Market Conduct Annual Statement 2017 Data Year Filings

Health

Data Elements & Validations

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Health

Data Elements

Visit the 2017 MCAS Web page at:
http://www.naic.org/mcas_2017.htm

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

2017 Data Year

The 2017 filing deadline is

September 30, 2018

January 1, 2017 – December 31, 2017

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.

In-Exchange Out-of-Exchange

In-Exchange Products

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

Out-of-Exchange Products

- Individual Health
- Small Group Health
- 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 Health
- Small Group Health
- 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 Health
- Small Group Health

Reporting for Grandfathered/Transitional Plans is broken out by:

- Large Group
- Small Group
- Individual

Reporting Totals for Product Types

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

Exceptions

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.

OUT-OF-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					Grandfathered/Transitional Plans				Catastrophic	All Large Group comprehensive major medical and managed care (Minimum Essential Coverage) policies	For Student Coverage
		Bronze	Silver	Gold	Platinum	Total	Bronze	Silver	Gold	Platinum	Total	Large Group	Small Group	Individual	Total			
Policy Administration																		
76	Earned premiums for Reporting Year.																	
77	Number of new policies issued during the period.						--	--	--	--	--		--		--			
78	Number of policies renewed during the period.						--	--	--	--	--		--		--			
79	Member months for policies issued during the period.																	
80	Member months for policies renewed during the period.																	
81	Number of policy terminations and cancellations initiated by consumer.						--	--	--	--	--		--		--			
82	Number of policy terminations and cancellations due to non-payment of premium.						--	--	--	--	--		--		--			
83	Number of lives impacted on terminations and cancellations initiated by the policyholder.																	
84	Number of lives impacted on policies terminated and cancelled due to non-payment.																	
85	Number of rescissions.	--	--	--	--		--	--	--	--								
86	Number of lives impacted by rescissions.																	
Prior Authorizations (Prospective Utilization Review Requests) Excluding Pharmacy																		
87	Number of prior authorizations requested.	--	--	--	--		--	--	--	--								
88	Number of prior authorizations approved.	--	--	--	--		--	--	--	--								
89	Number of prior authorizations denied.	--	--	--	--		--	--	--	--								

Health Entry Sections:

- Interrogatories
- Policy Administration
- Prior Authorizations (Excluding Pharmacy)
- 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, 2017

Interrogatories

		Response (Yes/No)	Comments
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11	Out-of-Exchange - Does the company have Grandfathered or Transitional plan data to report? (Y/N)		–
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Policy Administration Data Elements

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 period.
24	Number of policy terminations and cancellations initiated by consumer.
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28	Number of rescissions.
29	Number of lives impacted by rescissions.

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January 1, 2017 – December 31, 2017

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

Policy Administration Data Elements

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Terminations and Cancellations

Insured's Request

Non-Payment of Premium

Terminations and Cancellations

Policy Administration Data Elements

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Prior Authorizations Excluding Pharmacy

Prospective Utilization Review Requests

30	Number of prior authorizations requested.
31	Number of prior authorizations approved.
32	Number of prior authorizations denied.

Prior Authorizations Excluding Pharmacy

Prior Authorization – A decision by a carrier 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.

Prior Authorizations Excluding Pharmacy

You are to Report Prior Authorizations:

- Requested
- Approved
- 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.
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 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 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 Paid.
Insured/beneficiary co-payment responsibility.
Insured coinsurance responsibility.
Insured deductible responsibility.

January 1, 2017 – December 31, 2017

Claims Administration (Excluding Pharmacy

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Insured coinsurance responsibility.
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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.

Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

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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.

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.

Health

Data Elements

Validation and Review

MCAS Market Conduct Annual Statement

ABC Insurance Company (XXXXX)

Home | Filing Matrix | Data Upload | Waivers & Extensions | Attestation | Company Ratios | User Assignment | Help Desk Form

FILING MATRIX

	Private Passenger Auto	Homeowners	Long Term Care
Alabama	—	—	—
Alaska	—	—	—
Arizona	—	✓	—
Arkansas	—	—	—
California	—	—	—
Colorado	—	✓	—
Connecticut	—	—	—
Delaware	—	✓	—
District Of Columbia	—	—	—
Florida	—	✎	—
Georgia	—	—	—
Hawaii	—	—	—
Idaho	—	✓	—
Illinois	—	—	—
Indiana	—	✓	—
Iowa	—	—	—
Kansas	—	—	—

	Private Passenger Auto	Homeowners	Long Term Care
Kentucky	—	✓	—
Louisiana	—	✓	—
Maine	—	—	—
Maryland	—	—	—
Massachusetts	—	—	—
Michigan	—	—	—
Minnesota	—	—	—
Mississippi	—	✓	—
Missouri	—	—	—
Montana	—	—	—
Nebraska	—	—	—
Nevada	—	✎	—
New Hampshire	—	—	—
New Jersey	—	✓	—
New Mexico	—	—	—
North Carolina	—	✓	—
Ohio	—	—	—

	Private Passenger Auto	Homeowners	Long Term Care
Oklahoma	—	—	—
Oregon	—	—	—
Pennsylvania	—	✓	—
Rhode Island	—	✓	—
South Carolina	—	—	—
South Dakota	—	—	—
Tennessee	—	—	—
Texas	—	—	—
Utah	—	—	—
Vermont	—	—	—
Virginia	—	✓	—
Washington	—	—	—
West Virginia	—	—	—
Wisconsin	—	✓	—
Wyoming	—	—	—

Legend: =Required, =In Progress, =Filed, =Error, =Waived, =Extended, =Not Required

Validation and Review

- Listed warnings

Validation and Review

- Listed warnings
- Ratios

2017 Market Conduct Annual Statement Ratios

Property & Casualty (Private Passenger Auto & Homeowner)

Ratio 1. **The number of claims closed without payment compared to the total number of claims closed**

$$\left(\frac{[\text{\# of claims closed without payment}]}{[\text{\# of claims closed with payment}] + [\text{\# of claims closed without payment}]}\right)$$

Ratio 2. **Percentage of claims unprocessed at the end of the period**

$$\left(\frac{\text{\# of claims open at the Beginning of period} + \text{\# of claims opened during period} - \text{\# of claims closed with payment} - \text{\# of claims closed without payment}}{\text{\# of claims open at the beginning of period} + \text{\# of claims opened during the period}}\right)$$

Ratio 3. **Percentage of claims paid beyond 60 days**

$$\left(\frac{[\text{total \# of claims settled beyond 60 days}]}{[\text{total \# of claims settled for all durations}]}\right)$$

Ratio 4. **Non-renewals to policies in force**

$$\left(\frac{[\text{\# of non-renewals}]}{[\text{\# of policies in force}]}\right)$$

Ratio 5. **Cancellations over 60 days to policies in force**

$$\left(\frac{[\text{\# of cancellations 60 days or more after the effective date}]}{[\text{\# of policies in force}]}\right)$$

Ratio 6. **Cancellations under 60 days to new policies issued**

$$\left(\frac{[\text{\# of cancellations that occur in the first 59 days after effective date}]}{[\text{\# of new policies issued}]}\right)$$

Ratio 7. **Suits opened during the period to claims closed without payment**

$$\left(\frac{[\text{\# of suits open during the period}]}{[\text{\# of claims closed without payment}]}\right)$$

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Validation and Review

- Listed warnings
- Ratios
- Data comparisons

Validation and Review

- Listed warnings
- Ratios
- Data comparisons
- General review

MCAS Market Conduct Annual Statement

2017 | 2016 | 2015 | 2014 | Participating Jurisdictions 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)
- Life (PDF)
- Long-Term Care (PDF)
- Private Passenger Auto (PDF)

Data Call and Definitions (Instructions)

- Health (PDF)
- Homeowners (PDF)
- Life & Annuity (PDF)
- Hybrid LTC (PDF)
- Standalone LTC (PDF)
- Private Passenger Auto (PDF)

Summary of 2017 Changes (PDF)

2017 MCAS User Guide (PDF)

CSV Instructions and Resources

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

Key 2017 MCAS Dates

December 15, 2017	Call letters to companies
January 24, 2018	Last day to submit 2016 corrections (See FAQ Document)
February - March, 2018	MCAS training webinars (Webinar information coming later this year)
March 15, 2018	2017 filings may be submitted via the online MCAS filing tool
April 30, 2018	MCAS submissions due for all lines of business *except* Health
July 1, 2018	MCAS industry scorecards posted to MCAS Web page for all lines of business *except* Health
September 30, 2018	MCAS submissions due for Health only
December 1, 2018	MCAS industry scorecards posted to MCAS Web page for Health only

New for 2017 Data Year

- The Health MCAS was adopted on August 29, 2016 at the NAIC Executive/Plenary session during the NAIC Summer National Meeting. Health MCAS data will be collected for the first time beginning with the 2017 data year. The reporting deadline for the first filing year will be September 30, 2018.
- The reporting threshold for Arkansas has changed. The Arkansas threshold was previously $7 million in premium for all MCAS lines of business. Beginning with the 2017 data year, the Arkansas threshold is $50,000 for all MCAS lines of business. Please note that LTC for all other participating jurisdictions requires reporting for any business written.

What Do Documents Found on this Web Page Tell Me?

General Filing Information

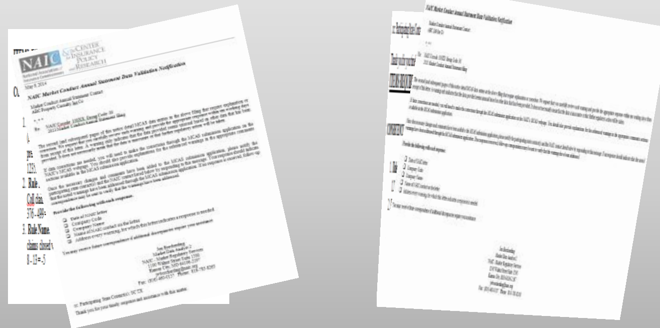
- Participation Requirements – Detailed information to assist in determining if your company is required to submit MCAS data

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

State Regulators have Oversight

Data Validation Notifications



The ABC Group

Company A

Company B

Company C

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

MCAS Market Conduct Annual Statement

ABC Insurance Company (XXXXX)

Home | Filing Matrix | Data Upload | Waivers & Extensions | Attestation | Company Ratios | User Assignment | Help Desk Form

ATTESTATION

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.

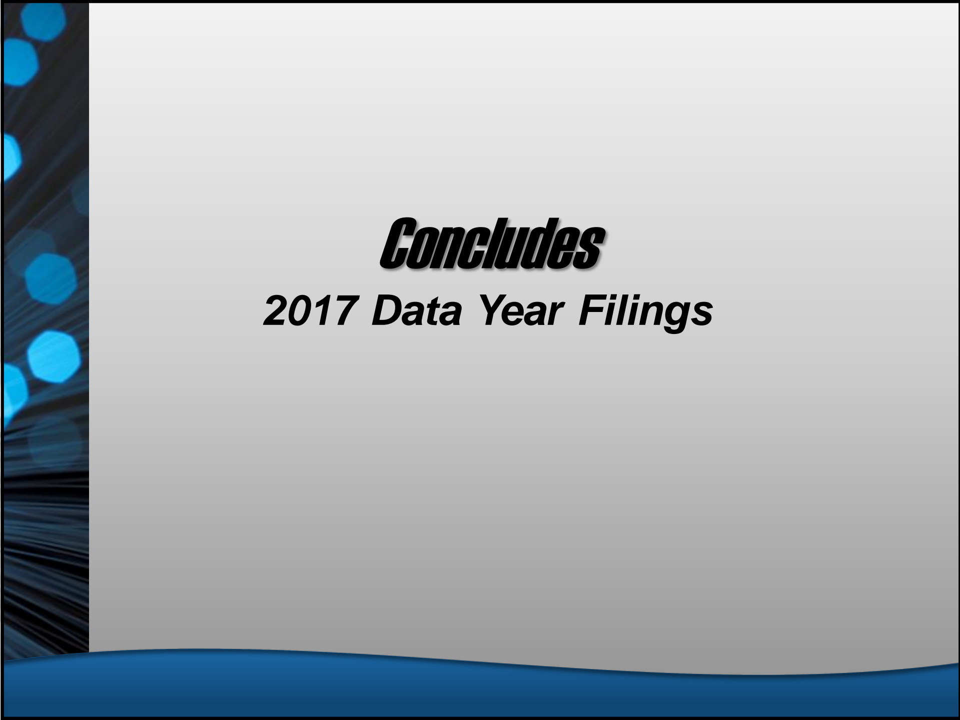
I attest: ☐ First Name | MI | Last Name | Suffix | Company Title

I attest: ☐ First Name | MI | Last Name | Suffix | Company Title

NOTE regarding signature requirements: 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 Company Comments for 2014 Filing Year

Save | Cancel | View 2014 submitted data | View 2013 submitted data


Concludes
2017 Data Year Filings