Market Conduct Annual Statement
2018 Data Year Filings
Health
Data Elements & Validations

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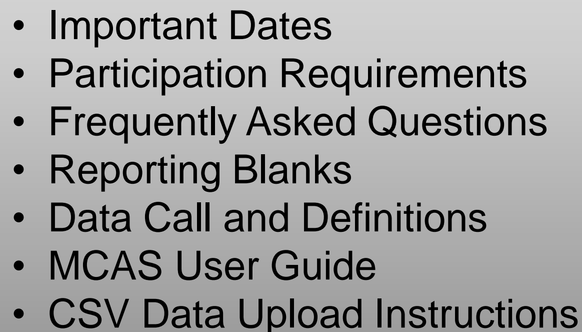
Market Conduct Annual Statement 2018 Data Year Filings

Health

Data Elements

Health MCAS Resources

Visit the MCAS Web page at:
http://www.naic.org/mcas_main.htm



- Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- MCAS User Guide
- CSV Data Upload Instructions

MCAS Blanks (D) Working Group Interim Meeting January 23rd and 24th

- Updated Health MCAS filing due date to June 30, 2019
- Clarifications to the Blanks
- Clarifications to the Data Call and Definitions
- FAQ updates

Drafted Updates to Blanks, Data Call & Definitions and FAQs, are NOT yet approved.

2018 Data Year

The 2018 filing deadline is

June 30, 2019

January 1, 2018 – December 31, 2018

MCAS Threshold

MCAS Threshold:

$50,000 in direct earned premium

What business is included in the health MCAS?

- Medical care benefits
  - Hospital or medical service policy or certificate.
  - Hospital or medical service plan contract.
  - Health maintenance organization contract

What business is NOT included in the health MCAS?

- Excepted benefits as defined in 42 U.S.C. § 300gg-91(c) (listing provided in the MCAS FAQs).
- Closed blocks not subject to Medical Loss Ratio reporting under CMS guidance.
- Self-funded plans.
- Government plans.

Frequently Asked Questions (FAQs)

MCAS Market Conduct Annual Statement

2019 | 2018 | 2017 | 2016 | Contacts and Scorecards

Log In

Don't have an MCAS login?
Click Here to get it.

| FAQ (PDF) | Contact

Key 2018 MCAS Dates

December 14, 2018	Call letters to companies
Mid-January 2019	Last day to submit 2017 corrections (See FAQ Document)
March – May, 2019	MCAS training opportunities (training information coming soon)
April 30, 2019	MCAS submissions due for all lines of business *except* Health and Lender-Placed

In-Exchange　　Out-of-Exchange

In-Exchange Health Products

- Individual
- Small Group
- Catastrophic
- Multi-State – Individual
- Multi-State – Small Group

Out-of-Exchange Health Products

- Individual
- Small Group
- Grandfathered/Transitional Plans
- Catastrophic
- Large Group
- Student

Metal Level Reporting – In-Exchange

Bronze, Silver, Gold and Platinum level reporting is required for the following in-exchange product types:

- Individual
- Small Group
- Multi-State – Individual
- Multi-State – Small Group

Bronze, Silver, Gold and Platinum level reporting is required for the following out-of-exchange product types:

- Individual
- Small Group

Reporting for Grandfathered/Transitional Plans is broken out by:

- Large Group
- Small Group
- Individual

In addition to metal level or break out reporting, it is required to report totals for those products with breakout reporting.

Metal Level, breakout and total reporting are not required for all data elements.

You will find greyed out cells on the health MCAS blank that indicate specific data that is not to be reported.

Exceptions

You will find “greyed out” cells on the health MCAS blank that indicate specific data that is not to be reported.

IN-EXCHANGE

		Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic or student					Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies					Catastrophic	Multi-State(Individual)					Multi-State (Small Group)				
		Bronze	Silver	Gold	Platinum	Total	Bronze	Silver	Gold	Platinum	Total		Bronze	Silver	Gold	Platinum	Total	Bronze	Silver	Gold	Platinum	Total
Policy Administration																						
19	Earned premiums for Reporting Year.																					
20	Number of new policies issued during the period.						--	--	--	--	--							--	--	--	--	--
21	Number of policies renewed during the period.						--	--	--	--	--							--	--	--	--	--
22	Member months for policies issued during the period.																					
23	Member months for policies renewed during the																					
24	Number of policy terminations and cancellations initiated by consumer.						--	--	--	--	--							--	--	--	--	--
25	Number of policy terminations and cancellations due to non-payment of premium.						--	--	--	--	--							--	--	--	--	--
26	Number of lives impacted on terminations and cancellations initiated by the policyholder.																					

Health Entry Sections:

- Interrogatories
- Policy Administration
- Prior Authorizations (Excluding Pharmacy)
- Prior Authorizations (Pharmacy Only) - NEW
- Claims Administration (Excluding Pharmacy)
- Claims Administration (Pharmacy Only)
- Consumer Requested Internal Reviews (Including Pharmacy)
- Consumer Requested External Reviews (Including Pharmacy)

Interrogatories

		Response (Yes/No)	Comments
01	In-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		--
02	In-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		--
03	In-Exchange - Does the company have Catastrophic data to report? (Y/N)		--
04	In-Exchange - Does the company have Multi-State (Individual) data to report? (Y/N)		--
05	In-Exchange - Does the company have Multi-State (Small Group) data to report? (Y/N)		--
06	In-Exchange - Number of small groups in-force at the end of the reporting period.	--	
07	In-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		--
08	In-Exchange Comments.	--	Comment (if necessary)
09	Out-of-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		--
10	Out-of-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		--
11	Out-of-Exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)		--
12	Out-of-Exchange - Does the company have Catastrophic data to report? (Y/N)		--
13	Out-of-Exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)		--
14	Out-of-Exchange - Does the company have Student Coverage data to report? (Y/N)		--
15	Out-of-Exchange - Number of small groups in-force at the end of the reporting period.	--	
16	Out-of-Exchange - Number of large groups in-force at the end of the reporting period.	--	
17	Out-of-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		--
18	Out-of-Exchange Comments.	--	Comment (if necessary)

December 31, 2018

Interrogatories

		Response (Yes/No)	Comments
01	In-Exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report? (Y/N)		--
02	In-Exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report? (Y/N)		--
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12	Out-of-Exchange - Does the company have Catastrophic data to report? (Y/N)		--
13	Out-of-Exchange - Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)		--
14	Out-of-Exchange - Does the company have Student Coverage data to report? (Y/N)		--
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16	Out-of-Exchange - Number of large groups in-force at the end of the reporting period.	--	
17	Out-of-Exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)		--
18	Out-of-Exchange Comments.	--	Comment (if necessary)

FAQ: Data Reporting

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 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.

Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of inusred lives impacted by rescissions.

Policy Administration Data Elements

Data Element
Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
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Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of inusred lives impacted by rescissions.

January 1, 2018 – December 31, 2018

FAQ: Policy Administration

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.

FAQ: Policy Administration

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.

FAQ: Policy Administration

How should individuals that change products mid-year be accounted for?

- 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.

FAQ: Policy Administration

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)*

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

Member Months

Member months for policies issued – The sum of total number of lives insured on policies (contracts) 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.

Member months for policies renewed – The sum of total number of lives insured on policies (contracts) renewed 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

FAQ: Member Months

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.

Member Month Examples:

1. Individual policy is renewed February 2018, but was in force for all 12 months of 2018.
   Report 12 member months

2. Individual policy is issued February 2018.
   Report 11 member months

Policy Administration Data Elements

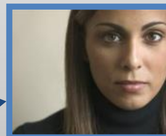
Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of inusred lives impacted by rescissions.

Terminations and Cancellations

Insured's Request

Non-Payment of Premium

Terminations and Cancellations



FAQ: Terminations

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)*

No. The change in plans within the same carrier should not be reported as a termination.

Policy Administration Data Elements

Earned premiums for Reporting Year.
Number of new policies issued during the period.
Number of policies renewed during the period.
Member months for policies issued during the period.
Member months for policies renewed during the period.
Number of policy terminations and cancellations initiated by the policyholder.
Number of policy terminations and cancellations due to non-payment of premium.
Number of insured lives impacted on terminations and cancellations initiated by the policyholder.
Number of insured lives impacted on policies terminated and cancelled due to non-payment.
Number of rescissions.
Number of inusred lives impacted by rescissions.

Prior Authorizations Excluding Pharmacy

Prospective Utilization Review Requests

Number of prior authorizations requested.
Number of prior authorizations approved.
Number of prior authorizations denied.
Number of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders.
Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders denied.
Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved.

Prior Authorizations Excluding Pharmacy

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. *(updated per interim meeting on 1/23 – 1/24/2019)*

Prior Authorizations Excluding Pharmacy

You are to Report Prior Authorizations:

- Requested
- Approved
- Denied

FAQ: Prior Authorizations

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.

FAQ: Prior Authorization – Multiple Services

If a request for prior authorization includes multiple services, some of the services may be approved while others are denied. 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.

Prior Authorizations Excluding Pharmacy

New for 2018 – Prior Authorizations reported in questions 30, 31 and 32 for in-exchange and questions 109, 110 and 111 for out-of-exchange you are asked to indicate how many Prior Authorizations for mental health benefits, behavioral health benefits, and substance use disorders were:

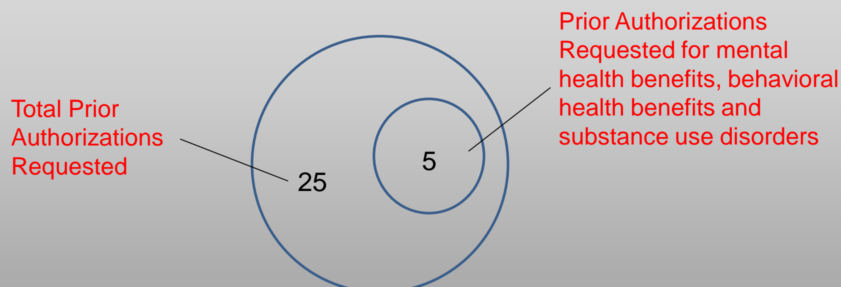
- Requested
- Approved
- Denied

FAQ: Prior Authorizations

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.

Prior Authorizations Excluding Pharmacy



Prior Authorizations Excluding Pharmacy

Mental Health Benefits – Benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Behavioral Health Benefits – Benefits to assist those with mental health or substance abuse issues.

Prior Authorizations Excluding Pharmacy

Substance Use Disorders Benefits – Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Prior Authorizations Pharmacy Only – NEW for 2018

Number of prior authorizations requested.
Number of prior authorizations approved.
Number of prior authorizations denied.

Claims Administration (Excluding Pharmacy

Questions focus on:

- Claims received
- Claims denied
- Claims paid
- Insured responsibility

January 1, 2018 – December 31, 2018

FAQ: Claims

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.

FAQ: Claims

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.

Claims Administration

Claim Received December 20, 2017

Claim paid January 5, 2018

Report as a claim received during the 2017 data year	Report as a paid claim in the 2018 data year

FAQ: Bundled Claims

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.

FAQ: Duplicate Claims

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

Duplicate claims should not be reported.

FAQ: Dental and Vision Claims

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.

FAQ: Claim Payment Adjustments

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.

FAQ: Claims with Insufficient Data

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

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

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.

If a claimed service is included in a prepaid capitated service, should this be reported as a denied claim or a paid claim?

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.

Claims Administration (Excluding Pharmacy

Number of claims received.
Number of claims submitted by network providers.
Number of claims submitted by out-of-network providers.

January 1, 2018 – December 31, 2018

Claims Administration (Excluding Pharmacy

Number of claim denials for in-network claims.
In-network claims denied within 0-30 days.
In-network Claims denied within 31-60 days.
In-network Claims denied within 61-90 days.
In-network Claims denied beyond 90 days.
Number of in-network denied, rejected or returned - Claims Submission Coding Error(s).
Number of in-network denied, rejected or returned - Prior Authorization Needed.
Number of in-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.
Number of in-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits)
Number of in-network denied, rejected or returned - Not Medically Necessary (Behavioral Health Benefits Only).

Number of claim denials for out-of-network claims.
Out-of-network claims denied within 0-30 days.
Out-of-network Claims denied within 31-60 days.
Out-of-network Claims denied within 61-90 days.
Out-of-network Claims denied beyond 90 days.
Number of out-of-network denied, rejected or returned - Claims Submission Coding Error(s).
Number of out-of-network denied, rejected or returned - Prior Authorization Needed.
Number of out-of-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.
Number of out-of-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits)
Number of out-of-network denied, rejected or returned - Not Medically Necessary (Behavioral Health Benefits Only).

January 1, 2018 – December 31, 2018

FAQ: Claim Denial Categories

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 are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.

Claims

Claims Administration (Excluding Pharmacy)

Number of paid claims for in-network services.
In-network claims paid within 0-30 days.
In-network claims paid within 31-60 days.
In-network claims paid within 61-90 days.
In-network claims paid beyond 90 days.
Number of paid claims for out-of-network services.
Out-of-network claims paid within 0-30 days.
Out-of-network claims paid within 31-60 days.
Out-of-network claims paid within 61-90 days.
Out-of-network claims paid beyond 90 days.

Claims Administration (Excluding Pharmacy)

Claims Paid.

Claims Administration (Excluding Pharmacy)

Insured/beneficiary co-payment responsibility.
Insured coinsurance responsibility.
Insured deductible responsibility.

Claims Administration (Pharmacy Only)

Number of claims received.
Number of claim denials for in-network claims.
Number of claim denials for out-of-network claims.
Number of paid claims for in-network services.
Number of paid claims for out-of-network services.
Claims Paid.
Insured/beneficiary co-payment responsibility.
Insured coinsurance responsibility.
Insured deductible responsibility.

Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)
Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of customer requests for internal reviews of grievances not involving adverse determinations.

Adverse Determinations

- Rescission
- Denial
- Reduction
- Termination of
- Failure to provide or make payment (in whole or in part)

These actions may be the result of:

- A determination of a member's or eligible dependent's eligibility to participate in a plan
- The application of any utilization review
- Determination of an item or service to be experimental or investigational or not medically necessary or appropriate

Grievance

A written or oral complaint involving an urgent care Request, submitted by or on behalf of a covered person regarding:

- Availability, delivery or quality or health care services (including a complaint regarding an adverse determination made pursuant to utilization review)
- Claims payment, handling or reimbursement for health care services
- Matters pertaining to the contractual relationship between a covered person and a health carrier.

FAQ: Grievance - Multiple Services

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?

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.

Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)
Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)
Number of customer requests for internal reviews of grievances not involving adverse determinations.

FAQ: Second Level Internal Reviews

Should second level internal review be reported in the MCAS?

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

Consumer Requested External Reviews (Including Pharmacy)

Number of customer requested appeals on final adverse determinations to an external review organization.
Number of final adverse determinations upheld upon request for external review.
Number of final adverse determinations overturned upon request for external review.

External Review Organization (ERO)

An entity that conducts independent external review of adverse determinations or final adverse determination.

Consumer Requested External Reviews (Including Pharmacy)

Number of customer requested appeals on final adverse determinations to an external review organization.
Number of final adverse determinations upheld upon request for external review.
Number of final adverse determinations overturned upon request for external review.

Concludes

Market Conduct Annual Statement

2018 Data Year Filings

Health

Data Elements

Validation and Review

MCAS Validations are data checks programmed within the MCAS data submission application.

- Errors - Some validations are considered to be Errors and must be corrected before submission of data is allowed.
- Warnings – Other validations are considered to be Warnings. Filings containing Warnings can be successfully submitted.

MCAS Validation Warnings

- MCAS Validations assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended.
- MCAS Validations assist state insurance regulators and NAIC staff in reviewing submitted MCAS data.

MCAS Validation Warnings

It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances.

Filing Matrix for Company - 2018

Expand All

Alaska Total Warnings: 4

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Homeowners	Filed	4	0		

California

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Lender-Placed Insurance	Filed	0	0		

Maryland

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Lender-Placed Insurance	Filed	0	0		

Filing Matrix for Company - 2018

Expand All

Alaska Total Warnings: 4

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Homeowners	Filed	4	0		

California

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Lender-Placed Insurance	Filed	0	0		

Maryland

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Lender-Placed Insurance	Filed	0	0		

Private Passenger Auto Interrogatories

		Yes No Response	Explanation
01	Were there policies in force during the reporting period that provided Collision coverage?		--
02	Were there policies in force during the reporting period that provided Comprehensive coverage?		--
03	Were there policies in force during the reporting period that provided Bodily Injury coverage?		--
04	Were there policies in force during the reporting period that provided Property Damage coverage?		--
05	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?		--
06	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?		--
07	Were there policies in force during the reporting period that provided Medical Payments coverage?		--
08	Were there policies in force during the reporting period that provided Combined Single Limits coverage?		--
09	Were there policies in force during the reporting period that provided Personal Injury Protection coverage?		--
10	Was the company actively writing policies in the state at year end?		--
11	Does the company write in the non-standard market?		--
12	If Yes, what percentage of your business is non-standard?	--	
13	If Yes, how is non-standard defined?	--	
14/15	Has the company had a significant event/business strategy that would affect data for this reporting period?		--
16/17	Has all or part of this block of business been sold, closed or moved to another company during the year?		
18	How does the company treat subsequent supplemental or additional payments on previously closed claims?	--	
19	Additional state specific Claims comments (optional):	--	
20	Additional state specific Underwriting comments (optional):	--	

Comments

By checking the "I attest" box below, I understand, agree and certify on behalf of the named company that:

1. I am 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. I am 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 my 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. I am 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. I 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.

I Attest	First name	MI	Last name	Suffix	Title	Clear
I Attest	First name	MI	Last name	Suffix	Title	Clear

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 attesters 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.

Overall comments for the filing year 2018

MCAS Market Conduct Annual Statement

2019 | 2018 | 2017 | 2016 | Contacts and Scorecards

Log In

Don't have an MCAS login?
Click Here to get it.

Help | FAQ (PDF) | Contact

GENERAL FILING INFORMATION

Participation Requirements (PDF)

RESOURCES

Data Collection Worksheets (Blanks)

- Annuity (PDF)
- Health (PDF)
- Homeowners (PDF)
- Lender-Placed Home and Auto (PDF)
- Life (PDF)
- Long-Term Care (PDF)
- Private Passenger Auto (PDF)

Data Call and Definitions (Instructions)

- Health (PDF)
- Homeowners (PDF)
- Lender-Placed Home and Auto (PDF)
- Life & Annuity (PDF)
- Long-Term Care - Hybrid (PDF)
- Long-Term Care - Stand-Alone (PDF)
- Private Passenger Auto (PDF)

Summary of 2018 Changes (PDF)

2018 MCAS User Guide (PDF)

CSV Instructions and Resources

- CSV Data Upload Instructions (PDF)
- CSV Assistant Instruction (PDF)

CSV Assistant Files

- Annuity
- Health

Key 2018 MCAS Dates

December 14, 2018	Call letters to companies
Mid-January 2019	Last day to submit 2017 corrections (See FAQ Document)
February - March, 2019	MCAS training webinars (Webinar information coming later)
April 30, 2019	MCAS submissions due for all lines of business *except* Health and Lender-Placed
June 30, 2019	MCAS submissions due for Lender-Placed and Health
July 1, 2019	MCAS industry scorecards posted to MCAS Web page for all lines of business *except* Health and Lender-Placed
August 1, 2019	MCAS industry scorecards posted to MCAS Web page for Health Only
September 1, 2019	MCAS industry scorecards posted to MCAS Web page for Lender-Placed Only

New for 2018 Data Year

- The lender-placed auto and homeowners MCAS was adopted on August 9, 2017 at the NAIC Executive/Plenary session during the NAIC Summer National Meeting. Lender-placed auto and homeowners MCAS data will be collected for the first time beginning with the 2018 data year. The reporting deadline for the first filing year will be June 30, 2019.

What Do Documents Found on this Web Page Tell Me?

General Filing Information

- Participation Requirements – Detailed information to assist in determining if your company is required to submit MCAS data

Resources

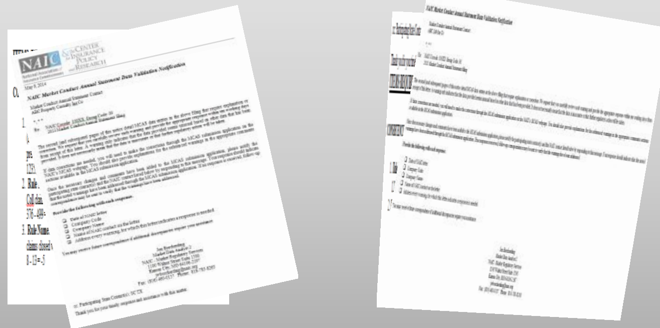
- Data Collection Worksheets (Blanks) – Table layout representation of the required data elements
- Data Call and Definitions (Instructions) – Listing of MCAS data elements and definitions to follow when preparing data for submission
- MCAS User Guide – Information about how to use the MCAS application and a listing of data validations used within the application
- CSV Data Upload Instructions – Layout guidelines for preparing a CSV file for uploading to the MCAS application (The use of a CSV file is not required.)
- CSV Assistant Instructions – Guidance for using the CSV Assistance Files
- CSV Assistant Files – Templates to assist in the creation of CSV data files
- Scorecard Ratio Formulas – Listing of standard scorecard ratios calculated for each MCAS lines of business

Additional Information

- FAQ (Frequently Asked Questions) - Contains both technical and definitional information not located in the other Help documents (Located just under the MCAS "Log In" icon) You will find answers to questions

State Regulators have Oversight

Data Validation Notifications



NAIC Market Conduct Annual Statement Data Validation Notification

May 9, 2014

Provide the following with each response:

The ABC Group

Company A

Company B

Company C

Comments