General Filing Questions

- Who has to complete the MCAS?
- How is the Financial Annual Statement premium amount determined that is

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Who has to complete the MCAS?

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

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

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

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

Health: All companies licensed and reporting at least $50,000 of health earned premium for all coverages reportable in MCAS (includes both in-exchange and out-of-exchange) within any of the participating MCAS states. (Note: For Tennessee, submission of health MCAS data is voluntary as the Commissioner does not have

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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.

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.

Private Flood Insurance: All companies licensed and reporting at least $50,000 of

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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.

The required to file indicator on the filing matrix cannot be removed. The required to file indicator is populated based on the reported financial

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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

state.

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

What

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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?
- If a renewal offer is made to the insured, but the insured does make the first premium payment, is this considered a cancellation by the insured or a non-

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MCAS Application

- Ø What is the role of the Market Conduct Contact?
- Ø How do I assign users to input MCAS data for my company?
- Ø 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?
- Ø Our Market Conduct Contact has changed. Whom do we notify so we can login to the MCAS application?
- Ø What is the role of the MCAS Contact?
- Ø I have already submitted my data for the current data year. How can I U CAo @
- Ø When is the latest date I can submit changes to my MCAS filings?
- Ø What are the system requirements for using the MCAS application?

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

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

What is the role of the MCAS Contact?

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

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

Regardless of the line of business, re-filing for the current data year is handled much the same as the initial filing. The appropriate screen is accessed through the Filing Matrix where the most recently saved data is

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Data Upload

- Can I use a data upload file instead of manually entering all of the data?
- Where can I find the specifications for the data upload file?
- What if I upload incorrect data?
- I am receiving error messages when

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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
o
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.

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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

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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.

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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 MCAo
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to be all-encompassing. The decision was made a few years ago to drop the
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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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Disability Income MCAS

- Should Disability Income (DI) Riders be included?
- When does claim processing tideTf 492]TJETQ EMC /P <</MCID 3>5 BDC q0.00000912 0

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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

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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Health MCAS

- Ø ‡ @ @
- Ø ‡ = h insurance coverage?
- Ø Who is the policy holder in a group policy or individual policy?
- Ø ‡ = @ C
- Ø Are Dental and Vision claims part of the Claims Administration if they are embedded in the medical policy (purchased as a package)?
- Ø How should individuals that change products mid-year be accounted for?
- Ø When reporting claims received and or claims denied, which date should we use as the anchor date for reporting?
- Ø How are line items on bundled claims reported?
- Ø Should duplicate claims be reported?
- Ø How are claim payment adjustments reported?
- Ø When a claim is received with insufficient data, would it count as a denial?
- Ø 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?
- Ø If a request for prior authorization includes multiple services, some of the

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- Ø 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?
- Ø How should group policies be counted if multiple policy products are included within a single contract?
- Ø Should an insured individual or group that changes to another product offered by the same carrier be reported as a termination?
- Ø 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?
- Ø How do we determine which data year prior authorization requests, approvals or denials are to be reported in?
- Ø How do we determine which data year claims received, paid or denied are to be reported in?

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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?

@ @

What is meant by "Health Insurance Coverage"?

The following is the defini

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(B) Coverage issued as a supplement to liability insurance.
(C) Liability insurance, including general liability insurance and automobile liability insurance.
D ‡
(E) Automobile medical payment insurance.
(F) Credit-only insurance.
(G) Coverage for on-site medical clinics.
(H[s)6(ite)3( )

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

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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

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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.

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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

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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"?

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range of 0-30 days. If the result of the division is not less than or equal to

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the next bucket and compares the result of the division to the sum of the

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within 31- @ he sum of

-

within 31-

Example

The company reports the following:

Number of claims closed with payment 25

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Lender-Placed Home and Private Passenger Auto MCAS

- Real Estate Owned (REO) is a term that describes property owned by a

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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?
- 7 \ C D -u C 7
-

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 7 o @ hat 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

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

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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?

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?

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.

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Long-Term Care MCAS

- ‡ O -Term Care?
- Is Schedule 6 on Long-Term Care referring to the amount of time between a benefit request and when the company makes the payment? Or is it the amount of time between subsequent payments after the initial payment?
- Are the number of benefit payment requests received during the reporting period referring to every transaction/payment made on any one policy with Long-Term Care?
- @ O -u C @ @ ‡ AkV@V8 o C O O o C O O O-Ay
- 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?

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

u

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

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.

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I'm receiving a warning on the Long-Term Care filing that I don't understand. It says, "WARNING: Sum of (Col 2 Ln !

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n 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.

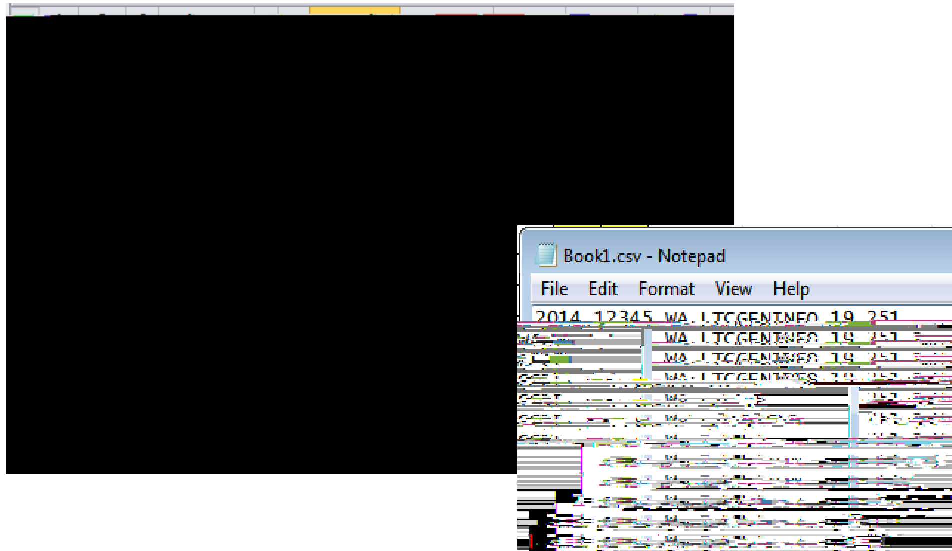

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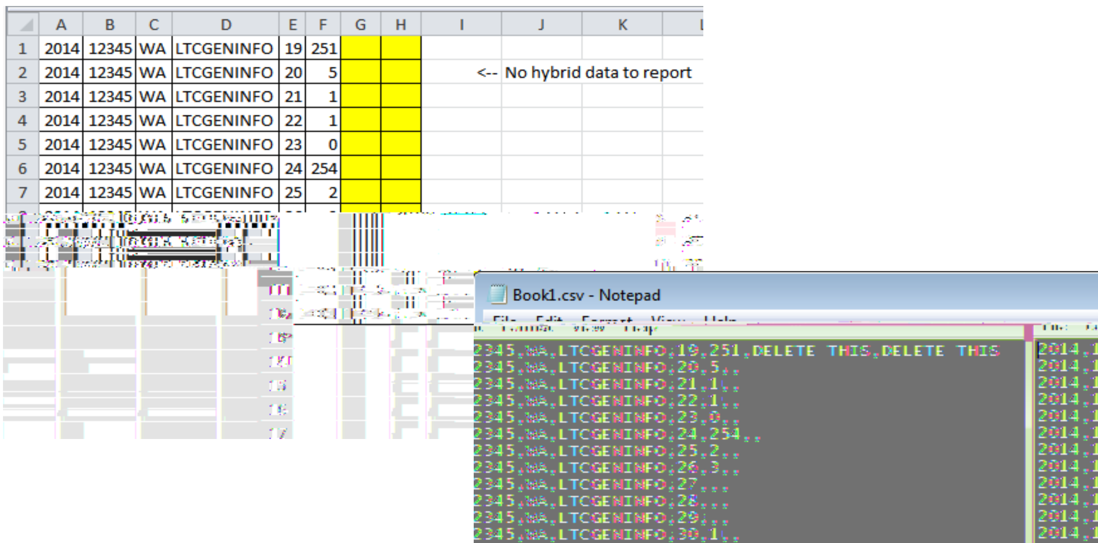
Figure 2

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 DEŒuE u=@ Co† opened in Notepad.



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Private Flood MCAS

- Ø When do I report data for prior year questions (Q13-14, Q20-21, Q27-28, Q34-35, Q41-42, Q48-49, Q70, and Q74)? *(Added 2/3/2022)*

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.

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