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.

Contents

General Filing Questions

- Who has to complete the MCAS?
-

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 Private Flood written premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions.

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.

How is the Financial Annual Statement premium amount determined that is used as the premium threshold for MCAS filings? 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 premium amount is determined from the financial annual statement that a company files with the NAIC. These are the financial annual statement references used:

Private Passenger Auto ς Direct Premiums Written, State Page, lines 19.1,19.2 and 21.1

Homeowners ς Direct Premiums Written, State Page, line 4

Life ς Ordinary premiums, State Page, line 1

Annuity ς Ordinary considerations, State Page, line 2

LTC ς Long-Term Care Experience Reporting Form 5, line 1 plus line 3 plus line 5 (stand alone and hybrid)

Health ς 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

Lender-Placed Insurance ς Credit Insurance Experience Exhibit ς 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

Disability Income Insurance ς Schedule T, Part 2, Disability Income (Group and Individual)

Private Flood ς Direct Premiums Written, State Page, line 2.5

Short-term Limited Duration ς Accident and Health Policy Experience Exhibit, Direct Premiums Written, line 2.3

Travel ς Currently no Financial Annual Statement references

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 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.

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 ŎƻҮǇŀɻèƻă ҮƻăŰ ǊŜŎŜƛvŰ ŦƛƴŀɻŎƛŀƛ ŀɻɻdzŀƛ ăŰŀŰŜҮŜƛvŰ óCA{ύΦ LŰ ƛă ǇƻăăƛōƛŜ ŦƻǊ ŀ 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. ¸ƻdz ǿƛƛƛ ɻƻŰ ăŜŜ ŀɻè ǎǊŜŀǘdzƛǊŜŘ Űƻ ŦƛƛŜέ ŀăŰŜǊƛăƪă dzɻŰƛƛ èƻdzǊ ŎƻҮǇŀɻèƻă [¢C Reporting Formt

General Data Questions

- ü If an individual has more than one policy and files claims for multiple policies, does this count as one claim or multiple claims?
- ü 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-renewal by the insured?
- ü 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?

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
[illegible]

MCAS Application

- What is the role of the Market Conduct Contact? *(Updated 04/27/2023)*
- Who can be the MCAS administrator? *(Added 04/27/2023)*
- How do I assign users to input MCAS data for my company?
- 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?
- Our Market Conduct Contact has changed. Whom do we notify so we can login to the MCAS application? *(Updated 04/27/2023)*
- What is the role of the MCAS Contact?
- I have already submitted my data for the current data year. How can I submit Ŏ2ŃŃŜŎűλ2yãκŎKI·yƎŜă ű2 űKŜ a CA{ ŦλfλyƎă LQØŜ I·fŃŜI·Řè ădzōYˆλűűŜŘK
- When is the latest date I can submit changes to my MCAS filings?
- What are the system requirements for using the MCAS application?

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 f792 r/F1 14.04 Tf1 0 0 1ETQq2 1E-3(CETt)

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?

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 ȅƻdz ŎfƛŎ] ƻƴ ǘƘŜ ά{dzōƳƛǘέ ōdzǘǘƻƴ ŦƻǊ 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.

MCAS Submission

- ü What is the Attestation?
- ü The data we are providing in MCAS may raise some additional questions. Whom should we contact?
- ü Do we provide jurisdiction specific or national data to each participating jurisdiction?
- ü CI·ƴ ǿŜ ŜŘƛű ǊŊƛƶŊ èŜI·ŊΩă a CA{ ădzōY ƛăăƛƶƴƙ
- ü The MCAS application returned a warning message about the company data. The data is correct. How do I submit the data?
- ü Where do I find data definitions and reporting guidelines?

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 [illegible] 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

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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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 no

Term Care, Health, Lender Placed Home and Auto, Disability Income, and Private Flood to determine data that should be included in MCAS filings.

Health MCAS

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- ü ² ƘI·ű ƛă űKŜ ŘŜ₣ƛy′ƛűƛ⊇y′⊇₣ áŁJ⊇fƛÖèɛΣ I·ă ƛű ŁJŜ₦ű I·ƛyã ű⊇ I ŜI·fűK ƛyãdz₦I·yŎŜ coverage?
- ü Who is the policy holder in a group policy or individual policy?
- ü ² ƘI·ű ƛă ϒŜI·yű ōè á I ŜI·fűK Łyãdz₦I·yŎŜ C⊇ØŜ₦I·ƎŜɛK
- ü Are Dental and Vision claims part of the Claims Administration if they are embedded in the medical policy (purchased as a package)?
- ü How should individuals that change products mid-year be accounted for?
- ü When reporting claims received and or claims denied, which date should we use as the anchor date for reporting?
- ü How are line items on bundled claims reported?
- ü Should duplicate claims be reported?
- ü How are claim payment adjustments reported?
- ü When a claim is received with insufficient data, would it count as a denial?
- ü 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?
- ü 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?
- ü If a claimed service is included in a prepaid capitated service, should this be reported as a denied claim or a paid claim?
- ü Should second level internal reviews be reported in the MCAS?

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?

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What is meant by “Health Insurance Coverage”?

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

> Health Insurance Coverage ς 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
>
> C2ℕ LJdzℕLJ2ăŜă 2₮ űKλă ăλ ! ɯ LJ2f ł 8 Ā

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.

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,

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

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

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

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ü 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?

ü 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-ʎƴʎǘʎI·ǘŜŘ ǑI·ƴǑŜfI·ǘʎƻƴ΄ ƻǁ I· ǑI·ƴǑŜfI·ǘʎƻƴ I·ǘ ǘKŜ ʎƴǎdzǁŜŘǲă ǁŜǊdzŜăǘK

ü When calculating the number of days until company initiated cancellation for homeowners and private passenger auto business, the data call and definitions specas]TJETQ108.02 569.86 408.19 0.95999 ref*q0.00000912 0 612 792/F1 14

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 samee samh Ee re fielde4(an)00

Home and Private Passenger Auto - Digital Claims

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

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-

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?

b2ű yŜŎŜăăl·ℕλfè℗ L₮ űĸŜ ₮ℕl·dzŘ Y˙2ŘŜf λă y2ű λyØ2fØŜŘ λy˙ űĸŜ áf2ăă l·LJLJℕl·λăl·f process, settlement determination, and/or in the production of the initial or ădzōăŜljdzŜyű f2ăă ăŜűűfŜY˙Ŝyű 2₮₮Ŝℕ€Σ dzăλy∃ űĸŜ ₮ℕl·dzŘ Y˙2ŘŜf Kl·ă y2 λY˙LJl·Ŏű 2y˙ 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 l·Ř?dzăűŜŘ l·ŎŎ2ℕŘλy∃fê ōè űĸŜ Ŏ2Y˙LJl·yè℺ă {LJŜŎλl·f LyØŜăűλ∃l·űλ2y˙ ¦ yλűΣ űĸŜ Ŏfl·λY˙ would be a considered a non-digital claim.

However, if the fra

Lender-Placed Home and Private Passenger Auto MCAS

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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.

Life and Annuity MCAS

- ü When reporting information that can be classified by issue state or by residence state, which should be used in relation to MCAS reporting?
- ü CƻǊ Ɩ·ɣɣdzʎűè Ŏƻɣãʎ ŘŜǊƖ·ŭʎƻɣãǔ Řƻ ǿŜ ʎɣŎfdzŘŜ ōdzăʎɣŜăă ǊŜLJƻǊúŜŘ Ɩ·ă ɑhűKŜǊ CƻɣãʎŘŜǊƖ·ŭʎƻɣãɛ ƻǊ ɑDŜLJƻăʎű-¢èLJŜ CƻɣűǊƖ·Ŏű CdzɣŘăɛK
- ü 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 two, five or 10 years old. How should these be reported?
- ü When a joint life or joint annuity policy/contract is issued, what age and resident state do I report?
- ü What should be considered as a surrender fee? *(Added 01/24/2022)*
- ü

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 ăI·Y Ŝ Y ŜűK2Ř2f2∃è I·ă űKŜ Cλyl·yŎλI·f {űI·ûŜY Ŝyűφ άLY ŘŜűŜℕY λyλy∃ øKI·ű 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 ŜI·ŎK I·LJLJfλŎI·ōfŜ ăűI·ûŜΩă ℕŜ∃dzfI·ûλ2yãφε

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.

When a joint life or joint annuity policy/contract is issued, what age and

Long-Term Care MCAS

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- 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?
- LQÝ ℕŜŎŜƛØƛyƎ I· ø I·ℕying on the Long-¢ŜℕÝ CI·ℕŜ ŦƛfƛyƎ űƘI·ű L Ř2yQű dzyŘŜℕăűI·yŘ¢ Lű ăI·èăΣ á ² AwbLbDʸ {dzÝ 2Ŧ óC2f н [ýпо űƘℕ2dzƎK [ýпcú Ґђ {dzÝ 2Ŧ óC2f н [ýoc űƘℕ2dzƎK [ýпнú Ềн ó[½A¦ лрлнрмúé¢
- 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?

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

¢KŜ ăŜŎűλ2ƴ2ƴŎfI·λY I·yű ℕŜIjʤŜăű ŘŜűŜℕYλyl·űλ2yã λă ű2 ōŜ Ř2yŜ 2ƴ I· άLJŜℕ ŎfI·λY I·yűέ ōI·ăλă ǿKλŎK YˆŜI·yã űKI·ű ǿŜ I·ℕŜ Ô2ʤyűλyヨ ŜI·ŎK λyŘλØλŘʤI·f ǿK2 makes on6 0 0 1 3ETQ92 remJET.5D0<0003>2 0 Aȁ.@OT$)0:ȸmmit.q0()5(rat o)-isq0.000

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.

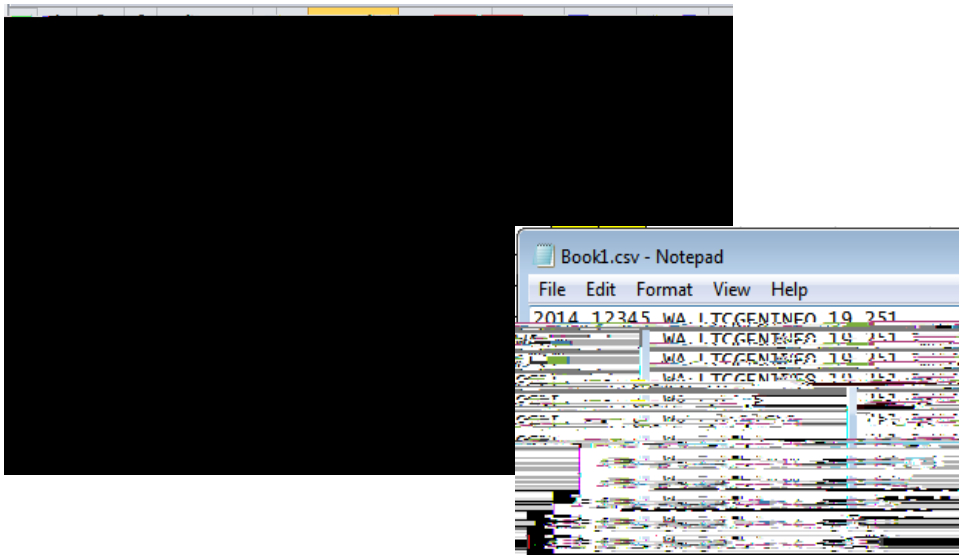

Figure 2

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)?

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

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