Conduct Contact is also the default contact person to receive MCAS communications until an MCAS contact is specified.

Who can be the MCAS administrator?

Any user requested by the Market Conduct Contact directly OR by letter of instruction on company letterhead (must be signed by an officer of the company) may be the MCAS administrator.

No user will be listed as the MCAS administrator or have access to a company within MCAS until NAIC staff assigns a user following an MCAS administrator set up request.

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

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

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

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

Our Market Conduct Contact has changed. Whom do we notify so we can login to the MCAS application? (Updated 04/27/2023)

The Market Conduct Contact change will be made at the NAIC when the revised annual or quarterly financial statement containing the new contact information is received. The MCAS administrator may be a different individual than the Market Conduct Contact. Please contact mcas@naic.org for MCAS administration details.

What is the role of the MCAS Contact?

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

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

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

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

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

When the system becomes available for accepting the next year's filings, you will again be able to make changes to your prior-year data. However, before you are able to make any changes to any prior MCAS filing, you must get written approval from the state to which the MCAS was originally submitted. State contacts can be located at MCAS Data Dashboard and selecting Click to view MCAS Contacts.

What are the system requirements for using the MCAS application?

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

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

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

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

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

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

What if I upload or enter incorrect data?

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

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

Here are some things that you can check for:

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

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

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

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What is the Attestation?

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

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

Contact the jurisdiction to which the information is being provided. The contact information can be found on the Participating Jurisdictions link. You are also provided with a comment box for each section of the MCAS. Be sure to use the comment boxes for any explanations of the data you are submitting. Comments about specific data elements can be made on the page where the data is entered. General comments about the company or the company data, as a whole, can be made on the Attestation page of MCAS.

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

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

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

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

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

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

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

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

Where do I find data definitions and reporting guidelines?

The data definitions and reporting guidelines can be found on the MCAS Web page under the Resources section.

What types of complaints should be reported?

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

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

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

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

You are to report one suit for each applicable claimant/coverage combination. So, if a suit seeks an award under HO Liability and HO Medical Payments, you would report the suit under both the Liability coverage and the Medical Payments coverage. If the suit seeks award on multiple policies, you will count a suit for each policy.

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

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

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

What types of coverage should be included in the report?

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

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Should Disability Income (DI) Riders be included?

If you are able to separate the DI premiums from the other lines, the DI falls within the MCAS definition, and the DI premium thresholds are met, then you should report it.

When does claim processing time start?

Processing time should begin the day that the claim was received in the mailroom or other claims intake unit, whether or not all required documents were submitted at that time.

When reporting Disability Income, should I report based on issue state (situs) or resident state of the insured?

In determining what business to report for a particular state, all reporting companies should follow the same methodology/definitions used to file the Financial Annual statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations.

Should Schedule 3 include processing times for all claims or only claims resulting in payment?

Schedule 3 should only include data for initial claim decisions resulting in payment.

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

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

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

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

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

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

What is meant by "Health Insurance Coverage"?

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

Health Insurance Coverage – Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. This is not intended to include excepted benefits as defined in 42 U.S.C. § 300gg-91(c). This is also not intended to include closed blocks not subject to Medical Loss Ratio (MLR) reporting under Centers for Medicare & Medicaid Services (CMS) guidance nor is it intended to include self-funded plans. (2019 MCAS Health Data Call and Definitions Documentation)

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

(c) Excepted benefits

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

(1) Benefits not subject to requirements

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

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

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

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

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

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

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

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

(3) Benefits not subject to requirements if offered as independent, non-coordinated benefits

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

For an individual that changes products during the reporting year:

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

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

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

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

How are line items on bundled claims reported?

Claims should be reported at the service line level.

Should duplicate claims be reported?

Duplicate claims should not be reported.

How are claim payment adjustments reported?

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

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

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

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

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

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

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

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

Partially approved prior authorizations should be reported as approved.

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.

Should second level internal reviews be reported in the MCAS?

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

If a grievance includes multiple services, some of the services may be upheld while others are overturned. In this situation, should the grievance be reported as approved or denied?

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

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

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

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

For individual: The change in policy within the same carrier should be treated as a termination.

For group: The change in product within the same carrier should not be reported as a termination.

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?

For individual: At renewal, if an individual changes to a new product with the same carrier this should be reported as a policy issued (not as a policy renewal) as policy is reported at the subscriber level.

For Group: At renewal, if a group changes to a new product offering with the same carrier, this should be reported as a policy renewal (not as a policy issued) as policy is reported at the account level.

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.

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.

Should capitated claims be reported?

Capitated claims are to be reported if an Explanation of Benefits (EOB) is generated.

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 and subsequent years are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.

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.

Homeowners and Private Passenger Auto MCAS

What if we reinstate a cancelled policy? Do we still need to report it as a cancellation?..... 29

Should confirmed third-party claims be included in either automobile or homeowners claims? 29

Within the "Homeowners Underwriting Activity" section, what does the data element, "Dwellings with policies in force at the end of the period" mean? How does this data element differ from "Policies in force at the end of period"? 29

What if we have no private passenger auto/homeowner claims data to enter, but do need to report underwriting data? How can this be done? 29

What if we send a cancellation notice to a policyholder, and the policyholder contacts us prior to the cancellation effective date and requests that the policy be cancelled? Do we report this as a company-initiated cancellation, or a cancellation at the insured's request? 29

When calculating the number of days until company initiated cancellation for homeowners and private passenger auto business, the definitions specify that the notice of cancellation is the date the cancellation notice was mailed to the insured. My company does not capture the mailing date within our system. What date do I use? 30

The MCAS application returned a warning message regarding median days to final payment. I do not understand how to read the warning message. What does it mean? 30

Does the method of reporting a claim have any bearing on whether the claim should be reported as digital, hybrid or non-digital? 31

If the claim evaluation is determined digitally but the settlement offer is transmitted to the claimant via a human would this be considered a hybrid claim? If not, does the answer change if the offer is declined and the company adjuster negotiates a different settlement amount with the claimant? 32

The company appraiser inspects photos of the damage submitted by a claimant and determines what should and should not be included in an evaluation tool. Would this be considered a hybrid claim or a non-digital claim? 32

At every stage of our claim handling process, there is a human who can override any evaluation of the algorithm used to establish the value of a claim. Would this mean all our claims are either hybrid or non-digital? 32

All of our claims are run through a fraud model to detect potential fraud. We use no other automation in our claims handling. Does the use of a fraud model make the claim hybrid?.. 33

If a claim is determined by the algorithm to be below the deductible would this be a digital claim? 33

Which claims-related lawsuits should be reported? Should only lawsuits with the company as a named defendant be reported? 33

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

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

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

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

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

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

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

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

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

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

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

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

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

The median days to final payment validation description will look something like this…Q26 should correspond to the date range of median claim reported on Q27-Q32.

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

Example

The company reports the following:

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

Number of claims closed with payment beyond 365 days	0

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

Does the method of reporting a claim have any bearing on whether the claim should be reported as digital, hybrid or non-digital?

Not necessarily. The definition of a Digital Claim states that it applies to "a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the production of the initial loss settlement offer." Additionally, the definition of a Hybrid Claim states that in addition to the digital elements of a claim, a hybrid claim "require(s) the use of human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer."

If a claim is reported by the submission of digital photos that prompts an in-person appraisal and no application of any loss algorithms are applied to the digital photos, the claim is non-digital.

If a claim is reported by the submission of digital photos that are first run through an application that appraises the damages and then subsequently a human appraiser is used to visually inspect and evaluate the damage, the claim is hybrid.

If the claim evaluation is determined digitally but the settlement offer is transmitted to the claimant via a human would this be considered a hybrid claim? If not, does the answer change if the offer is declined and the company adjuster negotiates a different settlement amount with the claimant?

It is only the process used to determine the value of the settlement offer, not the method in which the settlement offer is delivered, that determines whether a claim is digital or hybrid. A settlement offer transmitted to the insured/claimant via a human would be considered a digital claim if human resources were not used to determine the settlement offer and that initial offer is accepted by the insured/claimant. However, per the definition of a Hybrid Claim, any subsequent loss settlement where the amount of the offer was produced and/or adjusted by a human resource would result in the claim being considered a hybrid claim.

The company appraiser inspects photos of the damage submitted by a claimant and determines what should and should not be included in an evaluation tool. Would this be considered a hybrid claim or a non-digital claim?

The inspection of the photos by an appraiser and the decision to include or exclude certain aspects of the submitted photos into the evaluation tool would make the claim a hybrid claim. If the appraiser simply receives photos from the claimant and uploads the photos into the evaluation tool without any intervention, the claim would be digital.

At every stage of our claim handling process, there is a human who can override any evaluation of the algorithm used to establish the value of a claim. Would this mean all our claims are either hybrid or non-digital?

Not necessarily. It depends on whether the human applies their discretion and overrides any evaluation generated by the loss algorithms. For a claim to be considered a Hybrid Claim, human resources are "required in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer." If, at any point in the claim process, a human uses their discretion to override the appraisal, settlement determination or the production of the initial or subsequent settlement offers, then the claim would be reported as a hybrid claim. If, however, no human resources intercede to alter the appraisal or the settlement offer, and the insured/claimant accepts the initial offer the claim would be a Digital Claim.

All of our claims are run through a fraud model to detect potential fraud. We use no other automation in our claims handling. Does the use of a fraud model make the claim hybrid?

Not necessarily. If the fraud model is not involved in the "loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer", using the fraud model has no impact on whether the claim is digital, hybrid, or non-digital. For example, if a claim is appraised in person by an appraiser, evaluated by an adjuster, and then run through the fraud model which determines it may be fraudulent and then adjusted accordingly by the company's Special Investigation Unit, the claim would be a considered a non-digital claim.

However, if the fraud model can deny claims without the intervention of a human, the claims would be a digital or hybrid claim. For example, if the claim denied as a result of being run through the model, no human resources interceded at any point to affirm or override the model decision to deny the claim, and the denial was accepted by the insured/claimant, the claim would be a digital claim. However, if at some point in the claim life cycle, human resources were used to affirm or override the model decision to deny the claim, it would be a hybrid claim.

If a claim is determined by the algorithm to be below the deductible would this be a digital claim?

Yes, this would be a digital claim if the claim is closed accordingly without any human resources involved in the determination of the value of the damages and the insured accepts the determination.

Which claims-related lawsuits should be reported? Should only lawsuits with the company as a named defendant be reported?

All claims-related lawsuits should be reported if it arises from a claim being adjusted by the company, regardless of whether the insurance company is a named defendant. The first bullet point in the current definition of "Lawsuit" was intended to apply only to non-claims related lawsuits. The MCAS Blanks Working Group will be considering a revision to the bullet point to read: "***For non-claims related lawsuits****, include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer as a named defendant*."

Lender-Placed Home and Private Passenger Auto MCAS

Real Estate Owned (REO) is a term that describes property owned by a lender. If a company can distinguish between Real Estate Owned (REO) coverage and individual consumer coverage on a non-foreclosed-on property, should the REO coverage be reported?..... 34

Are the Lender-Placed underwriting data elements and suits data elements reported separately for each type of Lender-Placed business (Single-Interest Auto, Dual-Interest Auto, Single-Interest Home Hazard, etc.)?..... 34

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

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

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

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

Life and Annuity MCAS

When reporting information that can be classified by issue state or by residence state, which should be used in relation to MCAS reporting? 35

For annuity considerations, do we include business reported as "Other Considerations" or "Deposit-Type Contract Funds"? 35

The life and annuity policy/contract surrender data elements request that surrenders be split according to the date of issuance. It is not clear where surrenders should be reported if the policy/contract is 2, 5 or 10 years old. How should these be reported? 35

When a joint life or joint annuity policy/contract is issued, what age and resident state do I report? 36

What should be considered as a surrender fee? (Added 01/24/2022) 36

What is considered an affiliated company? (Added 01/24/2022) 36

What is the definition of third part administrators (TPAs) for the purposes of MCAS? 36

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

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

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

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

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

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

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

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

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

What should be considered as a surrender fee? (Added 01/24/2022)

The intent of the new surrender fee questions for 2021 data year is to capture the number of surrenders with penalty charges.

What is considered an affiliated company? (Added 01/24/2022)

An affiliated company is a company that belongs to the same group but has a distinct NAIC company code.

What is the definition of third part administrators (TPAs) for the purposes of MCAS?

While the data call and definitions doesn't specify the type of work for which the company is using a TPA, the definition should be used widely for any purposes that a company uses a TPA. This could include marketing, claims, underwriting, etc.

Long-Term Care MCAS

What is the difference between "pending" benefit payment requests versus "pending" claimant request determinations for Long-Term Care? 37

Is Schedule 6 on the Long-Term Care referring to the amount of time between a benefit payment request and when the company makes the payment? Or is it the amount of time between subsequent payments after the initial payment? 37

Are the number of benefit payment requests received during the reporting period referring to every transaction/payment made on any one policy with Long-Term Care? 38

I'm receiving a warning on the Long-Term Care filing that I don't understand. It says, "WARNING: Sum of (Col 2 Ln 43 through Ln 46) should be => Sum of (Col 2 Ln 36 through Ln 42) x2 (LZAU050251)". 38

I am uploading data for Stand-Alone Long-Term Care only from a CSV I created in Excel. I get an error saying that there are values missing in a record. What is this error and how do I fix it? 38

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

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

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

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

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

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

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

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

Basically, it is expected that you would be making twice the determinations as you are denying. We would absolutely expect that a company would be making at least as many determinations as they are denying (because each denial is a determination). Since the determinations that aren't denials are either pending or approved, we would expect there to be as many of these as there are denials or more.

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

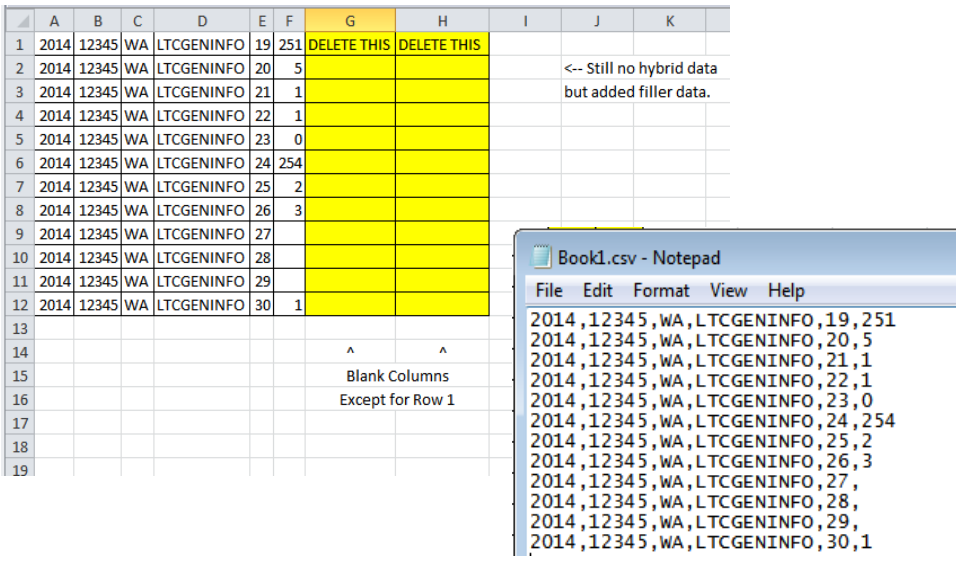
I am uploading data for Stand-Alone Long-Term Care only from a CSV I created in Excel. I get an error saying that there are values missing in a record. What is this error and how do I fix it?

This error most likely occurs because there are not places held for the data for the Hybrid LTC columns in the CSV file. You still need to have 8 columns of data (for all other schedules). If you have blank columns in Excel for the last two columns, saving as a CSV does not work because Excel does not know to create an "empty field" for those two. An example of how this would look follows in Figure 1. You can see that the blank columns don't show in the CSV file because they are empty. You can add a title at the top next to your data so that it creates "empty fields" in the CSV file. Once you have saved the file as a

CSV, open it in notepad and delete the text you added, leaving the commas. See Figure 2 for an example of how this looks. This will format the data so that all columns are included and it should upload properly. You also have the option of using the CSV Assistant.

Figure 1

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



	A	B	C	D	E	F	G	H
1	2014	12345	WA	LTCGENINFO	19	251	DELETE THIS	DELETE THIS
2	2014	12345	WA	LTCGENINFO	20	5		
3	2014	12345	WA	LTCGENINFO	21	1		
4	2014	12345	WA	LTCGENINFO	22	1		
5	2014	12345	WA	LTCGENINFO	23	0		
6	2014	12345	WA	LTCGENINFO	24	254		
7	2014	12345	WA	LTCGENINFO	25	2		
8	2014	12345	WA	LTCGENINFO	26	3		
9	2014	12345	WA	LTCGENINFO	27			
10	2014	12345	WA	LTCGENINFO	28			
11	2014	12345	WA	LTCGENINFO	29			
12	2014	12345	WA	LTCGENINFO	30	1		

<-- Still no hybrid data but added filler data.

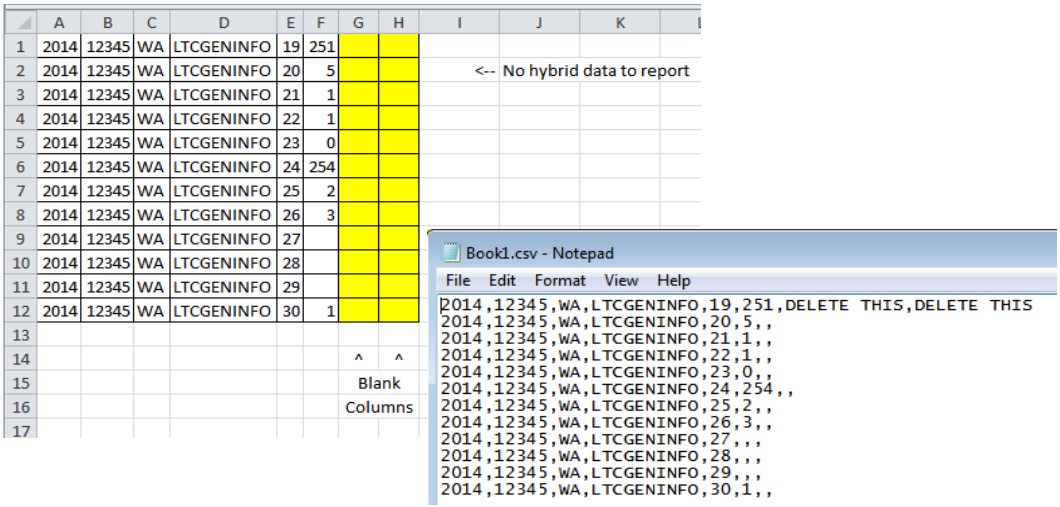
^ ^
Blank Columns Except for Row 1

Book1.csv - Notepad
File Edit Format View Help

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

Figure 2

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



	A	B	C	D	E	F	G	H
1	2014	12345	WA	LTCGENINFO	19	251		
2	2014	12345	WA	LTCGENINFO	20	5		
3	2014	12345	WA	LTCGENINFO	21	1		
4	2014	12345	WA	LTCGENINFO	22	1		
5	2014	12345	WA	LTCGENINFO	23	0		
6	2014	12345	WA	LTCGENINFO	24	254		
7	2014	12345	WA	LTCGENINFO	25	2		
8	2014	12345	WA	LTCGENINFO	26	3		
9	2014	12345	WA	LTCGENINFO	27			
10	2014	12345	WA	LTCGENINFO	28			
11	2014	12345	WA	LTCGENINFO	29			
12	2014	12345	WA	LTCGENINFO	30	1		

<-- No hybrid data to report

^ ^
Blank Columns

Book1.csv - Notepad
File Edit Format View Help

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

Does MCAS exclude government or state-sponsored groups? 40

Does the appeal count include member and provider appeal on behalf of member appeals or is there a broader scope? 41

Do appeals include Pre-Service, Post-Service, Concurrent, etc. or is there a specific definition that should be accounted for? 41

Do appeals include MH/SUD/Pharmacy data collected together, or are there specific parameters that BCBSVT should consider? 41

Are appeal dates considered by received date or resolved date? In other words, would an appeal received at the end of 2022 be potentially relevant for the 2023 report? 41

Please provide clarification on what is meant for Schedule 5, Marketing and Sales – Commissions: 5-102: Unearned commissions returned to company on policies/certificates sold during the period. Could you define "unearned commissions?"? 41

Specifically, as it relates to Accidental Death and Dismemberment portion, does the NAIC expect to receive data for products that are standalone Accidental Death & Dismemberment? 41

A policyholder has an Accident Only policy, with a waiver of premium benefit. The only benefit requested from the insured is the waiver of premium, would this be included as a claim in the "Other Health" MCAS reporting? 41

Do questions #5 through #21 apply only to business issued for the reporting period? 42

Do the Covered Lives include: certificate holder, dependent spouses/partners and dependent children? 42

Is this reporting applicable at the rider level? 42

I was wondering if anyone could tell me if Medicare supplement policies are to be included with the "Other Health" data? 42

Does the filing data pertaining to policies which meet the definition of "Other Health" which solely provide AD&D coverage to an individual and "Other Health" policies which may also have an AD&D component or rider. We want to be sure that the filing is NOT seeking data pertaining to life insurance policies which have AD&D riders. 42

Is Medicare reported as part of the Other Health submission? 42

Does MCAS exclude government or state-sponsored groups?

Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc., and and state-sponsored plans are currently excluded from health MCAS reporting

Does the appeal count include member and provider appeal on behalf of member appeals or is there a broader scope?

The appeal count just includes member and provider appeal on behalf of member appeals.

Do appeals include Pre-Service, Post-Service, Concurrent, etc. or is there a specific definition that should be accounted for?

Appeals include Pre-Service, Post-Service, Concurrent, etc.

Do appeals include MH/SUD/Pharmacy data collected together, or are there specific parameters that BCBSVT should consider?

All grievances and appeals are considered together

Are appeal dates considered by received date or resolved date? In other words, would an appeal received at the end of 2022 be potentially relevant for the 2023 report?

Use the resolve date, that way we can compare the number of appeals to the number overturned/upheld.

Please provide clarification on what is meant for Schedule 5, Marketing and Sales – Commissions: 5-102: Unearned commissions returned to company on policies/certificates sold during the period. Could you define "unearned commissions?"?

In terms of unearned commission, it generally relates to unearned premium. An agent is usually paid commission by the insurance company for writing the policies. If there is a cancellation, the premium and subsequently the commission is not paid in full, and the unearned portion is generally refundable to the finance company.

Specifically, as it relates to Accidental Death and Dismemberment portion, does the NAIC expect to receive data for products that are standalone Accidental Death & Dismemberment?

Yes, standalone should also be reported in this field.

A policyholder has an Accident Only policy, with a waiver of premium benefit. The only benefit requested from the insured is the waiver of premium, would this be included as a claim in the "Other Health" MCAS reporting?

Generally, to qualify for a waiver of premium, the insured must be disabled and unable to work. The disability does not need to be caused by an accident. So you will not report the waiver as a claim.

Do questions #5 through #21 apply only to business issued for the reporting period?

Yes, it is only for the reporting period.

Do the Covered Lives include: certificate holder, dependent spouses/partners and dependent children?

Covered Lives includes any lives the included on a policy issued.

Is this reporting applicable at the rider level?

Yes,rReport the rider and indicate in the comments section that they are including riders. The company should be able to separate out the premium since the coverage is so distinct from the life portion of the coverage, but even if they cannot, they should report anyway. The regulators want to know what health coverage is being written in the marketplace that is not subject to ACA requirements.

I was wondering if anyone could tell me if Medicare supplement policies are to be included with the “Other Health” data?

Currently Medicare, Medicaid, and other government health plans are not subject to MCAS reporting."

Does the filing data pertaining to policies which meet the definition of “Other Health” which solely provide AD&D coverage to an individual and “Other Health” policies which may also have an AD&D component or rider. We want to be sure that the filing is NOT seeking data pertaining to life insurance policies which have AD&D riders.

Correct, under the Other Health filing, the AD&D component is not pertaining to life insurance policies.

Is Medicare reported as part of the Other Health submission?

No, government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc., are currently excluded from health MCAS reporting.

Should duplicate claims be reported?

Duplicate claims should not be reported.

Pet MCAS

What year will Pet MCAS reporting begin? 43

What year will Pet MCAS reporting begin?

New MCAS reporting line of business 2025.

Private Flood MCAS

When do I report data for prior year questions (Q13-14, Q20-21, Q27-28, Q34-35, Q41-42, Q48-49, Q70, and Q74)?..... 44

When do I report data for prior year questions (Q13-14, Q20-21, Q27-28, Q34-35, Q41-42, Q48-49, Q70, and Q74)?

Prior year Private Flood questions will begin to be reported in the 2021 data year.

STLDI MCAS

Will the STLD line report on both of our products, Limited Medical and Short-Term Medical Insurance, or if Limited Medical products are excluded from STLD reporting? 45

Will the STLD line report on both of our products, Limited Medical and Short-Term Medical Insurance, or if Limited Medical products are excluded from STLD reporting?

If the product is a health product that meets the definition of having an expiration date less than 12 months, it should be reported.

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