Question 09: If Yes, how is non-standard defined? Response: High-Risk Policy-holders.

Question 16: Additional state specific Underwriting comments (optional): Response: Most of the policies written are on high-risk policyholders. In addition, the company also writes some creditor-placed business.

Homeowners Underwriting Activity

Question 42: Dollar amount of direct premium written during the period: Response: $500,000

FAS State Page:

Line 4: Homeowners Multiple Peril: Direct Premiums Written: $1,000,000.

Using the above example, we observe that:

1) The company reports only $500,000 for the MCAS HO dollar amount of direct premium written during the period.
2) Calculating the tolerance limits, we note that the amount reported in the FAS ($1,000,000) exceeds the tolerance limits for the premium reported in the MCAS filing, and therefore yield the warning message.
   a. Upper Limit: (1+20%) x $500,000 = $600,000
   b. Lower Limit: (1- 20%) x $500,000 = $400,000

If you encounter this warning message, please review the premium amounts reported in the MCAS filing for accuracy and/or make corrections as needed. If the MCAS premiums reported are correct, please include comments regarding the difference in premium amounts within the provided comment areas found in the interrogatory section of the MCAS filing.

Health MCAS

- *What should I report if I don't collect data for a specific data element?*
- *What is the definition of "policy", as it pertains to Health insurance coverage?*
- *Who is the policy holder in a group policy or individual policy?*
- *What is meant by "Health Insurance Coverage"? (Updated 02/27/2018)*
- *Are Dental and Vision claims part of the Claims Administration if they are embedded in the medical policy (purchased as a package)?*
- *How should individuals that change products mid-year be accounted for?*
- *When reporting claims received and or claims denied, which date should we use as the anchor date for reporting?*
- *How are line items on bundled claims reported? (Updated per interim meeting on 1/23 - 1/24/2019)*
- *Should duplicate claims be reported? (updated per interim meeting on 1/23 - 1/24/2019)*
- *How are claim payment adjustments reported?*
- *When a claim is received with insufficient data, would it count as a denial?*
- *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?*
- *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? (Updated per interim meeting on 1/23 - 1/24/2019)*
- *If a claimed service is included in a prepaid capitated service, should this be reported as a denied claim or a paid claim? (Updated 03/23/2018)*
- *Should second level internal reviews be reported in the MCAS? (Updated 03/23/2018)*
- *If a grievance includes multiple services, some of the services may be upheld while others are overturned. In this situation, should the grievance be reported as approved or denied? (Updated 03/23/2018)*
- *How should group policies be counted if multiple policy products are included within a single contract? (Updated per interim meeting on 1/23 - 1/24/2019)*

- *Should an insured individual or group that changes to another product offered by the same carrier be reported as a termination? (added per interim meeting on 1/23 - 1/24/2019)*
- *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? (added per interim meeting on 1/23 - 1/24/2019)*
- *How do we determine which data year prior authorization requests, approvals or denials are to be reported in? (added per interim meeting on 1/23 - 1/24/2019)*
- *How do we determine which data year claims received, paid or denied are to be reported in? (added per interim meeting on 1/23 - 1/24/2019)*
- *Should capitated claims be reported? (added per interim meeting on 1/23 - 1/24/2019)*
- *Should the number of total claim denials be equal to the sum of the five claim denial reporting categories? (added per interim meeting on 1/23 - 1/24/2019)*
- *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? (added per interim meeting on 1/23 - 1/24/2019)*

- What should I report if I don't collect data for a specific data element?

  If the carrier does not currently collect the necessary information, a note should be added to the comments questions (line 8 and 18) on the MCAS Health Interrogatories section. It is expected that this information is available for reporting. Contact the state MCAS Contact if you have further questions.

- 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?

  If the policy is a "group policy" then the policy holder is the group. If the policy is an "individual policy" then the individual is the policy holder.

What is meant by "Health Insurance Coverage"? *(Updated 02/27/2018)*

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

Health Insurance Coverage – 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. (2018 MCAS Health Data Call and Definitions Documentation)

Following are the excepted benefits found in 42 U.S.C. § 300gg-91:

(c) Excepted benefits

For purposes of this subchapter, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, non-coordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1395ss (g)(1) of this title), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

In addition to the exclusions covered within the Health Insurance Coverage definition and the excepted benefits found in 42 U.S.C. § 300gg-91, the following should be excluded from health MCAS reporting:

- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

- 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.
  - Member months for the previous policy would be reported as a renewed policy if applicable.
  - If the previous policy was terminated at the consumer's request, it would be reported as such.

  Member months are counted only for the months during the reporting period. No more than 12 member months should be counted for one individual.

- When reporting claims received and or claims denied, which date should we use as the anchor date for reporting?

  In an effort to create uniformity with the anchor date used for claims received and denied it is recommended that the received/determination date be used as the anchor date.

- How are line items on bundled claims reported? *(Updated per interim meeting on 1/23 - 1/24/2019)*

  Claims should be reported at the service line level.

- Should duplicate claims be reported? *(updated per interim meeting on 1/23 - 1/24/2019)*

  Duplicate claims should not be reported.

- How are claim payment adjustments reported?

  A claim payment adjustment would only be considered as a separate claim if it receives a different/new claim number. If the original claim number is used (reopened), it would be considered as part of the original claim and would be aged from receipt of the original claim.

- When a claim is received with insufficient data, would it count as a denial?

  Incomplete claims would not be included in the count of denied claims.

- Should the number of member months only include member months that occur during the reporting period, or should the number of months since inception of the policies that were issued or renewed during the reporting period be included?

  The request is for member months where policies were in force during the reporting period. The member months for an individual will never exceed 12 months.

  Example: A policy for one individual renewed in February 2017, but was in force for the entire 12 months of 2017 would be counted as 12 member months.

  Note: The health MCAS definition of member months is taken directly from the financial annual statement supplemental health care exhibit instructions. The member months reported in the MCAS should be calculated in the same fashion as for the financial statement.

- 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? *(Updated per interim meeting on 1/23 - 1/24/2019)*

  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? *(Updated 03/23/2018)*

  If the Explanation of Benefits indicates that the service was paid or covered, then it should be reported as paid. If the Explanation of Benefits indicates that the service was denied, then it should be reported as denied.

- Should second level internal reviews be reported in the MCAS? *(Updated 03/23/2018)*

  Only first level internal reviews should be reported. However, one of the questions within the interrogatory section of the health MCAS asks if the company has an additional voluntary level of review for grievances. Second level reviews should be noted in response to this question.

- If a grievance includes multiple services, some of the services may be upheld while others are overturned. In this situation, should the grievance be reported as approved or denied? *(Updated 03/23/2018)*

  If the company tracks the grievances separately, then report separately. Otherwise partially overturned (found in favor of the member) are considered overturned. A comment should be added to the filing to indicate how this is reported.

- How should group policies be counted if multiple policy products are included within a single contract? *(Updated per interim meeting on 1/23 - 1/24/2019)*

  One group policy should be reported regardless of the number of products made available to the group.

- Should an insured individual or group that changes to another product offered by the same carrier be reported as a termination? *(added per interim meeting on 1/23 - 1/24/2019)*

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? *(added per interim meeting on 1/23 - 1/24/2019)*

  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? *(added per interim meeting on 1/23 - 1/24/2019)*

  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? *(added per interim meeting on 1/23 - 1/24/2019)*

  Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.

- Should capitated claims be reported? *(added per interim meeting on 1/23 - 1/24/2019)*

  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? *(added per interim meeting on 1/23 - 1/24/2019)*

  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? *(added per interim meeting on 1/23 - 1/24/2019)*

  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

- *What if we reinstate a cancelled policy? Do we still need to report it as a cancellation?*
- *Should confirmed third-party claims be included in either automobile 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"?*
- *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?*
- *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-initiated cancellation, or a cancellation at the insured's request?*
- *When calculating the number of days until company initiated cancellation for homeowners and private passenger auto business, the data call and definitions specify that the notice of cancellation is the date the cancellation notice was mailed to the insured. My company does not capture the mailing date within our system. What date do I use?*
- *The MCAS application returned a warning message regarding median days to final payment. I do not understand how to read the warning message. What does it mean?*

- 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 same policy, there would be a higher number of dwellings than policies. If your company writes renters policies that do not insure the dwelling, there would be a lower number of dwellings than policies.

- 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?

  Within the interrogatory questions, companies can select the coverage(s) that are included in their in force policies, then all zeros can be entered for the coverage(s) if no claims are applicable. This allows for the entry of underwriting data while designating the coverage(s) that the company has included in its policies.

- 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-initiated cancellation, or a cancellation at the insured's request?

  If a cancellation notice is sent to the policyholder, and the insured notifies the company that they want to cancel the policy prior to the cancellation

notice effective date, the cancellation should be reported as a company-initiated cancellation.

- When calculating the number of days until company initiated cancellation for homeowners and private passenger auto business, the definitions specify that the notice of cancellation is the date the cancellation notice was mailed to the insured. My company does not capture the mailing date within our system. What date do I use?

  If the mailing date is not captured in the company system, the cancellation processing date may be used in place of the mailing date as long as the processing date and mailing date are within a reasonable time apart that can be justified upon request.

- The MCAS application returned a warning message regarding median days to final payment. I do not understand how to read the warning message. What does it mean?

  The median days to final payment validation description will look something like this…**Col 1 Ln 26 should correspond to the date range of median claim reported.**

  Here is what it means…The system takes the number of claims that you reported as "closed with payment" and divides it by 2 (If the number of claims closed with payment is odd, then it rounds the division result up to the next whole number.) The result of the division is then compared to the number of claims that were reported as "closed with payment within 0-30 days". If the division result is less than or equal to the "closed with payment within 0-30 days", then the median days to final payment should be in the range of 0-30 days. If the result of the division is not less than or equal to the "closed with payment within 0-30 days" then the validation moves to the next bucket and compares the result of the division to the sum of the "closed with payment within 0-30 days" plus the "closed with payment within 31-60 days". If the division result is less than or equal to the sum of the "closed with payment within 0-30 days" plus "closed with payment within 31-60 days", then the median days to final payment should be in the range of 31 to 60 days…and so on.

Example

The company reports the following:

Number of claims closed with payment	25
Median days to final payment	82
Number of claims closed with payment within 0-30 days	7
Number of claims closed with payment within 31-60 days	5
Number of claims closed with payment within 61-90 days	10
Number of claims closed with payment within 91-180 days	2
Number of claims closed with payment within 181-365 days	1
Number of claims closed with payment beyond 365 days	0

1. Number of claims closed with payment divided by 2 is 25/2=12.5, which is then rounded up to 13.
2. Thirteen is compared to claims closed with payment within 0-30 days. 13 is not <=7
3. Comparison moves to the next bucket. 13 is compared to claims closed within 0-30 days plus claims closed within 31-60 days. 13 is not <= (7+5)
4. Comparison moves to the next bucket. 13 is compared to claims closed within 0-30 days plus claims closed within 31-60 days plus claims closed within 61-90 days. 13 is <=(7+5+10)
5. The median days to final payment should be in the 61-90 days range. 82 is within 61-90 days.
6. The validation passes.

Lender-Placed Home and Private Passenger Auto MCAS

- *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? (Added 01/30/2018)*
- *Are the Lender-Placed underwriting data elements and suits data elements reported separately for each type of Lender-Placed business (Single-Interest Auto, Dual-Interest Auto, Single-Interest Home Hazard, etc.)? (Added 01/30/2018)*

- 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? *(Added 01/30/2018)*

  Real Estate Owned coverages are not to be included in MCAS reporting.

- Are the Lender-Placed underwriting data elements and suits data elements reported separately for each type of Lender-Placed business (Single-Interest Auto, Dual-Interest Auto, Single-Interest Home Hazard, etc.)? *(Added 01/30/2018)*

  Yes, each underwriting and suits data element is reported separately for each type of Lender-Placed business, as shown in the Lender-Placed insurance blank.

Life and Annuity MCAS

- *When reporting information that can be classified by issue state or by residence state, which should be used in relation to MCAS reporting?*
- *For annuity considerations, do we include business reported as "Other Considerations" or "Deposit-Type Contract Funds"?*
- *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?*
- *When a joint life or joint annuity policy/contract is issued, what age and resident state do I report?*

- 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 same methodology as the Financial Statement. "In determining what business to report for a particular state, all reporting companies should follow the same methodology/definitions used to file the Financial Annual statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations."

- For annuity considerations, do we include business reported as "Other Considerations" or "Deposit-Type Contract Funds"?

  No. MCAS is only collecting information on individual annuities that have an element of insurance risk.

- The life and annuity policy/contract surrender data elements request that surrenders be split according to the date of issuance. It is not clear where surrenders should be reported if the policy/contract is 2, 5 or 10 years old. How should these be reported?

The life and annuity policy/contract surrender data element date of issuance splits should be interpreted as follows:

Data element wording	Clarification
Under 2 years	< 2 years
Between 2 years and 5 years	>=2 years and < 6 years
Between 6 years and 10 years	>=6 years and < 11 years

- When a joint life or joint annuity policy/contract is issued, what age and resident state do I report?

  When a joint life policy or joint annuity contract is issued, the eldest policy holder/annuitant should be used to determine the reporting state and age bucket to report the issued policy/contract in.

Long-Term Care MCAS

- *What is the difference between "pending" benefit payment requests versus "pending" claimant request determinations for Long-Term Care?*
- *Is Schedule 6 on Long-Term Care referring to the amount of time between a benefit request and when the company makes the payment? Or is it the amount of time between subsequent payments after the initial payment?*
- *Are the number of benefit payment requests received during the reporting period referring to every transaction/payment made on any one policy with Long-Term Care?*
- *I'm receiving a warning on the Long-Term Care filing that I don't understand. It says, "WARNING: Sum of (Col 2 Ln 43 through Ln 46) => Sum of (Col 2 Ln 36 through Ln 42) x2 (LZAU050251)".*
- *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?

  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).

- 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.

- I'm receiving a warning on the Long-Term Care filing that I don't understand. It says, "WARNING: Sum of (Col 2 Ln 43 through Ln 46) should be => Sum of (Col 2 Ln 36 through Ln 42) x2 (LZAU050251)".

  The warning you are receiving should be read as "should be equal to or greater than". So, in this case, the Sum of (Col 2 Ln 43 through Ln 46) should be equal to or greater than twice the Sum of (Col 2 Ln 36 through Ln 42). Here is how the warning text appears in the MCAS User Guide: Number of LHLTC claimant request determinations made during the period => Two times the number of claimant requests denied, not paid, or closed without payment during the period.

  Basically, it is expected that you would be making twice the determinations as you are denying. We would absolutely expect that a company would be making at least as many determinations as they are denying (because each denial is a determination). Since the determinations that aren't denials are

either pending or approved, we would expect there to be as many of these as there are denials or more.

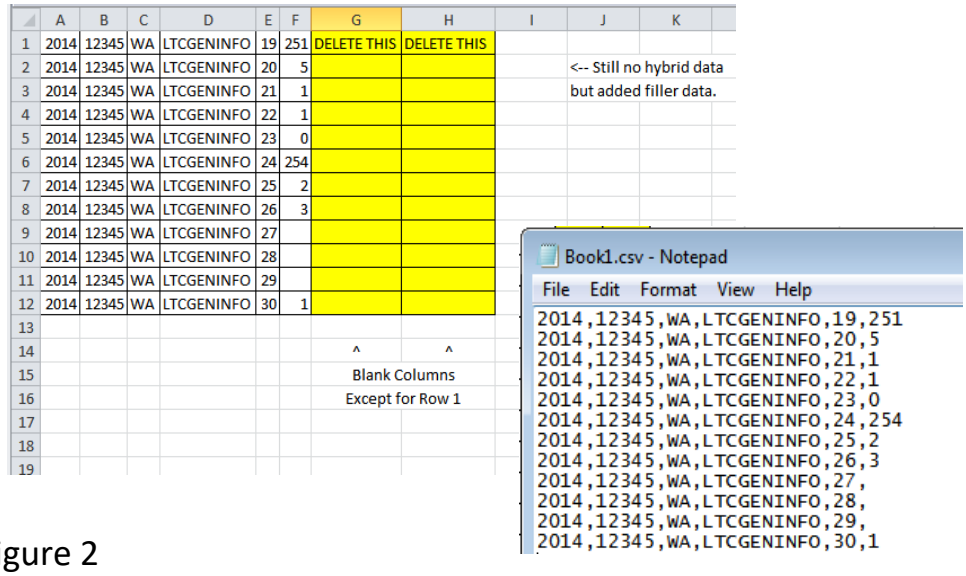
You can also read this warning as “the number of claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations”.

- 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?

  This error most likely occurs because there are not places held for the data for the Hybrid LTC columns in the CSV file. You still need to have 8 columns of data (for all other schedules). If you have blank columns in Excel for the last two columns, saving as a CSV does not work because Excel does not know to create an “empty field” for those two. An example of how this would look follows in Figure 1. You can see that the blank columns don’t show in the CSV file because they are empty. You can add a title at the top next to your data so that it creates “empty fields” in the CSV file. Once you have saved the file as a CSV, open it in notepad and delete the text you added, leaving the commas. See Figure 2 for an example of how this looks. This will format the data so that all columns are included and it should upload properly. You also have the option of using the CSV Assistant.

Figure 1

No data is included in columns G and H. When it is saved as a CSV, only 6 columns of data appear.



	A	B	C	D	E	F	G	H	I	J	K
1	2014	12345	WA	LTCGENINFO	19	251	DELETE THIS	DELETE THIS			
2	2014	12345	WA	LTCGENINFO	20	5				<-- Still no hybrid data	
3	2014	12345	WA	LTCGENINFO	21	1				but added filler data.	
4	2014	12345	WA	LTCGENINFO	22	1					
5	2014	12345	WA	LTCGENINFO	23	0					
6	2014	12345	WA	LTCGENINFO	24	254					
7	2014	12345	WA	LTCGENINFO	25	2					
8	2014	12345	WA	LTCGENINFO	26	3					
9	2014	12345	WA	LTCGENINFO	27						
10	2014	12345	WA	LTCGENINFO	28						
11	2014	12345	WA	LTCGENINFO	29						
12	2014	12345	WA	LTCGENINFO	30	1					
13											
14							^	^			
15							Blank Columns				
16							Except for Row 1				
17											
18											
19											

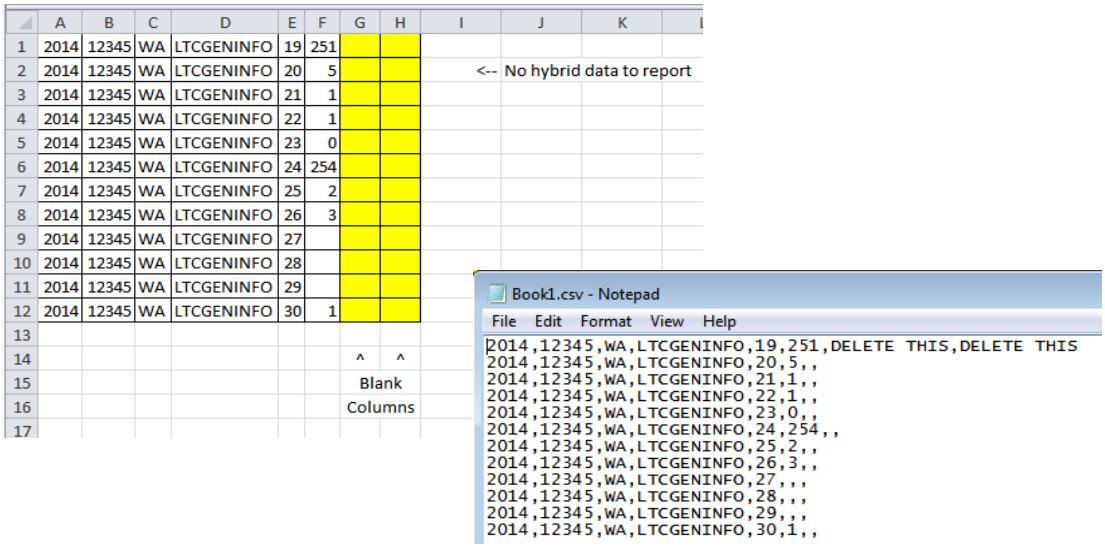
Book1.csv - Notepad

File Edit Format View Help

```
2014,12345,WA,LTCGENINFO,19,251
2014,12345,WA,LTCGENINFO,20,5
2014,12345,WA,LTCGENINFO,21,1
2014,12345,WA,LTCGENINFO,22,1
2014,12345,WA,LTCGENINFO,23,0
2014,12345,WA,LTCGENINFO,24,254
2014,12345,WA,LTCGENINFO,25,2
2014,12345,WA,LTCGENINFO,26,3
2014,12345,WA,LTCGENINFO,27,
2014,12345,WA,LTCGENINFO,28,
2014,12345,WA,LTCGENINFO,29,
2014,12345,WA,LTCGENINFO,30,1
```

Figure 2

The filler data included in columns G and H forces Excel to create a column for these fields. When it is saved as a CSV, all 8 columns of data appear. You can then just delete the words “DELETE THIS” from the CSV file when it is opened in Notepad.



	A	B	C	D	E	F	G	H	I	J	K
1	2014	12345	WA	LTCGENINFO	19	251					
2	2014	12345	WA	LTCGENINFO	20	5				<-- No hybrid data to report	
3	2014	12345	WA	LTCGENINFO	21	1					
4	2014	12345	WA	LTCGENINFO	22	1					
5	2014	12345	WA	LTCGENINFO	23	0					
6	2014	12345	WA	LTCGENINFO	24	254					
7	2014	12345	WA	LTCGENINFO	25	2					
8	2014	12345	WA	LTCGENINFO	26	3					
9	2014	12345	WA	LTCGENINFO	27						
10	2014	12345	WA	LTCGENINFO	28						
11	2014	12345	WA	LTCGENINFO	29						
12	2014	12345	WA	LTCGENINFO	30	1					
13											
14							^	^			
15							Blank				
16							Columns				
17											

Book1.csv - Notepad

File Edit Format View Help

```
2014,12345,WA,LTCGENINFO,19,251,DELETE THIS,DELETE THIS
2014,12345,WA,LTCGENINFO,20,5,,
2014,12345,WA,LTCGENINFO,21,1,,
2014,12345,WA,LTCGENINFO,22,1,,
2014,12345,WA,LTCGENINFO,23,0,,
2014,12345,WA,LTCGENINFO,24,254,,
2014,12345,WA,LTCGENINFO,25,2,,
2014,12345,WA,LTCGENINFO,26,3,,
2014,12345,WA,LTCGENINFO,27,,,
2014,12345,WA,LTCGENINFO,28,,,
2014,12345,WA,LTCGENINFO,29,,,
2014,12345,WA,LTCGENINFO,30,1,,
```

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