# Market Conduct Annual Statement
# Short-Term Limited Duration Insurance
# Data Call & Definitions

**Line of Business:** Short-Term Limited Duration Insurance

**Reporting Period:** January 1, 2026 through December 31, 2026

**Filing Deadline:** May 31, 2027

## Contact Information

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| MCAS Administrator | The person responsible for assigning who may view and input company data. |
| MCAS Contact | The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator. |
| MCAS Attestor | The person who attests to the completeness and accuracy of the MCAS data. |

## Schedule 1 – Interrogatories

| ID | Description | Response |
|---|---|---|
| 1-01 | List the states where your STLD products are marketed | Comment |
| 1-02 | Does the company offer STLD policies/certificates with up to a 90-day duration? | Yes/No |
| 1-03 | Does the company offer STLD policies/certificates with 91- to 180-day duration? | Yes/No |
| 1-04 | Does the company offer STLD policies/certificates with 181- to 364-day duration? | Yes/No |
| 1-05 | Number of STLD forms offered to residents in this state | Comment |
| 1-06 | Number of STLD forms offered in all states | Comment |
| 1-07 | Number of STLD forms filed in this state | Comment |
| 1-08 | Number of STLD forms filed in all states | Comment |
| 1-09 | List the states where your STLD products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing | Comment |

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| 1-10 | How many policy forms have waiting periods that apply to the entire policy/certificate? | Number |
| 1-11 | How many policy forms have waiting periods that apply per specific benefits? | Number |
| 1-12 | Do any waiting periods exceed the policy/certificate term? | Yes/No |
| 1-13 | If yes, please explain | Comment |
| 1-14 | Does the company issue STLD products through associations? | Yes/No |
| 1-15 | If yes, list the associations | Comment |
| 1-16 | If yes, do you have a contractual relationship with each Association? | Yes/No |
| 1-17 | If yes, does the contract cover the marketing of your product? | Yes/No |
| 1-18 | If yes, does the contract cover the collection of dues and fees? | Yes/No |
| 1-19 | If yes, does the contract cover commissions? | Yes/No |
| 1-20 | If yes, what other operational areas are covered in the contract? | Comment |
| 1-21 | Does the company issue STLD products through trusts? | Yes/No |
| 1-22 | If yes, how many? | Comment |
| 1-23 | Does the company issue STLD products through administrators? | Yes/No |
| 1-24 | If yes, how many? | Comment |
| 1-25 | Does the company contract with third-party administrators for administrative services related to STLD products? | Yes/No |
| 1-26 | If yes, does your delegation structure include claims related to STLD products? | Yes/No |
| 1-27 | If yes, does your delegation structure include complaints related to STLD products? | Yes/No |
| 1-28 | If yes, does your delegation structure include medical underwriting related to STLD products? | Yes/No |
| 1-29 | If yes, does your delegation structure include pricing related to STLD products? | Yes/No |
| 1-30 | If yes, does your delegation structure include producer appointments related to STLD products? | Yes/No |
| 1-31 | If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLD products? | Yes/No |
| 1-32 | Does your company audit Third parties to whom you have delegated responsibilities? | Yes/No |
| 1-33 | If yes, please provide frequency of audits | Comment |

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| 1-34 | Does the company offer renewals/reissues? | Yes/No |
| 1-35 | Are any renewals/reissues subject to optional or mandatory underwriting? | Yes/No |
| 1-36 | If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue | Comment |
| 1-37 | Are there limitations on the number renewals per individual? | Yes/No |
| 1-38 | Does your company offer renewal(s) without underwriting for an additional charge? | Yes/No |
| 1-39 | If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge | Comment |
| 1-40 | Are the limitations on renewals based on state, federal, or company rules? | Yes/No |
| 1-41 | Does your company distribute its product through independent agents? | Yes/No |
| 1-42 | Does your company distribute its products through captive agents? | Yes/No |
| 1-43 | Does your company distribute its products through its employees? | Yes/No |
| 1-44 | What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other) | Comment |
| 1-45 | Additional State Specific Comments (optional) | Comment |

# Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

**Products**

| Product Identifiers | Explanation of Product Identifiers |
|---|---|
| STLD <=90 | Short-Term Limited Duration Insurance not sold through an Association with a term less than or equal to 90 days |
| STLD 91-180 | Short-Term Limited Duration Insurance not sold through an Association with a term greater than 90 and less than or equal to 180 days |
| STLD 181 - 364 | Short-Term Limited Duration Insurance not sold through an Association with a term greater than 180 days and less than 364 days |
| STLD Not Sitused <=90 | Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term less than or equal to 90 days |
| STLD Not Sitused 91-180 | Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 90 and less than or equal to 180 days |
| STLD Not Sitused 181 - 364 | Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 180 days and less than 364 days |
| STLD Sitused <=90 | Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term less than or equal to 90 days |
| STLD Sitused 91-180 | Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 90 and less than or equal to 180 days |
| STLD Sitused >181 - 364 | Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 180 days and less than 364 days |

## Schedule 2 – Policy/Certificate Administration

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| 2-46 | Direct Written Premium. |
| 2-47 | Earned premiums for Reporting Year |
| 2-48 | Number of Policies/Certificates in Force at the Beginning of the Period |
| 2-49 | Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period |
| 2-50 | Number of new policy/certificate applications received during the period |
| 2-51 | Number of new policy/certificates issued during the period |
| 2-52 | Number of new policies/certificates denied during the period |
| 2-53 | Number of Covered Lives on New Policies/Certificates Issued During the Period |
| 2-54 | Member months for policies/certificates newly issued during the period |
| 2-55 | Number of policy/certificate renewal/reissue applications received during the period |
| 2-56 | Number of policies/certificates renewed/reissued during the period |
| 2-57 | Number of policies/certificates non-renewed or denied at the option of insurer during the period |
| 2-58 | Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period |
| 2-59 | Number of renewals/reissues allowed |
| 2-60 | Member months for policies/certificates renewed/reissued during the period |
| 2-61 | Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting |
| 2-62 | Member months for other than new policies/certificates or renewal/reissued policies/certificates during the period |
| 2-63 | Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder |
| 2-64 | Number of policies/certificates cancelled during the free look period |
| 2-65 | Number of policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period |
| 2-66 | Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period |
| 2-67 | Number of policy/certificate terminations and cancellations due to non-payment of premium |
| 2-68 | Number of policies/certificates cancelled by insurer for any reason other than non-payment of premium during the period |

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| 2-69 | Number of policies/certificates cancelled by insurer following filing of a claim or prior authorization request by the policyholder/certificate holder during the period |
| 2-70 | Number of lives on policies/certificates cancelled by insurer following filing of a claim or prior authorization request by the policyholder/certificate holder during the period |
| 2-71 | Number of rescissions |
| 2-72 | Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificate holder |
| 2-73 | Number of insured lives impacted on termination and cancellations due to nonpayment |
| 2-74 | Number of insured lives impacted by rescissions |
| 2-75 | Number of Policies/Certificates in Force at the End of the Period |
| 2-76 | Number of Covered Lives on Policies/Certificates in Force at the End of the Period |

**Schedule 3 – Prior Authorizations**

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| 3-77 | Number of Prior Authorization Requests Pending at the Beginning of the Period |
| 3-78 | Number of prior authorizations requested during period |
| 3-79 | Number of prior authorizations approved during period |
| 3-80 | Number of prior authorizations denied during period |
| 3-81 | Number of claims where prior authorization penalties were assessed |
| 3-82 | Number of Prior Authorization Requests Pending at the End of the Period |
| 3-83 | Median Number of Days from Receipt of Prior Authorization Request to Decision |
| 3-84 | Average Number of Days from Receipt of Prior Authorization to Decision |

**Schedule 4 – Claims Administration (Including Pharmacy)**

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| 4-85 | Number of Claims Pending at the Beginning of the Period |
| 4-86 | Number of claims received |
| 4-87 | Total number of claims denied, rejected or returned |
| 4-88 | Number of denied, rejected, or returned due to claims submission coding error(s) |
| 4-89 | Number of denied, rejected, or returned for lack of Prior Authorization |

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| 4-90 | Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation |
| 4-91 | Number of denied, rejected, or returned as Not medically necessary |
| 4-92 | Number of denied, rejected, or returned as Subject to pre-existing condition exclusion |
| 4-93 | Number denied, rejected, or returned due to failure to provide adequate documentation |
| 4-94 | Number denied, rejected, or returned due to being within the waiting period |
| 4-95 | Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded |
| 4-96 | Number of denied, rejected, or returned for Out-of-Network provider |
| 4-97 | Number of Claims Pending at End of Period |
| 4-98 | Median Number of Days from Receipt of Claim to Decision for Denied Claims |
| 4-99 | Average Number of Days from Receipt of Claim to Decision for Denied Claims |
| 4-100 | Median Number of Days from Receipt of Claim to Decision for Approved Claims |
| 4-101 | Average Number of Days from Receipt of Claim to Decision for Approved Claims |
| 4-102 | Number of Claim Decisions Appeals Pending At Beginning of Period |
| 4-103 | Number of Claim Decision Appeals Received During the Period |
| 4-104 | Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period |
| 4-105 | Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period |
| 4-106 | Number of Claim Decision Appeals Rejected and Not Considered for Any Reason |
| 4-107 | Number of Claim Decision Appeals Pending at End of Period |
| 4-108 | Average Number of Days from Receipt of Appeal to Decision |
| 4-109 | Number of claims paid |
| 4-110 | Dollar amount of claims paid during the period |

**Schedule 5 – Consumer Complaints and Lawsuits**

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| 5-111 | Number of complaints received ~~by Company (other than through the DOI)~~ directly from any person or entity other than the DOI |
| 5-112 | Number of complaints received through DOI |
| 5-113 | Number of complaints resulting in claims reprocessing |
| 5-114 | Number of Lawsuits Open at Beginning of the Period |
| 5-115 | Number of Lawsuits Opened During the Period |
| 5-116 | Number of Lawsuits Closed During the Period |

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| 5-117 | Number of Lawsuits Closed During the Period with Consideration for the Consumer |
| 5-118 | Number of Lawsuits Open at End of Period |

**Schedule 6 – Marketing and Sales**

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| 6-119 | Number of Individual Applications Pending at the Beginning of the Period |
| 6-120 | Number of applications received |
| 6-121 | Number of Renewal/Reissue Individual Applications Received During the Period |
| 6-122 | Number of New Individual Applications Denied During the Period for Any Reason |
| 6-123 | Number of New Individual Applications Denied During the Period - Health Status or Condition |
| 6-124 | Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason |
| 6-125 | Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition |
| 6-126 | Number of New Individual Applications Approved During the Period |
| 6-127 | Number of Renewal/Reissue Individual Applications Approved During the Period |
| 6-128 | Number of Individual Applications Pending at the End of the Period |
| 6-129 | Number of applications initiated via phone |
| 6-130 | Number of applications completed via phone |
| 6-131 | Number of applications initiated face-to-face |
| 6-132 | Number of applications completed face-to-face |
| 6-133 | Number of applications initiated online (Electronically) |
| 6-134 | Number of applications completed online (Electronically) |
| 6-135 | Number of New Individual Applications initiated by Mail During the Period |
| 6-136 | Number of New Individual Applications completed by Mail During the Period |
| 6-137 | Number of New Individual Applications initiated by Any Other Method During the Period |
| 6-138 | Number of New Individual Applications completed by Any Other Method During the Period |
| 6-139 | Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period) |
| 6-140 | Unearned Commissions returned to company on policies/certificates sold during the period |

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| 6-141 | Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period) |

**Schedule 7– Short-Term Limited Duration Attestation**

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

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| 7-142 | First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title) |
| 7-143 | Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title) |
| 7-144 | Overall Comments for the Period |

**Participation Requirements:** All companies licensed and reporting at least $50,000 of Short-Term Limited Duration Insurance (STLD) premium for all coverages reportable in

MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

**Report by Residency**: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situsted.

**General Definitions:**

**Short-Term Limited-Duration Insurance** - Health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract. (state and federal government guidelines may have renewal duration limitations)

**Association –** For purposes of this MCAS blank, a non-employer group that secures benefits for its members.

**Individual STLD Product –** Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance. An individual STLD policy is **not** issued to a trust, association, or administrator.

**Group STLD Product/Coverage -** Policies issued to a trust, association, or administrator for the purpose of marketing, selling, and issuing certificates to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance and regardless of where the association, trust, or administrator is situsted.

**New Policies/Certificates Issued -** STLD policy/certificate issued to an individual or family for whom no prior short-term coverage has been placed with the same insurer within the previous 63 days

**Policies / Certificates** - Refers to the coverage documents provided to individuals or families (i.e., state residents) who are enrolled in coverage (not the association)

**Policyholder / Certificateholder –** Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association). Policyholder is the individual when purchased in the individual market.

Certificateholder is the individual when purchased through an Association, which is the policyholder.

**Renewal / Reissue -** STLD policy/certificate issued to an individual or family for whom prior short-term coverage has been placed with the same insurer within 63 days of the prior coverage. If a policy is re-underwritten based on health factors or provides different benefits, it should be reported as a new policy/certificate issued.

**Schedule 2 Definitions (Policy/Certificate Administration):**

**Rescission –** A rescission is a cancellation or discontinuance of coverage that is retroactive to the issue date. (Does not include cancellations for non-payment.)

**Written Premium** - Provide the total annual written premium for all policies and/or certificates issued to insureds residing in the state for which reporting is being completed

**Earned Premium –** Total premium earned from all policies/certificates written by the insurer during the specified period.

**Free Look** – A set number of days provided in an insurance policy/certificate that allows time for the purchaser to review the contract provisions with the right to return the policy/certificate for a full refund of all premium paid. Report the number of policies/certificates that were returned by the insured under the free look provision during the period, regardless of the original issuance date.

**Member months–** The *sum* of total number of lives insured on policies/certificates issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

**Schedule 3 and 4 Definitions (Prior Authorization and Claims Administration):**

**Prior Authorization –** A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification, this includes any provision requiring the insured to notify the company prior to treatment.

**Claim** – For the purposes of this data call a claim means any individual line of service within a bill for services.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Claims are to be reported at the service line level.
- Capitated claims are to be reported if an Explanation of Benefits (EOB) is generated.
- Duplicate claims should not be reported.

**Claims Received** - provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

**Claims Denied -** provide the total number of claims denied during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed; includes rejected and returned claims, whether in whole or in part

Clarification:

- The nine claim denial reporting categories are not exhaustive. Claim denials reported in the categories should be a subset of the reported total denials.

**Claims Paid -** provide the total number of claims paid during the reporting period for individual policyholders and/or group certificateholders residing in the state for which reporting is being completed.

**Waiting Period**: Period of time a covered person who is entitled to receive benefits for sicknesses must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

## Schedule 5 Definitions (Consumer Requested Reviews/Grievance/Complaints):

**Lawsuit**—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Short-Term Limited Duration Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

**Lawsuits Closed During the Period with Consideration for the Consumer**—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

## Schedule 6 Definitions (Marketing and Sales)

**Commissions** - The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. NOTE: For products *not* related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting.

**Other Remuneration** - Any monetary consideration provided by the insurer through the course of the insurance transaction. This is not commissions and are separate amounts paid for as a result of the insurance transaction.