

Long-Term Care Data Call and Definitions – Areas for Review

1. Handling of class action lawsuit reporting
2. Actively Writing – New Interrogatory questions
3. Managing General Agent (MGA) – An insurance producer authorized by an insurance company to manage all or part of the insurer’s business. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs. (From Pet MCAS)
4. Third Party Administrator (TPA) - From the MCAS FAQs: For MCAS purposes, the definition of third-party administrators (TPAs) should be used broadly for any purpose for which a company uses a TPA. This may include, but is not limited to, marketing, claims, underwriting, or other administrative functions.
5. Cancellations / Terminations:

From Homeowner MCAS DCDs:

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium or non-sufficient funds.
 - o These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)
- Policies cancelled at the insured’s request.
- Policies cancelled for underwriting reasons.

Exclude: Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.

From Health MCAS DCDs

Number of policy terminations and cancellations initiated by the policyholder–

Number of policies terminated at the insured's request.

Number of policy terminations and cancellations due to non-payment of premium

– Number of policies terminated because the insured never paid, or stopped paying, the required premium for coverage.

6. Adverse Determination – From Health DCDs
A rescission, or a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a

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member's, or eligible dependent's, eligibility to participate in a plan, and including a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

7. Overturned Decision – From Health DCDs

A reversal of a denial of an adverse determination by a health carrier or its designee utilization review organization.

8. Upheld Decision – From Health DCDs

A denial of an adverse determination that has been found to be supported by a health carrier or its designee utilization review organization.

9. Possibly remove definition of Lapse if question #22 is removed from the blank.

Current Data Reporting FAQs - Long-Term Care MCAS

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).

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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.