

Market Conduct Annual Statement Frequently Asked Questions

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This Frequently Asked Questions (FAQ) document is not a formally adopted NAIC document. The document contains questions that have been asked by insurers to NAIC staff. When available, answers are taken directly from the Data Call and Definitions. In instances where the Data Call and Definitions do not provide answers to the specifically asked questions, NAIC staff collaborates with state insurance regulators to ensure the answer is consistent with the intent of the Data Call and Definitions. The FAQ document is not intended to replace the Data Call and Definitions. It should be noted that state insurance regulators have authority to provide state specific clarifications or guidance.

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- When is the MCAS filing due date? *(Updated 1/29/19)*

The due date for submitting MCAS filings is **April 30th** of each year for all lines of business except Health, Lender-Placed Insurance, and Disability Income Insurance. For the Health filing, the submission deadlines are as follows:

Data Year	Health Due Date	LPI Due Date	Disability Income Due Date	All Others Due Date
2018	May-June 3 1 0, 2019	June 30, 2018	N/A	April 30, 2018
2019	April 30, 2019	April 30, 2019	TBD	April 30, 2019

- Do companies in a group file separately or as a group? *(Updated 1/29/19)*

Each company within a group must file separately for each state in which it meets the minimum threshold. Data for the members of a group or insurance holding company cannot be combined into a single filing.

See ***Participation Requirements***

- Whom do we contact if the company did not receive a call letter? *(Updated 2/5/19)*

If your company did not receive a call letter and you believe that your company should have been included based on business written, you should contact mcas@naic.org.

Copies of the call letters for each MCAS line of business can be found on the **[MCAS Web page](#)**.

MCAS call letters are sent to all companies licensed to write business within the MCAS jurisdictions and which submitted financial data on the property/casualty, life or health statement types.

See ***Participation Requirements***.

the Medical Payments coverage. If the suit seeks award on multiple policies, you will count a suit for each policy.

If you are reporting to more than one state, you should report the lawsuit to the state in which the claim was reported on the MCAS. For example, if your MCAS reports a claim received in Indiana, but the lawsuit was filed in Michigan, you would report the lawsuit to Indiana.

If the lawsuit is a class action, only report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Also include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

You can find additional clarification for suits in the data call and definitions for each applicable line of business.

- What types of coverage should be included in the report? *(Updated 1/29/19)*

Please refer to the *Data Call and Definitions* for **Life and Annuity, Private Passenger Auto, Homeowners, Stand-Alone Long-Term Care, Hybrid Long-Term Care, Health** and **Lender Placed Home and Auto** to determine data that should be included in MCAS filings.

- The MCAS application returned a warning message regarding reported MCAS premiums expected to be within 20% (+/-) of the premiums reported in the Financial Annual Statement Filing. What does this warning message mean?

As a rule, MCAS checks if the premium reported on the state MCAS filing is within 20% (+/-) of the premium amount reported on the state Financial Annual Statement (FAS) Filing. If the premiums reported in the MCAS filing are outside the 20% tolerance, a warning message is displayed. The message will vary depending on the MCAS line of business. Below are the descriptions for this warning message and the lines of business where it applies:

- 1) HO: MCAS state Homeowners direct written premium reported is expected to be within 20% (+/-) of the Property/Casualty Financial Annual Statement (FAS) State Page Direct Written Premium (Line no. 4).

- 2) PPA: The reported MCAS state Private Passenger Auto direct written premium is expected to be within 20% (+/-) of the Property/Casualty FAS State Page Direct Written Premium (Line nos. 19.1 + 19.2 + 21.1).
- 3) ANNUITY: MCAS state Annuity Considerations (Fixed + Variable) are expected to be within 20% (+/-) of the Life, Accident and Health FAS State Page Part 1, Annuity Considerations (Ordinary + Industrial).
- 4) LIFE: For Life Premiums: The reported MCAS state direct premiums (Cash Value + Non-Cash Value) should be within (+/-) 20% of the Life, Accident and Health FAS State Page part 1, Life Insurance (Ordinary + Industrial) or within (+/-) 20% of the Health FAS State Page total direct life premium.
- 5) HEALTH: The reported MCAS state direct premiums (for all reported business) should be within (+/-) 20% of the Individual Comprehensive, Small Group Employer Comprehensive, Large Group Employer Comprehensive, and Student Health Plans reported on the Supplemental Health Care Exhibit Part 1, Health Premiums Earned. **Note: It is currently not necessary for Health insurers to explain deviations between the MCAS reported premium and the premium reported on the Supplemental Health Care Exhibit Part 1.**

Commented [CT1]: Int Mtg Recap #8

Commented [HR2R1]: As we discussed, we need to reconsider this one. The answer in its entirety makes it clear that this is an explanation for a warning message that will be generated. Since the warning message is not going away, neither should the FAQ answer

There may be legitimate reasons for the MCAS reported premiums to vary from the FAS premiums by more than 20%. For example, companies may report applicable MCAS homeowners' premiums on lines other than line 4 of the Property/Casualty FAS State Page or companies may write creditor-placed coverage that is included in the premium amount reported on the FAS State Page lines. As such, the MCAS tries to allow for such instances while providing tolerance limits to ensure data quality. The warning descriptions above outline the specific line numbers on the FAS that the MCAS premium amounts are checked against.

Example: A company reports the following Homeowner data for a specific state:

Homeowners Interrogatories

Question 07: Does the company write in the non-standard market?

Response: Y

Question 08: If Yes, what percentage of your business is non-standard?

Response: 50%

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 03/29/2018 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 - 1/24/2019/23/2018)*
- *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 ~~7/11/2018~~)
- Should an insured group that changes to another plan 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? (Note: the interim meeting recap indicated “consumer”, and it has been asked if this applies to both individuals and consumers.) (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)

Commented [CT3]: Int Mtg Recap #11

Commented [CT4]: Int Mtg Recap #12

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Commented [CT9]: Int Mtg Recap #22

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- 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?

~~It has come to our attention that some carriers may not be able to report certain claims for bundled services by line of service as the Data Call requests. Carriers are to report claims for bundled services as they are capable of reporting, in the most practical and reasonable manner possible. Within the Interrogatories section of each Health MCAS submission, carriers~~

Commented [CT10]: Int Mtg Recap #18

~~are to provide a written explanation of their coding and reporting methodology for services that are subjected to bundling. (Updated 03/29/2019)~~ Claims should be reported at the service line level. (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)

Duplicate claims should **not** be reported. ~~The reporting of duplicate claims accounts for all decisions made on claims. A duplicate claim may have a different result (payment or denial) than the original claim.~~

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- 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 of 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 03/23/2018)* *(Updated per interim meeting on 1/23 - 1/24/2019)*

If the company tracks prior authorizations at the service level, then the company should report prior authorizations based on the service level data. If the company does not track prior authorizations at the service level, then the company should report according to the level of data tracked by the company. A comment should be added to the submission to indicate how the data is reported. 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)*

Commented [CT12]: Int Mtg Recap #15

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 7/11/2019; Updated per interim meeting on 1/23 - 1/24/2019)*

Commented [CT13]: Int Mtg Recap #6

~~It is intended that each product issued to a group as a policy be counted separately. If a contract includes multiple policies/products, you would count each policy/product separately. Likewise, if a product has multiple metal levels issued to the group, those would also need to be counted separately by metal level. One group policy should be reported regardless of the number of products made available to the group.~~

- ~~Should an insured group that changes to another plan offered by the same carrier be reported as a termination?~~

Commented [CT14]: Int Mtg Recap #11

~~No. The change in plans 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? (Note: the interim meeting recap indicated "consumer". "Consumer" includes, and it has been asked if this applies to both individuals and consumer groups.)~~

Commented [CT15]: Int Mtg Recap #12

~~In this situation, the policy should be reported as a policy issued should be reported (not as a renewal).~~

- ~~How do we determine which data year prior authorization requests, approvals or denials are to be reported in?~~

Commented [CT16]: Int Mtg Recap #16

~~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?

Commented [CT17]: •Int Mtg Recap #17

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

- Should capitated claims be reported?

Commented [CT18]: Int Mtg Recap #19

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?

Commented [CT19]: Int Mtg Reap #20

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?

Commented [CT20]: Int Mtg Recap #22

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