2024 Market Conduct Annual Statement Industry User Guide

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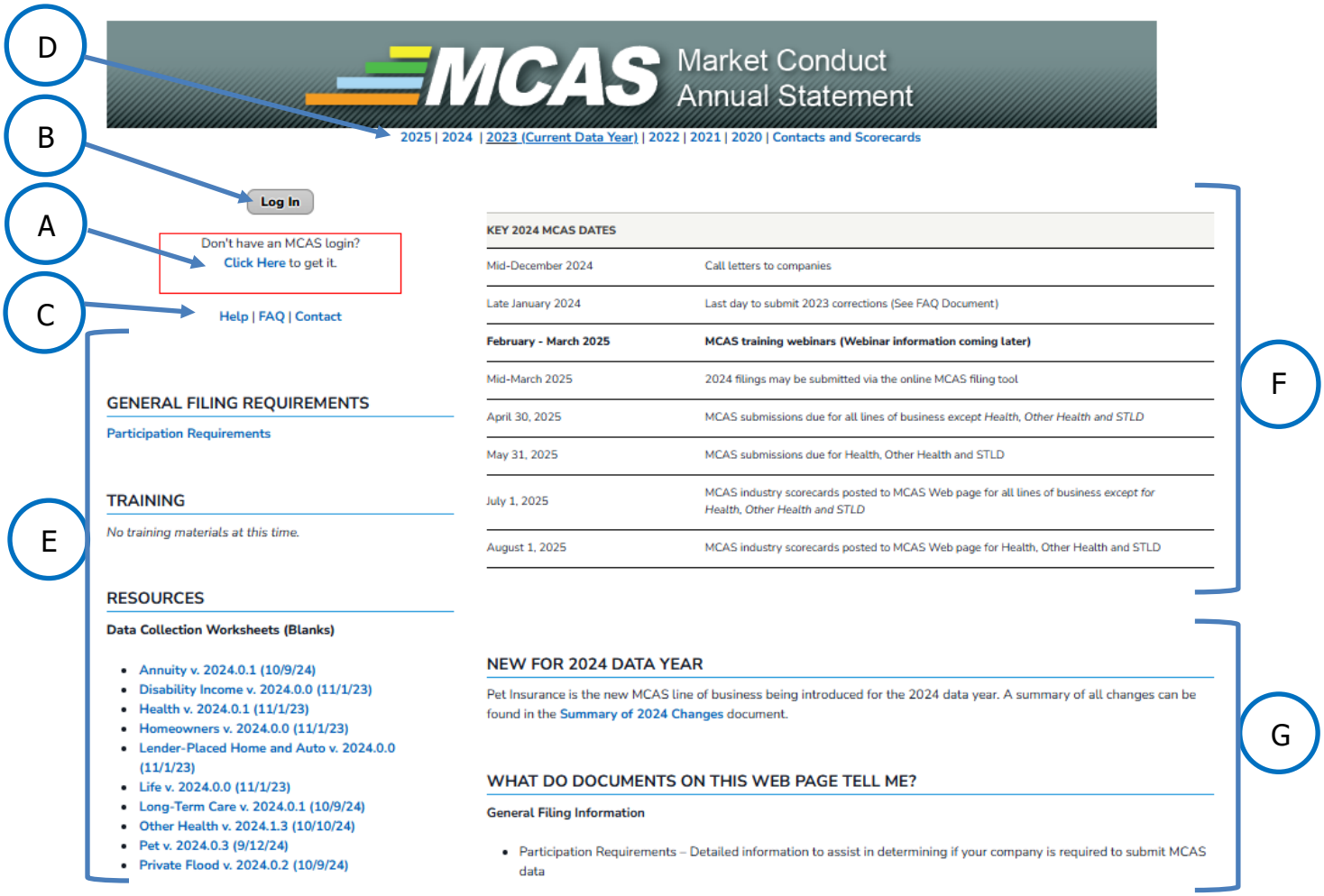
MCAS Web Page

Getting Started

The NAIC MCAS Web page (2024 MCAS) is the primary source of information related to MCAS. A company might find it helpful to bookmark this page and check it frequently during the MCAS filing period.



A - Request for MCAS Login or Password Reset

Every individual wanting entry into the MCAS system must first request an MCAS login through the NAIC. This is done by completing and submitting the Request New MCAS UserID or Password Reset form available through the Click Here link in the red box. Anyone who received an MCAS login in a previous year does **not** need to request another one. For password reset, enter your MCAS ID on the form, and a request will be generated and sent to the NAIC Help Desk. Typically, the NAIC Help Desk creates a new MCAS login and completes the password resets within four business hours of request receipt, but please allow two business days for completion of this task.

B - Log In

A click on this button launches the sign-in screen for the online application. The confidentiality of MCAS data is taken very seriously. Therefore, an individual must have both an NAIC MCAS login **and** must be authorized to access a company's data by the company's MCAS Administrator. Further information about obtaining company authorization is available in the User Assignment section of this guide.

C - Help | FAQ | Contact

A click on the **Help** link will open an online NAIC Help Desk form designed specifically for those seeking MCAS technical assistance. Help requests received on this form are prioritized higher than phone calls or general e-mail correspondence. The **FAQ** link will open a document of common MCAS questions and answers for those who prefer do-it-yourself assistance. The **Contact** link opens an email pre-addressed to the MCAS area of the NAIC where MCAS business questions should be directed.

D - MCAS Navigation Bar

Because the information in the E, F, and G areas vary from one filing year to the next, a navigation bar was introduced to allow ease of movement between year-specific web pages. In addition, this navigation bar includes access to state MCAS contacts, state specific MCAS instructions and annual publicly posted MCAS scorecards.

E - Link Categories

There are additional links grouped into the categories of General Filing Information, Resources, and Communication. Among the Resources category is a tool called Data Collection Worksheets (Blanks). These worksheets are printable PDF files patterned after the MCAS application entry screens. They are designed to assist a company with manual data collection in preparation for data entry into the MCAS online system.

F - Key Dates

The key dates associated with the selected MCAS filing year are located in this area. The highlighting of key dates changes as the current filing year progresses.

G - Body

This area contains information relevant to the filing year for the web page displayed. Items regarding changes and clarifications from the previous year, announcements, and MCAS status updates may be found in this section.

MCAS Application

Overview

The Market Conduct Annual Statement (MCAS) application is the method by which industry files its market data with the states. The current web-based MCAS application was introduced for the 2018 data filing year. This portion of the User Guide contains instructions on how to access the MCAS application and details about each of the application's components:

- Log In
- Terms of Use
- Home
- Filing Matrix
- Lines of Business
    - Annuity
    - Life
    - Homeowners
    - Private Passenger Auto
    - Long-Term Care
    - Health
    - Lender-Placed Insurance
    - Disability Income
    - Pet
    - Private Flood
    - Short-Term Limited Duration
    - Travel
    - Other Health
- Data Upload
- Waivers and Extensions
- Attestation
- Company Ratios
- User Assignments

Helpful Hints

Before beginning the MCAS filing process, here are some things to note to improve your experience with this application.

System Requirements

The NAIC recommends using Chrome or Firefox when working with MCAS. However, Internet Explorer (IE) v9, IE v10, or IE v11 can be used.

An 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.

Browser Back Button

Once inside the MCAS application, the NAIC discourages use of your browser's [Back] button. The recommended method for movement within the application is through use of the blue navigation bar, located at the top of the screen, and the grey sidebar, located on the left side of the screen. Because different browsers behave differently with this application, using your browser's [Back] button might cause an error screen to display or force an immediate exit from the MCAS application. In either situation, there is a risk of losing any unsaved data.

Help Desk Form

The NAIC Help Desk form (described in a previous section) is available within the MCAS application by selecting MCAS Resources on the navigation bar. This selection will take you to the MCAS web page where the form may be selected as previously described.

Log In

The  button on the MCAS webpage launches a sign-in screen where an individual enters his/her NAIC user ID and password. A multi-factor authentication will need to be completed before logging in. New NAIC users will be asked to set up security questions and change their password at initial log in. Once security questions are in place, future password resets can be handled by the individual without the need for involvement of the NAIC Help Desk.

Terms of Use

The first time an individual logs into the MCAS application, the Terms of Use screen is displayed. It is necessary to click the "I accept" box in order to proceed into the application. This acknowledgement of acceptance is valid for 365 days during which time the Terms of Use screen will not appear again. At the end of the 365-day period the individual will be prompted to accept the terms of use once more.

Filing Matrix

Select Filing Matrix

On this portion of the screen, the company and year options for use during the current MCAS session may be selected in the left-hand side bar. These choices may be changed at any time by returning to the Filing Matrix screen and making different selections. A click on the [Select] button displays the Filing Matrix screen for the selected company and year.

The list of companies that appears in the drop-down box is customized to display only the signed-on individual's authorizations. If an expected company is missing from the list, or an unexpected company is included in the list, please contact the MCAS Administrator for the company in question. The company's MCAS Administrator manages who has access to its MCAS data.

Filing Matrix Selection Results

The purpose of this screen is to display a list of participating states for the selected company and data year. The selected company and data year is displayed at the top of the screen.

When a state is selected, the state expands to display a list of all lines of business. A required filing is represented by a red asterisk. In the status column of the drop-down list, the current filing status appears.

This dynamic screen provides up-to-the-minute, at-a-glance information by state and line of business. The information available in the state expansion displayed as columns is as follows:

Required*	The * icon will appear on the right-hand side of a line of business where data submission is expected (see ***Premium** note below).
Status	Possible statuses include:
	In Progress - Some data entered, but not submitted.
	Filed - Data successfully submitted.
	Processing - Data submitted for processing but has not yet filed.
	Not Started - No data entered.
Warnings	Displays number of warnings after data is validated.
Errors	Displays number of errors after data is validated.
Waiver	Status of 'PENDING', 'APPROVED', or 'DENIED' when request submitted.
Extension	Status of 'PENDING', 'APPROVED', or 'DENIED' when request submitted.

*Premium: The "required" or lack of the "required" indicator is based on a company's licensure in a state and its state premium as reported in its financial annual statement. It is important to note that premium reported in the financial annual statement may include coverages that are excluded from MCAS premium. Therefore, depending on a company's product lines, MCAS premium might or might not match financial annual statement premium. Regardless of the status displayed, it is the responsibility of each company to calculate its own MCAS premium to determine if filing in a state is or is not required. Each company needs to indicate if they are required or not required to file fore the applicable lines of business in the MCAS Premium Exhibit in the Financial Annual Statement. Please refer to the MCAS Participation Requirements and General Information document for further information.

The lines of business screens for any given state are accessible by clicking on the state followed by clicking the name of the desired line of business. The Actions section provides a summary view of filing, waiver, and extension status for all states per line of business by clicking the [Filing Summary] button. The Filters section may also be utilized to filter by state, line of business, filing status, required indicator, warnings, errors, extension status, or waiver status. Returning to the Filing Matrix from any screen is accomplished through the navigation bar.

Lines of Business

Common Functionality

The Lines of Business screens contain the line of business name and the state name above the data entry and message areas. Before beginning the entry process, it is important to verify that the data to be entered is associated with the state displayed. There is no automated method to move or copy data from one state to another if entered for an incorrect state.

The data entry area for each line of business is arranged in columns and rows similar to a spreadsheet where the rows are the questions for each filing. Error and Warning messages on the screen include questions (Q) in addition to the appropriately highlighted cells to assist in identifying which cells contain an error or warning. For additional information about messages, their severities, and their meanings, refer to the MCAS Message section at the end of this User Guide.

The following buttons are available on the Line of Business screens, although *not all buttons are always available.* They function as described below.

Button	Action	Description
Save	Saves data without validating it.	Displays message for form or format errors (i.e., alpha characters in a numeric field).
Save & Validate	Saves (see above) then performs calculation checks and tests data business rules.	Displays informational, warning and/or error messages that might require correction before data submission.
Submit*****	Saves & Validates (see above) then releases the data to the NAIC for use by the states if there are no errors.	Appears only on the Summary screen. Displays informational message when submission is successful (see ***Submit** note below).
View Submitted Data	Downloads a pdf file of submitted data for the year specified on the button selected.	PDF downloads and is available for selection in the browser's designated downloaded files section.

Close	Closes the filing for the selected state and line of business.	Exits the filing and returns to Filing Matrix for the selected company and data year.
Print Displayed Data	Displays prompt message to confirm printing options and print displayed screen.	Prints the viewable information currently on the screen regardless of filing status.
Previous	Displays previous screen as listed in Filing Navigation tool.	Displays screen for the previous section of the filing.
Next	Displays next screen as listed in Filing Navigation tool.	Displays screen for the next section of the filing.
Summary	Shows a summary of all data fields for the selected filing.	Displays all sections of the filing in one screen to review data. *****Single page view not available for any previous data year

***Submit**: When a record is submitted for a particular state and line of business, that record goes into a "Processing" status temporarily. During this time, the record is unavailable for update by the company while the data is transferred to the appropriate state. Typically, the transfer process completes in less than two hours. However, if the record remains in "Processing" for 24 hours or more after submission, please complete and submit a Help Desk form.

Annuity

As with Life, the Annuity screen contains three sections: Interrogatory, Data, and Attestation. As of the 2021 data year, there are four coverage columns in the Data section: Individual Indexed Fixed Annuities, Individual Other Fixed Annuities, Individual Indexed Variable Annuities, and Individual Other Variable Annuities. The data in each column is unrelated to the other, although the combined premium for the two columns is used to meet the $50,000 threshold for filing. Responses to questions in the Interrogatory section determine which columns require completion in the Data section.

Disability Income (DI)

The Disability Income (DI) screen contains ten sections: Interrogatories, Claims Information, Claims Decisions Processed, Resulting in Closed Without Payment, Claims Denied-Reasons, Claims Closed After Initial Payment(s), Underwriting Activity (Group & Individual), Covered Lives Related to Underwriting Activity (Group Only), Complaints and Lawsuits, and Attestation. Data elements are collected for eight coverage types namely:

- Individual Voluntary Short-Term (IVST)
- Individual Voluntary Long-Term (IVLT)
- Individual Employer-Paid Short-Term (IEST)
- Individual Employer-Paid Long-Term (IELT)
- Group Voluntary Short-Term (GVST)
- Group Voluntary Long-Term (GVLT)
- Group Employer-Paid Short-Term (GEST)

- Group Employer-Paid Long-Term (GELT)

Accordingly, responses to questions in the Interrogatory section determine which columns require completion.

Homeowners (HO)

The Homeowners screen contains four sections: Interrogatories, Claims Activity, Underwriting Activity, and Attestation. There are five coverage columns in the Claims Activity section: Dwelling, Personal Property, Liability, Medical Payments, and Loss of Use. Responses to questions in the Interrogatory section determine which columns require completion in the Claims Activity section. All data in the Underwriting Activity section is mandatory.

If your company has no claims information to report, but does have underwriting data to report, you will then enter all zeros in the claims sections for those coverages for which you answered "Y" to the interrogatory question, "Were there policies in force during the reporting period that provided "xxx" coverage. Conversely, you will leave all data elements null (i.e., unanswered) in the claims section for those coverages for which you answered "N" to the interrogatory question, "Were there policies in force during the reporting period that provided "xxx" coverage.

Health

The Health screen contains 13 sections including Interrogatories, Attestation, and the following coverage types:

- In-Exchange (Individual) [IEIH]
- In-Exchange (Small Group) [IESG]
- In-Exchange (Catastrophic) [IECA]
- In-Exchange (Multi-State Individual) [IEMI]
- In-Exchange (Multi-State Small Group) [IEMS]
- Out-of-Exchange (Individual) [OEIH]
- Out-of-Exchange (Small Group) [OESG]
- Out-of-Exchange (Grandfathered) [OEGT]
- Out-of-Exchange (Catastrophic) [OECA]
- Out-of-Exchange (Large Group) [OELG]
- Out-of-Exchange (Student) [OESP]

Each coverage type has seven subsections: Policy Administration, Prior Authorizations Excluding Pharmacy, Prior Authorizations – Pharmacy Only, Claims Administration (Excluding Pharmacy), Claims Administration (Pharmacy Only), Consumer Requested Internal Reviews/Grievances (Including Pharmacy), Consumer Requested External Reviews (Including Pharmacy).

Each In-Exchange subsection, with the exception of the Catastrophic section, has five columns broken down into metal levels (Bronze, Silver, Gold, Platinum and Total). Catastrophic is reported in total only. The Out-of-Exchange Individual and Small Group sections each have five columns broken down into metal levels (Bronze, Silver, Gold,

Platinum and Total). The Out-of-Exchange Grandfathered Plan is broken down into four columns: Large Group, Small Group, Individual, and Total. Catastrophic, Large Group, and Student Coverage are reported in total only. Responses to questions in the Interrogatories section determine which tables require completion.

Lender-Placed Insurance (LPI)

The Lender-Placed Insurance (LPI) screen contains four sections: Interrogatories, Claims Activity, Underwriting Activity, and Attestation. Data elements in the claims and underwriting activity sections are collected for ten coverage types (or subsections):

- Single-Interest Auto (SIA)
- Dual-Interest Auto (DIA)
- Single-Interest Home Hazard (SIHH)
- Dual-Interest Home Hazard (DIHH)
- Single-Interest Home Flood (SIHF)
- Dual-Interest Home Flood (DIHF)
- Single-Interest Home Wind-Only (SIHWO)
- Dual-Interest Home Wind-Only (DIHWO)
- Blanket Vendor Single-Interest Auto (BVSIA)
- Blanket Vendor Single-Interest Home (BVSIH)

Accordingly, responses to questions in the Interrogatories section determine which columns require completion.

Life

As of the 2021 data year, the Life screen contains three sections: Interrogatories, Data, and Attestation. There are two coverage columns in the Data section: Individual Life Cash Value and Individual Life Non-Cash Value. The data in each column is unrelated to the other, although the combined premium for the two columns is used to meet the $50,000 threshold for filing. Responses to questions in the Interrogatory section determine which columns require completion in the Data section.

Long-Term Care (LTC)

The Long-Term Care screen contains six sections: Interrogatories, General Information, Claimants and Claimant Requests Activity, Benefit Payment Requests Activity, Lawsuit Activity, and Attestation. There are three coverage columns in the sections following the Interrogatories section: Stand Alone LTC, Life LTC Hybrid, and Annuity LTC Hybrid. Responses to questions in the Interrogatories section determine which columns require completion.

Private Passenger Auto (PPA)

The Private Passenger Auto screen contains four sections: Interrogatories, Claims Activity, Underwriting Activity, and Attestation. There are nine coverage subsections in the Claims Activity section: Collision, Comprehensive, Bodily Injury, Property Damage, UMBI & UIMBI, UMPD & UIMPD, Medical Payments, Combined Single Limits, and Personal Injury Protection. Responses to questions in the Interrogatory section determine which

columns require completion in the Claims section. All data in the Underwriting Activity section is mandatory.

If your company has no claims information to report, but does have underwriting data to report, you will then enter all zeros in the claims sections for those coverages for which you answered "Y" to the interrogatory question, "Were there policies in force during the reporting period that provided "xxx" coverage. Conversely, you will leave all data elements null (i.e., unanswered) in the claims section for those coverages for which you answered "N" to the interrogatory question, "Were there policies in force during the reporting period that provided "xxx" coverage.

Other Health

The Other Health (OTHLTH) screen contains six sections: Interrogatories, Policy/Certificate Administration, Claims Administration (Including Pharmacy), Consumer Complaints and Lawsuits, Marketing and Sales, and Attestation. Data elements are collected for three main coverage types, each of which is further broken down:

- Individual
    - Accident Only
    - Accidental Death and Dismemberment
    - Specified Disease-Limited Benefit / Critical Illness
    - Hospital / Other Indemnity
    - Hospital / Surgical / Medical Expense
- Association
    - Accident Only
    - Accidental Death and Dismemberment
    - Specified Disease-Limited Benefit / Critical Illness
    - Hospital / Other Indemnity
    - Hospital / Surgical / Medical Expense
- Employer Group
    - Accident Only
    - Accidental Death and Dismemberment
    - Specified Disease-Limited Benefit / Critical Illness
    - Hospital / Other Indemnity
    - Hospital / Surgical / Medical Expense

Pet

The Private Flood (PF) screen contains six sections: Interrogatories, Underwriting Activity, Claims Activity, Marketing and Sales, Lawsuit and Complaint Activity, and Attestation.

Private Flood (PF)

The Private Flood (PF) screen contains five sections: Interrogatories, Claims Information, Underwriting, Lawsuits and Complaints, and Attestation. Data elements are collected for six coverage types:

- Stand-Alone (First Dollar Coverage)

- Stand-Alone (Excess Coverage)
- Endorsement to a Homeowner's Policy (First Dollar Coverage)
- Endorsement to a Homeowner's Policy (Excess Coverage)
- Endorsement to a Homeowner's Other Policy (First Dollar Coverage)
- Endorsement to a Homeowner's Other Policy (Excess Coverage)

Accordingly, responses to questions in the Interrogatory section determine which columns require completion.

Short-Term Limited Duration

The Short-Term Limited Duration (STLDI) screen contains seven sections: Interrogatories, Policy/ Certificate Administration, Prior Authorizations, Claims Administration (Including Pharmacy), Consumer Complains and Lawsuits, Marketing and Sales, and Attestation. Data elements are collected for nine coverage types:

- STLDI <= 90
- STLDI < 180
- STLDI 181-364
- STLDI Not Sitused <= 90
- STLDI Not Sitused < 180
- STLDI Not Sitused 181-364
- STLDI Sitused <= 90
- STLDI Sitused < 180
- STLDI Sitused > 181-364

Travel

The Travel (TRVL) screen contains five sections: Interrogatories, Claims Activity (Counts Reported by Claimant, by Coverage), Lawsuits and Complaints, Underwriting, and Attestation. Data elements are collected for seven main coverage types, each of which is broken down into Domestic and International (Emergency Medical/ Dental further broken down into Excess and Primary):

- Trip Cancellation
    - Domestic
    - International
- Trip Interruption
    - Domestic
    - International
- Trip Delay
    - Domestic
    - International
- Baggage Loss/ Delay
    - Domestic
    - International
- Emergency Medical/ Dental
    - Domestic
        - Excess
        - Primary

    - International
        - Excess
        - Primary
- Emergency Transportation/ Repatriation
    - Domestic
    - International
- Other
    - Domestic
    - International

Re-filing

Current Data Year

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. Changes are made by replacing the old values with new ones where needed. The csv upload option is also available for re-filings. 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.

Previous Data Year

Re-filing for previous data years requires approval by the impacted state(s). Upon receipt of approval from the state(s), NAIC staff will "unlock" the filing for the year, cocode, state, and line of business specified. A filing must also be unlocked to view previous year data. Once in the unlocked status the company may view the filing and process the re-filing as described in the Current Data Year section above.

Re-filings for three years or more prior to the current data year cannot be accepted through the online system. Special arrangements must be made directly with the state(s). If a previous data year filing is being updated, but not submitted, and the filing closes, the data will revert to the original filing data that was submitted.

Data Upload

The data upload process is an optional alternative to the manual data entry process. The Data Upload screen accepts data exclusively in a .csv file format to populate the line of business screens. Use the [Browse] button on the Data Upload screen to locate and select the file. An uploaded data file may contain records for multiple lines of business, only some columns within a line of business, or only a few fields for a column.
Data submitted through the file upload process overlays whatever data currently exists on the respective Line of Business screen. The details about .csv file structure and record layouts are in the MCAS 2022 Data File Instructions Guide.

Waivers & Extensions

In some instances, a company might need to request an extension of the filing due date or a complete waiver in a particular state. The MCAS application includes the capability for a company to generate an electronic request to one or more states for consideration.

After the affected state receives notification of the request, it can approve or deny the request online. Once the state action is determined and the request is updated, the decision is immediately available for viewing by the requesting company through the MCAS application.

List

By selecting [Waivers] or [Extensions] from the Actions section in the left-hand sidebar, the Waivers or Extensions screen displays. This screen provides a drop-down selection option for a line of business. After a line is selected, available states to request a waiver or extension appears. Multiple states may be selected at one time.

The status of a request is displayed in the respective Waiver or Extension column under each state and line of business as previously described in the Filing Matrix section. The request status options are:

Status	**Description**
Pending	Company submitted a request to the state and is awaiting a response.
Approved	State granted the request.
Denied	State rejected the request.

Access to an existing request is available by selecting the request status under the respective column. For example, if an extension for Health in Missouri says PENDING, select the word PENDING. The request previously submitted will appear with options to update or delete the request. It is the company's responsibility to check the waivers or extensions status in the Filing Matrix periodically to see if the state has taken action.

Attestation

The Attestation screen is located as the last section in each individual filing for each line of business. It includes fields to record the names and titles of the company representatives serving as attesters. By completing the attestation, the company's representatives are attesting to the accuracy of the MCAS data for the original filings as well as any re-filings necessary for the selected data year and line of business. The Attestation screen must be completed before the filings can be submitted.

The Company Comments field is located on this screen, as well. This field is available for the company to proactively communicate circumstances or conditions that might affect the company's MCAS numbers for a particular line of business as a whole.

Company Ratios

The Company Ratios screen provides a post-filing report by state of the statistics associated with the company's submission. This information is available for review immediately following a successful submission where filing status is Filed. As filings are completed in additional states, additional data is displayed on this screen. Once a company completes all of its filings, it is beneficial to print a final copy of this report. When the states' Scorecards become available, the company can use this report to compare their ratios to the Scorecard ratios of those states in which they do business.

User Administration
Administration of access to the MCAS application is controlled by way of the User Administration screen. Through this screen the company's MCAS Administrator has the authority to add and remove users to the MCAS application on behalf of the company. In addition, the Administrator may designate a specific MCAS contact to serve as the point person for MCAS filing issues and regulator questions. All users, including the Administrator and Contact, must obtain an MCAS user ID from the NAIC help desk prior to being added to the User Administration screen.

Administrator
The Administrator has the authority to add and remove MCAS system access for other users on behalf of the company and the authority to assign the Contact. NAIC staff can assign the Administrator role to the Market Conduct Contact, or Financial Statement Contact, as identified on the latest financial annual statement filing. This role may be assigned or reassigned to another company user, but only by special request of a company officer to the NAIC.

After an initial Administrator has been assigned by the NAIC, any subsequent changes may be made by the current Administrator by selecting the Administrator bubble for a secondary user.

Contact
The Contact person is the company's designated "go to" person for any questions from state insurance regulators and/or the NAIC related to the company's MCAS filing. Only one individual may have this role at a time, although it may be reassigned by the Administrator any time the company wishes to make a change.

Users
Users under the selected company will display in two sections on this screen: Administrator and Secondary Users. View and edit capabilities are available to all individuals associated with the company code. An Administrator or Contact role assignment is indicated with a filled bubble button in the Administrator and/or Contact column next to an individual's name.

Median Day Validation
A median is defined as the middle value in a series of ordered values. A median is found by counting the entities in the series and selecting the entity that has an equal number of entities above it and below it. MCAS is requesting the days to payment of the median (or the middle) claim which was closed with payment. To verify that the value reported in this field passes the "reasonableness" test, a validation is performed using the following steps.

Example using an **odd** number of claims closed with payment:

Calculation Steps	Example	
1. Divide the value reported as "claims closed with payment" by 2 to determine median value. When the total claims are an odd number, the median value is definite.	Claims closed with payment = 101 101/2 = 50.5 Median = 51 (rounded up) Because an equal number of values come before (1-50) and after (52-101) the number 51, it is the middle value.	
2. Count the number of claims reported in each timeframe bucket (0-30 days, 31-60 days, etc.) until the median claim value is reached.		Running Total
	0-30 days = 30	30
	31-60 days = 14	(30 + 14) = 44
	61-90 days = 12	(44 + 12) = **56**
	91-180 days = 21	(56 + 21) = 77
	181-365 days = 24	(76 + 24) = 101
3. Compare value entered in MCAS to timeframe bucket calculated.	MCAS value entered = 66 Median range calculated = 61-90	
4. Test that the 51st value is within the 61 - 90 range AND the MCAS entered value of 66 is also within the 61 - 90 range.	Validation passes.	

Example using an **even** number of claims closed with payment:

Calculation Steps	Example	
1. Divide the value reported as "claims closed with payment" by 2 to determine median value. When the total claims are an even number, the median value includes the calculated number and the calculated number +1 in order to maintain an equal number of entities above and below the median.	Claims closed with payment = 100 100/2 = 50 Median = 50 and 51 To have an equal number of values before and after 100, the median would be 50.5. This is not a valid number of claims, therefore 50 and 51 are both used.	
2. Count the number of claims reported in each timeframe bucket (0-30 days, 31-60 days, etc.) until the median claim values are reached. Both		Running Total
	0-30 days = 30	30
	31-60 days = 14	(30 + 14) = 44
	61-90 days = 12	(44 + 12) = **56**
	91-180 days = 20	(56 + 20) = 76

median values must be tested for the timeframe bucket. *	181-365 days = 24	(76 + 24) = 100
3. Compare value entered in MCAS to timeframe bucket calculated.	MCAS value entered = 62 Median range calculated = 61-90	
4. Test that both the 50th and 51st values are within the 61 - 90 range AND the MCAS entered value of 62 is also within the 61 - 90 range.	Validation passes.	

*If the 50th claim was in the 31-60 timeframe bucket and the 51st claim was in the 61-90 timeframe bucket, then an acceptable MCAS "median days to final payment" value would be a number that falls between 31-90 days.