Market Conduct Annual Statement

2023 Data Year Filings

Other Health

Data Elements & Validations

NAIC
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

MCAS
Market Conduct Annual Statement

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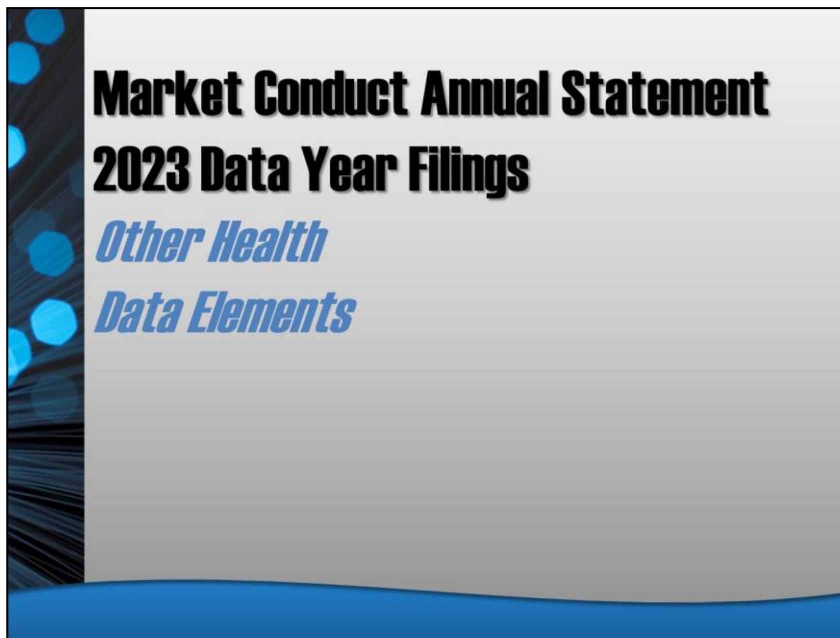

In this handout, we will be reviewing the data elements that must be provided for the Other Health MCAS.

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Other Health MCAS Resources

Visit the MCAS Web page at:
https://content.naic.org/mcas-2023.htm

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

Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

The available resources include:

- A Listing of Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- Copy of the Call Letter
- MCAS User Guide
- And CSV Data Upload Instructions

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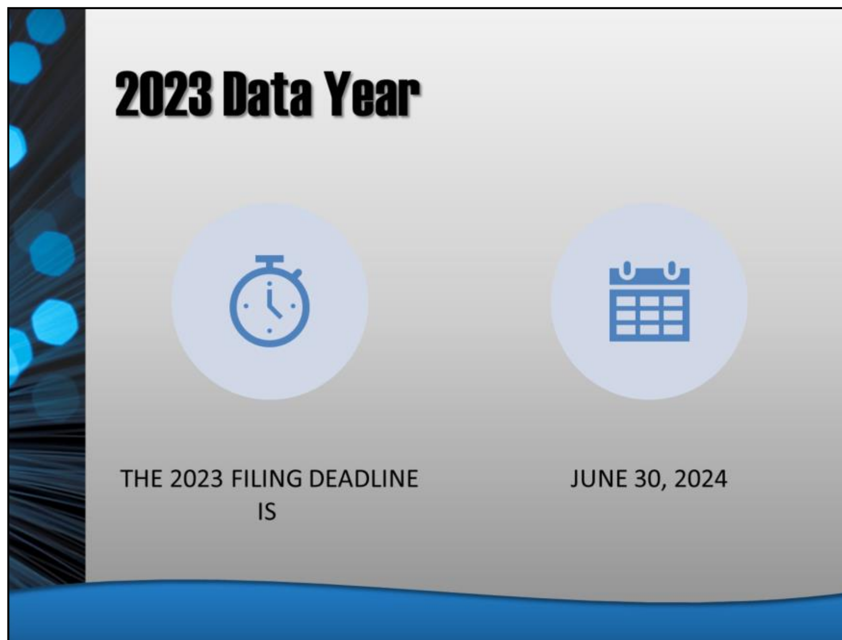

The health MCAS data reporting period is January 1st through December 31st of the reporting year, and the Other Health MCAS filing deadline is June 30th

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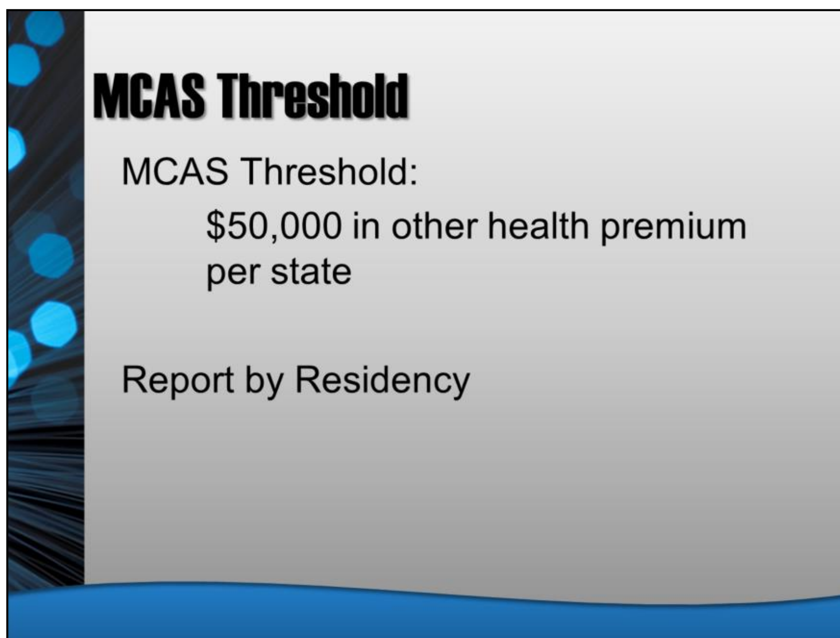

Companies reporting at least $50,000 of premium for applicable MCAS other health insurance, in a MCAS participating jurisdiction, are required to submit other health MCAS data to those participating jurisdictions where they meet the premium threshold. There are currently 49 participating MCAS jurisdictions.

Additionally, the company should report to the state where the insured resides. For example, if an association places 50 policies in Missouri and 50 policies is Kansas,, the company will report the data for the 50 Missouri policies/certificates to Missouri and the other 50 to Kansas.

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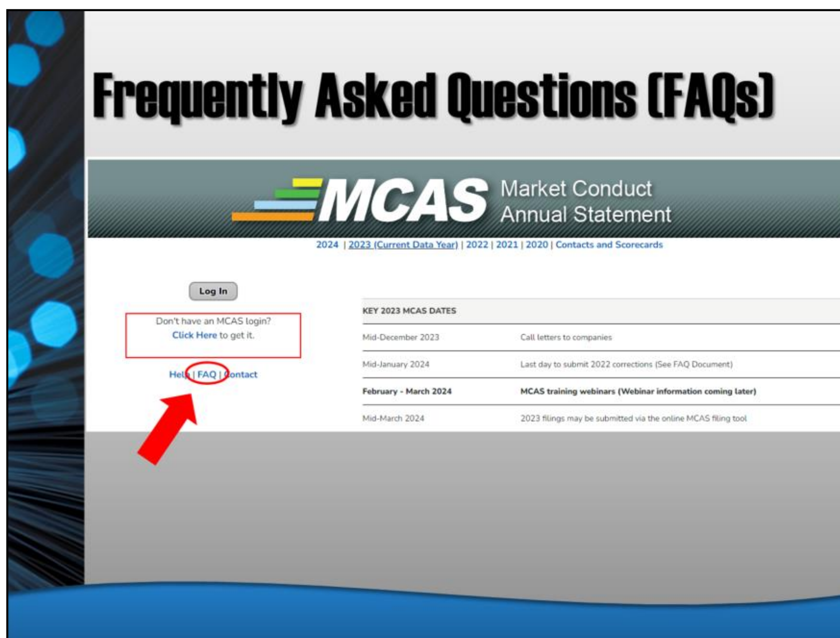

The MCAS Frequently Asked Questions or FAQs document can be found on the MCAS webpage. We will refer to questions found in the FAQ document throughout this tutorial.

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What business is included in the Other Health MCAS?

- Health insurance products not subject to the Affordable Care Act (ACA)
  - Accident Only
  - Accidental Death and Dismemberment
  - Specified Disease-Limited Benefit/Critical Disease
  - Hospital/Other Indemnity
  - Hospital/Surgical/Medical Expense

Other Health insurance business reported in the MCAS includes products not subject to the Affordable Care Act. Specifically, these products are

- Accident Only
- Accidental Death and Dismemberment
- Specified Disease-Limited Benefit/Critical Disease
- Hospital/Other Indemnity
- Hospital/Surgical/Medical Expense

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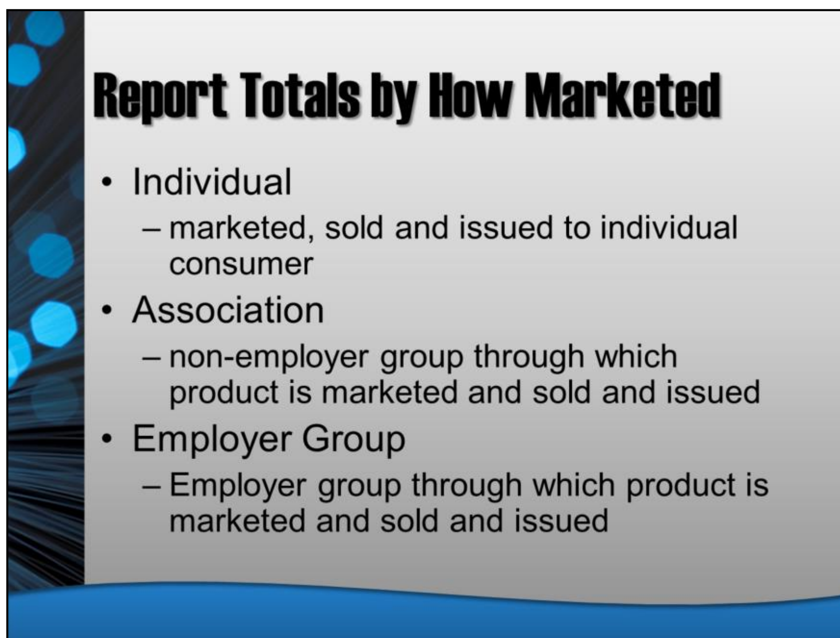

For those products listed on the previous slide,

- Accident Only
- Accidental Death and Dismemberment
- Specified Disease-Limited Benefit/Critical Disease
- Hospital/Other Indemnity
- Hospital/Surgical/Medical Expense

You will report according to whether they are marketed to individuals directly, through an association or through an employer group.

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Exceptions

aims Administration (Including Pharmacy)

	Individual		
	Accident Only	Accidental Death and Dismemberment	Specified Disease Limited Benefit/ Critical Illness
Number of claims pending at the beginning of the period			
Number of claims received (include non-clean claims)			
Total number of claims denied, rejected or returned			
Number denied, rejected, or returned as non-covered or maximum benefit exceeded			
Number denied, rejected, or returned as subject to pre-existing condition exclusion			
Number denied, rejected, or returned due to failure to provide adequate documentation			
Number denied, rejected, or returned due to being within the waiting period		---	
Number denied, rejected, or returned (in whole or in part)			

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

As shown on the slide, if a data element is not to be reported for product/marketing type, it will be denoted by a “lined out” cell on the Other Health MCAS reporting blank. In the example above, MCAS does not expect a response to the number of claims denied because it is within the waiting period for Accidental Death and Dismemberment claims.

When entering data into the MCAS submission application you will see the data elements that are not to be reported, however they are not fillable. You will be unable to enter data for these elements.

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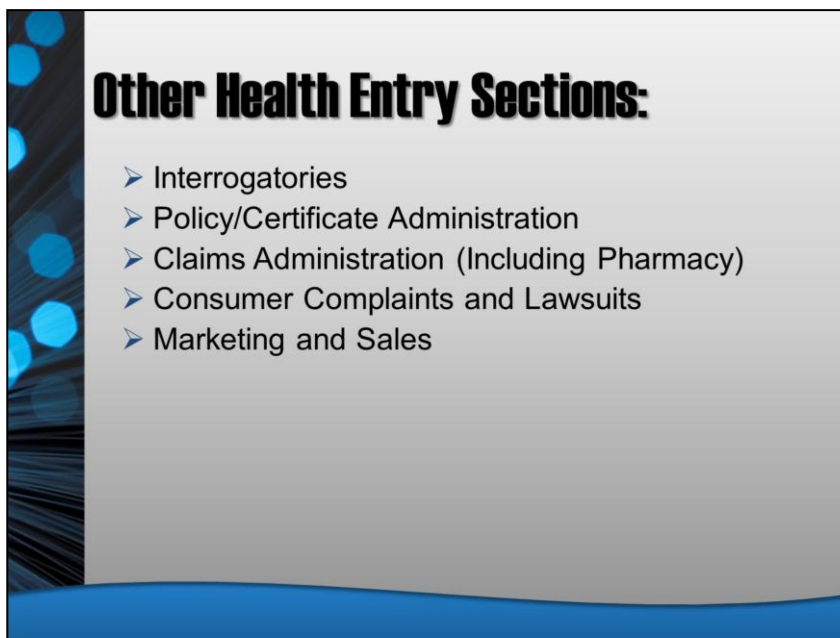

The Other Health MCAS data elements are divided into five sections:

- Interrogatories
- Policy/Certificate Administration
- Claims Administration (Including Pharmacy)
- Consumer Complaints and Lawsuits
- Marketing and Sales

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Interrogatories

Other Health Insurance Interrogatories

01	Are you currently marketing these products in this jurisdiction?
02	Do the products you are reporting on in response to this blank include closed or frozen blocks of business?
03	If yes, list the closed or frozen blocks of business?
04	Number of Other Health products offered to residents in this state.
05	For products reported to this MCAS jurisdiction, list the states where your Other Health products are filed (provide SERFF tracking number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing.
06	For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?
07	If yes, list the associations/trusts.
08	If yes, do you have a contractual relationship with any association/trust?
09	If yes, please identify which associations/trusts.
10	If yes, does the contract allow any association/trust to market the product?
11	If yes, please identify which associations/trusts.
12	If yes, does the contract allow any association/trust to collect policy or contract premiums?
13	If yes, does the contract allow any association/trust to collect and pay commissions?
14	If yes, please identify which associations/trusts.
15	If yes, does the contract allow any association/trust to adjudicate claims?
16	If yes, please identify which associations/trusts.
17	Has the company filed the associations by-laws and articles of incorporation in their state of domicile?
18	Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?
19	If yes please provide the state, and the SERFF tracking number, if applicable.
20	Has the company filed the association by-laws and articles of incorporation in the filing state?
21	Has the company filed the certificate of insurance in the filing state, if applicable?

The first section of questions that you will see in the data entry screen is the interrogatories. The interrogatories provide one location for all comments and questions that require a text response.

MCAS is filed on a per state basis. If you are reporting to state A that you have Accidental Death and Dismemberment to report in state A, then for Interrogatory question 5, you need to also tell state A where else you market Accidental Death and Dismemberment products. This may be quite a bit of text.

Questions 6 through 21 are about whether your company issues products through Associations. If yes, you must provide a list of the associations and answer a series of questions about your company’s relationship with the associations.

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Interrogatories

22	Does the company contract with third-party administrators for administrative services related to Other Health products?
23	If yes, does the company issue Other Health products through administrators/TPAs?
24	If yes, how many administrators/TPAs?
25	If yes, list the TPAs and provide their respective National Producer Number (NPN), if required by the state.
26	If yes, does your company contract claims services related to Other Health products?
27	If yes, does your company contract complaints-related services related to Other Health products?
28	If yes, does your company contract medical underwriting services related to Other Health products?
29	If yes, does your company contract pricing services related to Other Health products?
30	If yes, does your company contract producer appointment services related to Other Health products?
31	If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?
32	If yes, does your company contract policyholder services related to Other Health products?
33	If yes, does your company contract premium collection services related to Other Health products?
34	Does your company audit third parties to whom you have delegated responsibilities?
35	If yes, please provide frequency of audits.
36	Does your company distribute its product through independent agents?
37	Does your company distribute its products through captive agents?
38	Does your company distribute its products through its employees?
39	Does the company use pre-existing condition exclusions?
40	If yes, identify which products.
41	Does the company contract with producers to collect premium or bind coverage on behalf of the company?
42	For fees that are included in reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.
43	For fees not included in the reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.
44	Additional state specific comments (optional)

The next set of interrogatories are designed to collect information on your use of third-party administrations which you use to manage a variety of operations. Again, as with associations, you will be asked to provide a list of TPA's your company uses.

Questions 36 through 38 are asking whether you sell you products through agents or directly. Please note that question 41 asks if your producers are authorized to bind coverage and collect premium.

Question 39 and 40 ask which, if any, of your products contains a pre-existing condition exclusion.

Question 42 and 43 are seeking to determine if any fees (but not commissions) are charged to customers and whether or not they are included in the total premium charged.

Please note the star by question 44 – The interrogatories ask for any comments that the submitter would like to add. Any areas of your data that may cause questions, or that generated a warning message when validating your data, should be explained fully in these comment areas. At the end of this tutorial, we will discuss the MCAS validations in more detail along with the importance of using the comments sections.

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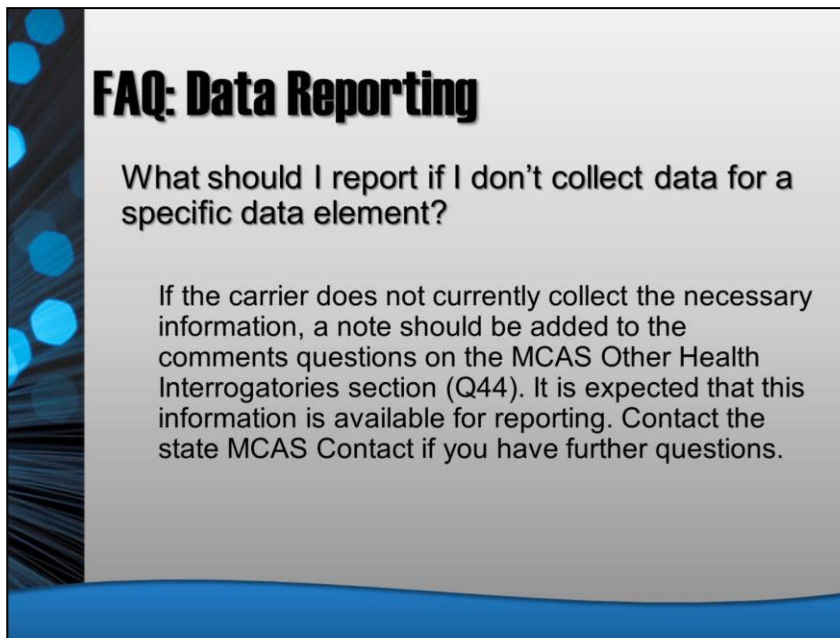

The first FAQ that we'll review deals with data the company is unable to report…If your company is unable to report data for a specific data element within the Other Health MCAS, a note should be added to the Interrogatories section of the filing to explain the reason for the company's inability to report.

It is expected that any company unable to report some of the requested data will work to enable the reporting in future years.

The list of MCAS State Contacts can be found at this link: https://content.naic.org/mcas_data_dashboard.htm

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Policy/Certificate Administration

45	Direct Written Premium.
46	Earned premiums for reporting year
47	Number of policies/certificates in force at the beginning of the period
48	Number of covered lives on policies/certificates in force at the beginning of the period
49	Number of new policy/certificate applications/enrollments received during the period
50	Number of new policy/certificates issued during the period
51	Number of new policies/certificates denied during the period
52	Number of covered lives on new policies/certificates issued during the period
53	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
54	Number of policies/certificates cancelled during the free look period
55	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
56	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period
57	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
58	Number of rescissions during the period
59	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder
60	Number of covered lives impacted on terminations and cancellations due to nonpayment
61	Number of covered lives impacted by rescissions
62	Number of policies/certificates in force at the end of the period
63	Number of covered lives on policies/certificates in force at the end of the period

Individual				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Association				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Employer Group				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

This is a list of all the data elements collected in the Policy/Certificate Administration section of the Other Health blank.

Please note that each data element needs to broken out by product type and whether it was marketed directly to individuals, through an association, or through an employer group. For example, if you had premium in each of the 5 different products through associations ***only*** – you would report 0's in each of the "Individual" and "Employer Group" data cells; and each data cell under "Association" should reflect you sold each of the products.

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Policy/Certificate Administration

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46	Earned premiums for reporting year
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48	Number of covered lives on policies/certificates in force at the beginning of the period
49	Number of new policy/certificate applications/enrollments received during the period
50	Number of new policy/certificates issued during the period
51	Number of new policies/certificates denied during the period
52	Number of covered lives on new policies/certificates issued during the period
53	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
54	Number of policies/certificates cancelled during the free look period
55	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
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57	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
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59	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder
60	Number of covered lives impacted on terminations and cancellations due to nonpayment
61	Number of covered lives impacted by rescissions
62	Number of policies/certificates in force at the end of the period
63	Number of covered lives on policies/certificates in force at the end of the period

The reported direct and earned premium should correspond to only that business that is applicable to MCAS reporting.

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Policy/Certificate Administration

45	Direct Written Premium.
46	Earned premiums for reporting year
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60	Number of covered lives impacted on terminations and cancellations due to nonpayment
61	Number of covered lives impacted by rescissions
62	Number of policies/certificates in force at the end of the period
63	Number of covered lives on policies/certificates in force at the end of the period

The Other Health MCAS blank collects policy administration data by number of policies and number of covered lives. The expectation for covered lives is that you provide an accurate number. If an estimate is needed please provide an explanation in the comments section located in the interrogatories.

The data elements highlighted in red boxes ask for the number of policies and/or certificates open at the beginning of the reporting period (January 1) and the end of the reporting period (December 31) as well as the number of covered lives on those policies marked by the red arrow.

Questions 49, 50 and 51 are highlighted in a blue box and ask for the number of policies/certificates received, the number issued, and the number denied. Again, the covered lives on newly issued policies are noted by the blue arrow.

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Policy/Certificate Administration

45	Direct Written Premium.
46	Earned premiums for reporting year
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48	Number of covered lives on policies/certificates in force at the beginning of the period
49	Number of new policy/certificate applications/enrollments received during the period
50	Number of new policy/certificates issued during the period
51	Number of new policies/certificates denied during the period
52	Number of covered lives on new policies/certificates issued during the period
53	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
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59	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder
60	Number of covered lives impacted on terminations and cancellations due to nonpayment
61	Number of covered lives impacted by rescissions
62	Number of policies/certificates in force at the end of the period
63	Number of covered lives on policies/certificates in force at the end of the period

The remaining data elements in the Policy/Certificate section concern terminations and cancellations of policies and/or certificates. This information is collected by the reason for the cancellation.

Again, the red arrows mark the questions asking for covered lives impacted by the cancellations, terminations or rescissions.

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Terminations and Cancellations

Insured's Request

Non-Payment of Premium

Terminations and Cancellations are to be reported separately if the termination was at the insured's request (Q. 53) or if the termination was due to non-payment of premium (Q. 56)

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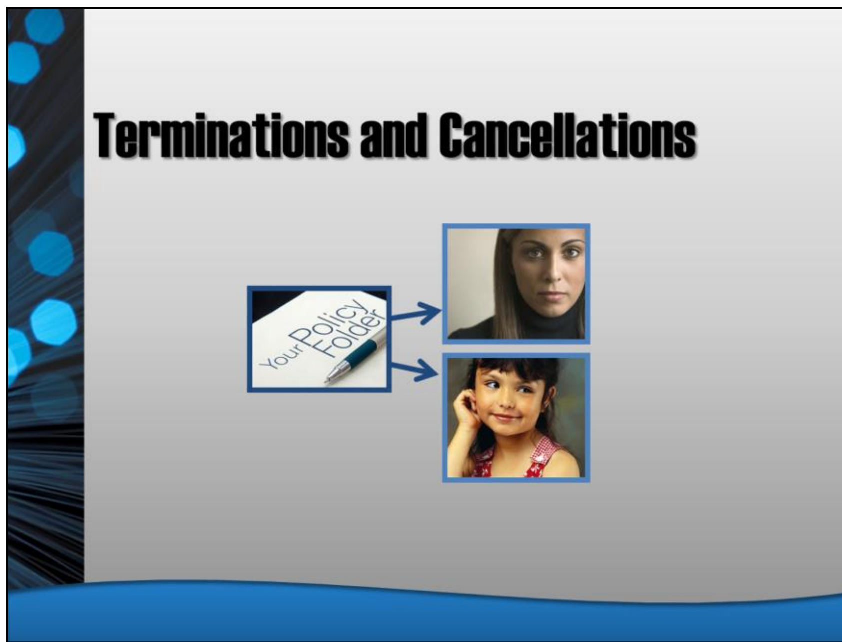

The number of covered lives impacted by Terminations and Cancellations will not always be equal to the number of policies or contracts terminated. A single policy or contract may cover more than one person.

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Claims (including Pharmacy)

64 Number of claims pending at the beginning of the period
65 Number of claims received (include non-clean claims)
66 Total number of claims denied, rejected or returned
67 Number denied, rejected, or returned as non-covered or maximum benefit exceeded
68 Number denied, rejected, or returned as subject to pre-existing condition exclusion
69 Number denied, rejected, or returned due to failure to provide adequate documentation
70 Number denied, rejected, or returned due to being within the waiting period
71 Number denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
72 Number of claims pending at the end of the period
73 Median number of days from receipt of claim to decision for denied claims
74 Average number of days from receipt of claim to decision for denied claims
75 Median number of days from receipt of claim to decision for approved claims
76 Average number of days from receipt of claim to decision for approved claims
77 Number of claims paid
78 Aggregate dollar amount of paid claims during the period
79 Number of claims where the claims payment was reduced by premium owed
80 Dollar amount of claims payments applied to unpaid premiums.

Individual				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Association				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Employer Group				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

This is a list of all the data elements collected in the Claims Administration section of the Other Health blank. Please note that claims include pharmacy claims.

As with the Policy/Certificate section, each data element needs to broken out by product type and whether it was marketed directly to individuals, through an association, or through an employer group.

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Claims (including Pharmacy)

64	Number of claims pending at the beginning of the period
65	Number of claims received (include non-clean claims)
66	Total number of claims denied, rejected or returned
67	Number denied, rejected, or returned as non-covered or maximum benefit exceeded
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69	Number denied, rejected, or returned due to failure to provide adequate documentation
70	Number denied, rejected, or returned due to being within the waiting period
71	Number denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
72	Number of claims pending at the end of the period
73	Median number of days from receipt of claim to decision for denied claims
74	Average number of days from receipt of claim to decision for denied claims
75	Median number of days from receipt of claim to decision for approved claims
76	Average number of days from receipt of claim to decision for approved claims
77	Number of claims paid
78	Aggregate dollar amount of paid claims during the period
79	Number of claims where the claims payment was reduced by premium owed
80	Dollar amount of claims payments applied to unpaid premiums.

The first half of the claims section is designed to gather data on the number of claims that were received, approved and denied. This section starts by asking how many claims were pending at the beginning of the period (January 1st) and ends with the number of claim pending at the end of the period (December 31st).

As indicated, claims include non-clean claims. For this MCAS, a "claim" includes any request or demand, even those with incomplete or inadequate documentation and those made by an individual not eligible or covered under the policy against which the claim is made. However, communications by an insured that are not explicit claims should not be reported on this MCAS. Questions 67 through 71 are designed to capture the reasons claims were denied, rejected or returned.

Claims that are closed and later re-opened should be treated as a new claim.

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Claims (including Pharmacy)

64	Number of claims pending at the beginning of the period
65	Number of claims received (include non-clean claims)
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75	Median number of days from receipt of claim to decision for approved claims
76	Average number of days from receipt of claim to decision for approved claims
77	Number of claims paid
78	Aggregate dollar amount of paid claims during the period
79	Number of claims where the claims payment was reduced by premium owed
80	Dollar amount of claims payments applied to unpaid premiums.

The next four questions are to establish the speed at which claims are handled.

Questions 74 and 76 ask for the average number of days to approve claims and to deny claims.

Questions 73 and 75 ask for the median number of days to approve claims and to deny claims.

A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is ***not*** the average of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

Claim Nbr 1 – 2 days

Claim Nbr 2 – 4 days

Claim Nbr 3 – 4 days

Claim Nbr 4 – 5 days

Claim Nbr 5 – 6 days

Claim Nbr 6 - 8 days

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Claim Nbr 7 – 20 days

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values.

The average value is, of course, 7 days.

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Claims (including Pharmacy)

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75	Median number of days from receipt of claim to decision for approved claims
76	Average number of days from receipt of claim to decision for approved claims
77	Number of claims paid
78	Aggregate dollar amount of paid claims during the period
79	Number of claims where the claims payment was reduced by premium owed
80	Dollar amount of claims payments applied to unpaid premiums.

The last part of the claims administration section are intended to collect information on the dollar amount of claims paid and claims payments that were reduced by premium owed to the company.

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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.

When reporting claims received it is recommended that you use the date the claim was “received” as the anchor date. Likewise, when reporting claims denied, it is recommended that you use the claim determination date as the anchor.

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How do we determine which data year claims received, paid or denied are to be reported in?

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

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

If a claim is received during the data year, it should be reported as received.

If a claim is paid during the data year, it should be reported as paid.

If a claim is denied during the data year, it should be reported as denied.

It is understood that a claim may have been opened in the prior data year and paid or denied during the current data year. In this case, the claim would only be reported as paid or denied during the current data year.

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Claims Administration

Claim Received December 20, 2023

Claim paid January 5, 2024

Report as a claim received during the 2023 data year	Report as a paid claim in the 2024 data year

For example, if the claim is received December 20th of the current reporting year, and paid January 5th of the next reporting year, the claim would be reported as received in the current reporting year and paid in the next reporting year.

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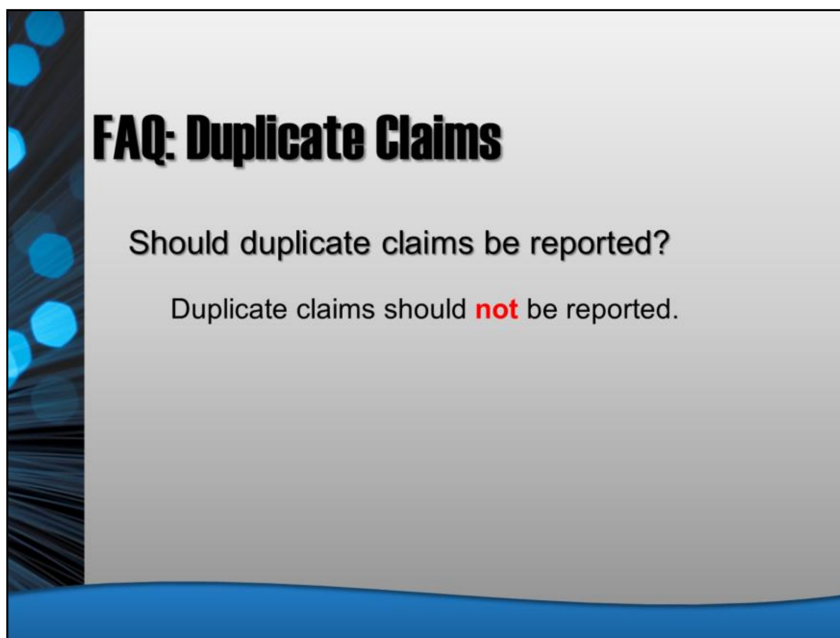

Duplicate claims have resulted in several questions. This FAQ clarifies that duplicate claims should NOT be reported within the Other Health MCAS.

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Consumer Complaints and Lawsuits

81	Number of complaints received by Company (other than through the DOI)
82	Number of complaints received through DOI
83	Number of complaints resulting in claims reprocessing
84	Number of lawsuits open at the beginning of the period
85	Number of lawsuits opened during the period
86	Number of lawsuits closed during the period
87	Number of lawsuits closed during the period with consideration for the consumer
88	Number of lawsuits open at the end of the period

Individual				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Association				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Employer Group				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

This is a list of the data elements collected in the Consumer Complaints and Lawsuits section of the Other Health blank.

Each data element needs to broken out by product type and whether it was marketed directly to individuals, through an association, or through an employer group.

You will need to make a distinction between complaints made directly to the company by a consumer and complaints received through the state's insurance department.

A complaint is defined as any written communication that expresses dissatisfaction with a specific person or entity. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose. Include complaints received from third parties.

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Marketing and Sales

89	Number of individual applications/enrollments pending at the beginning of the period
90	Number of individual applications/enrollments denied during the period for any reason
91	Number of individual applications/enrollments denied during the period - health status or condition
92	Number of individual applications/enrollments approved during the period
93	Number of individual applications/enrollments pending at the end of the period
94	Number of applications/enrollments received via phone (audio only)
95	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx)
96	Number of applications/enrollments received online (electronically)
97	Number of applications/enrollments received by mail during the period
98	Number of applications/enrollments received by any other method during the period
99	Commissions paid during reporting period (dollar amount of commissions incurred during the period)
100	Unearned commissions returned to company on policies/certificates sold during the period

Individual				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Association				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

Employer Group				
Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense

In this final section of the MCAS blank, we are concerned first with the number of applications and enrollments that were processed and how many were approved or denied. If denied, we ask that you report how many were denied either (1) due to health status or condition, or (2) for all other reasons. All the first 5 questions, are applicable to individual, association or employer group sales.

Questions 94 to 98 ask you to identify how the application was received: 1) by phone; 2) by video; 3) online; 4) by mail; or 5) any other method. These are only applicable to products marketed directly to individuals.

The last two questions ask for commissions paid, and commissions returned if policies that terminate early. Commission is defined for the Other Health MCAS blank as: The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. For products not related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting. Do not include any fees or other compensation paid for outsourced services.

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Other Health

Data Elements

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