

**Market Conduct Annual
Statement**

2019 Data Year Filings

Long-Term Care

Data Elements & Validation

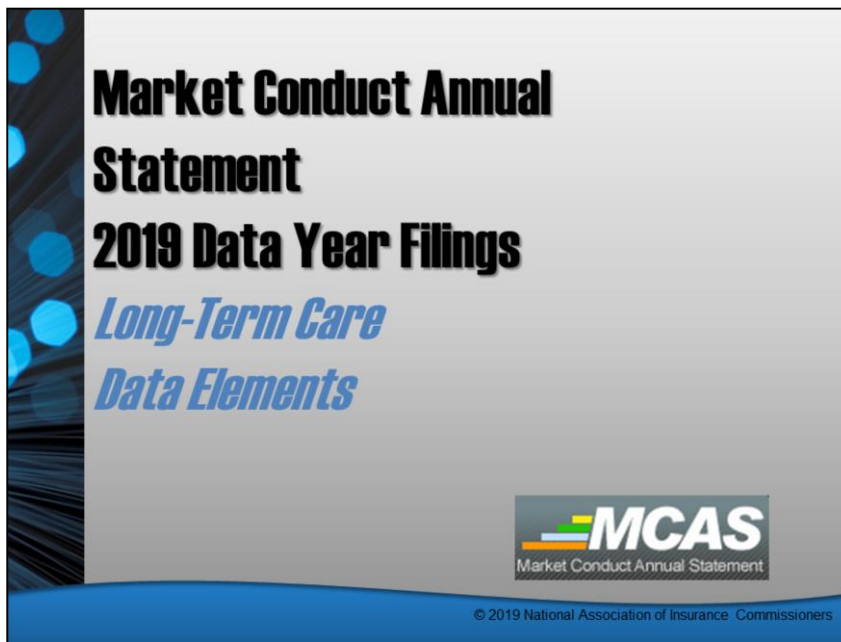




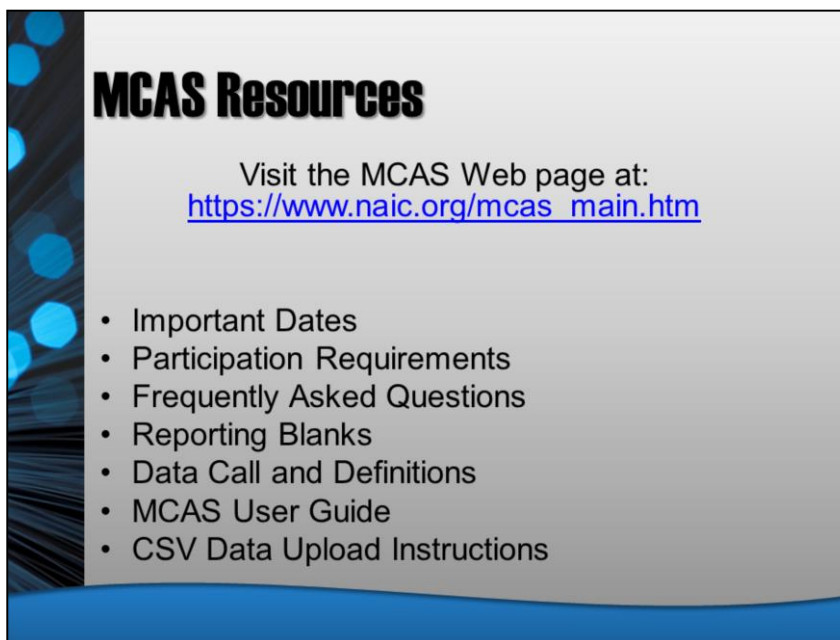
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Hi, I'm _____ . In this section of the Market Conduct Annual Statement training we will be reviewing the data elements that must be provided for the Long-Term Care MCAS.



MCAS Resources

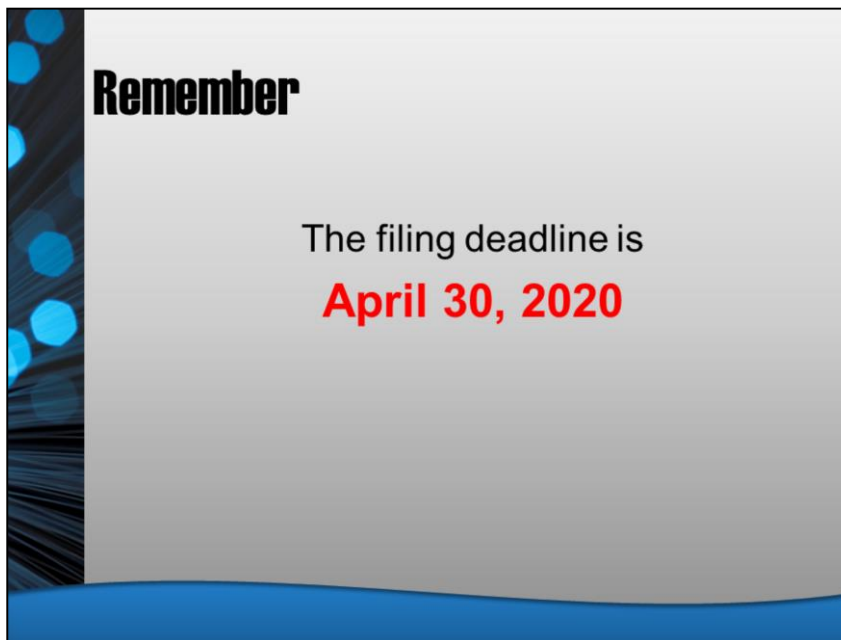
Visit the MCAS Web page at:
https://www.naic.org/mcas_main.htm

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

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



Before we begin, please be sure to remember that the current year MCAS filing deadline is April 30th.

Remember

MCAS Threshold:

There is no premium threshold - any positive premium in any state for stand-alone LTC, hybrid Life-LTC, or hybrid Annuity-LTC is reported for that state

Arkansas Threshold:

\$50,000 in direct written premium

Long-term care (LTC) was a new MCAS line of business included for the 2014 data year. With only one exception, there is no premium threshold for this line of business. Companies with any in-force LTC policies are required to report in all participating jurisdictions (for those jurisdictions in which they have in-force policies).

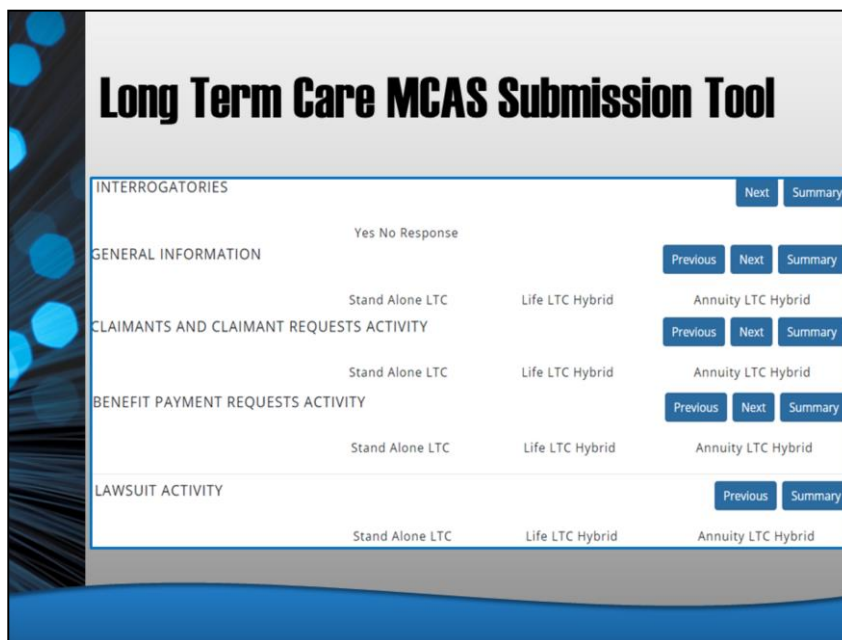
The Arkansas LTC threshold is \$50,000. A company is required to report LTC MCAS data for Arkansas if they wrote at least \$50,000 in stand-alone LTC, hybrid LTC-Life, or hybrid Annuity-LTC premium; or all for the state.

Interrogatories

Long-Term Care Interrogatories

		Yes No Response	Explanation
01	Does the company have data to report for Stand-Alone Long-Term Care?	--	--
02	Does the company have data to report for Life Long-Term Care Hybrid?	--	--
03	Does the company have data to report for Annuity Long-Term Care Hybrid?	--	--
04/05	Stand-alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.	--	--
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.	--	--
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.	--	--
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.	--	--
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.	--	--
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.	--	--
16	Additional state specific Stand-Alone Long-Term Care comments (optional):	--	--
17	Additional state specific Life Long-Term Care Hybrid comments (optional):	--	--
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):	--	--

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.



You will notice on your data entry screen within the MCAS submission tool that there is one page for Interrogatory questions and four separate pages of data questions for the policy types.

There are a total of 7 sections or schedules for the Long-Term Care MCAS, with the Interrogatories being the first, however, within the MCAS submission tool the data questions are separated into five total pages for a better user experience within the tool itself.

The five pages of data entry are Interrogatories, General Information, Claimants and Claimant Requests Activity, Benefit Payment Requests Activity and Lawsuit Activity.

We will discuss the details of each section throughout this tutorial, but the way each page of information begins for the Long-Term Care MCAS appear here.

Long-Term Care Interrogatories		Yes	No	Explanation
		Response		
01	Does the company have data to report for Stand-Alone Long-Term Care?			n/a
02	Does the company have data to report for Life Long-Term Care Hybrid?			n/a
03	Does the company have data to report for Annuity Long-Term Care Hybrid?			n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
16	Additional state specific Stand-Alone Long-Term Care comments (optional):			
17	Additional state specific Life Long-Term Care Hybrid comments (optional):			
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):			
Long-Term Care General Information				
		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.			
20	Number of new business policies/contracts issued during the period.			
21	Number of free look cancellations during the period.			
22	Number of lapses during the period.			
23	Number of rescissions during the period.			
24	Number of policies/contracts in-force as of the end of the period.			
25	Number of internal replacements during the period.			
26	Number of external replacements during the period.			
27	Number of policies/contracts replaced where age of insured at replacement was < 65.		n/a	
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.		n/a	
29	Number of policies/contracts replaced where age of insured at replacement was > 80.		n/a	
30	Number of complaints received directly from consumers.			

The first interrogatories ask insurers to indicate if they will be reporting data for each of the policy types for the line of business selected.

Long-Term Care Interrogatories			
	Yes No Response	Explanation	
01	Y	n/a	
02	Y	n/a	
03	Y	n/a	
04/05			
04/05			
06/07			
06/07			
10/11			
12/13			
14/15			
16			
17			
18			
Long-Term Care General Information			
	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19			
20			
21			
22			
23			
24			
25			
26			
27		n/a	n/a
28		n/a	n/a
29		n/a	n/a
30			

If you answer "YES" you must provide data to each of the data questions in the schedule;

Long-Term Care Interrogatories

Q1	Does the company have data to report for Stand-Alone Long-Term Care?	Yes No Response Y N Y	Explanation
Q2	Does the company have data to report for Life Long-Term Care Hybrid?		n/a
Q3	Does the company have data to report for Annuity Long-Term Care Hybrid?		n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.		
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.		
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.		
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.		
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.		
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.		
16	Additional state specific Stand-Alone Long-Term Care comments (optional):		
17	Additional state specific Life Long-Term Care Hybrid comments (optional):		
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):		

Long-Term Care General Information

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.		
20	Number of new business policies/contracts issued during the period.		
21	Number of free look cancellations during the period.		
22	Number of lapses during the period.		
23	Number of rescissions during the period.		
24	Number of policies/contracts in-force as of the end of the period.		
25	Number of internal replacements during the period.		
26	Number of external replacements during the period.		
27	Number of policies/contracts replaced where age of insured at replacement was < 65.		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.		
30	Number of complaints received directly from consumers.		

If you respond “NO”, you must leave all the response boxes blank for that line of business. You should only provide data for schedules that you are required to report on.

Interrogatories

Long-Term Care Interrogatories

		Yes	No	Explanation
		Response		
01	Does the company have data to report for Stand-alone Long-Term Care?			n/a
02	Does the company have data to report for Life Long-Term Care Hybrid?			n/a
03	Does the company have data to report for Annuity Long-Term Care Hybrid?			n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
16	Additional state specific Stand-Alone Long-Term Care comments (optional):			
17	Additional state specific Life Long-Term Care Hybrid comments (optional):			
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):			

If you indicate that you will be reporting data for a policy type, you are asked if there has been a significant event or business strategy change that would affect the data for this reporting period. These could include assuming blocks of business, shifting market strategies, or underwriting changes.

Interrogatories

Long-Term Care Interrogatories

		Yes	No	Explanation
		Response		
01	Does the company have data to report for Stand-alone Long-Term Care?			n/a
02	Does the company have data to report for Life Long-Term Care Hybrid?			n/a
03	Does the company have data to report for Annuity Long-Term Care Hybrid?			n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.			
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.			
16	Additional state specific Stand-Alone Long-Term Care comments (optional):			
17	Additional state specific Life Long-Term Care Hybrid comments (optional):			
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):			

You are also asked if any part of the block of business has been sold, closed or moved to another company during the reporting period. These questions are your opportunity to explain any of your data that you anticipate may generate an inquiry from the state regulators. It is important that these questions be answered fully to allow regulators to have an understanding of your company's MCAS filing results.

Interrogatories

Long-Term Care Interrogatories

		Yes No Response	Explanation
01	Does the company have data to report for Stand-alone Long-Term Care?		
02	Does the company have data to report for Life Long-Term Care Hybrid?		n/a
03	Does the company have data to report for Annuity Long-Term Care Hybrid?		n/a
04/05	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.		
06/07	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.		
08/09	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? If yes, please explain.		
10/11	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.		
12/13	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.		
14/15	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? If yes, please explain.		
16	Additional state specific Stand-Alone Long-Term Care comments (optional):		
17	Additional state specific Life Long-Term Care Hybrid comments (optional):		
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional):		

The interrogatories also provide space where you may enter any state specific comments for the policy types. Any areas of your data that may raise questions or generated a warning when your data was validated 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.

Long-Term Care MCAS Data Elements



The LTC MCAS requests market conduct data on three types of policies that offer long-term care coverage.

Market Conduct Data

Long-Term Care

- Stand-Alone LTC
 - Life-Hybrid LTC
 - Annuity-Hybrid LTC
- Report experience on individual LTC hybrid policies and contracts.
 - Do not report experience on group policies and contracts.

Stand-Alone LTC policies, Life LTC Hybrid policies and Annuity LTC Hybrid policies. Please note, that MCAS is only collecting data on individual policies, not LTC offered through group coverage.

Market Conduct Data

Stand-Alone Long-Term Care in MCAS:

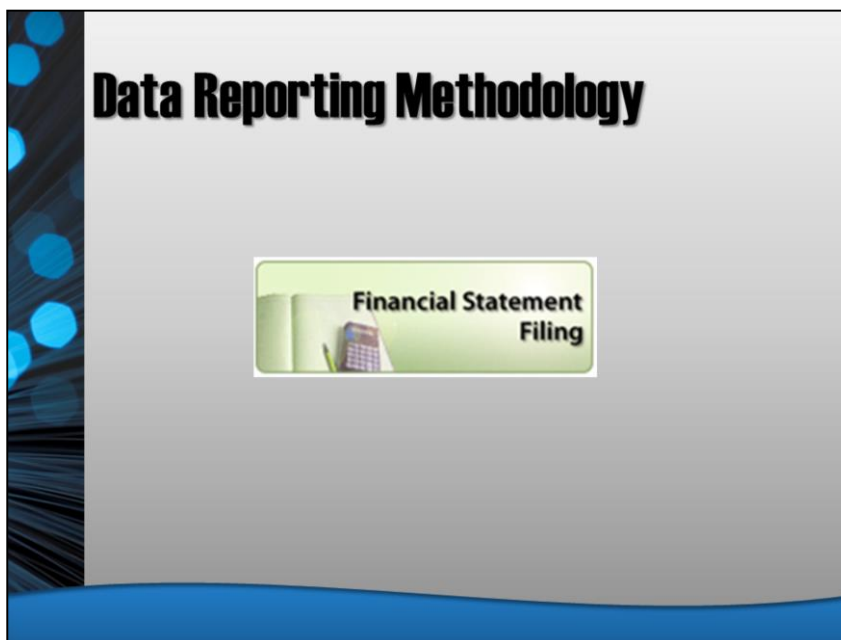
- NAIC Long-Term Care Insurance Model Act (#640), Sec. 4A
 - ... any insurance policy ... designed to provide coverage ... for each covered person ... for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services

LTC-Hybrid Insurance in MCAS:


- Products providing LTC insurance [which is] 'built into the life policy or annuity contract, or ... attached to such policy or contract by a rider....'
- NAIC Long-Term Care Insurance Model Act (#640), Sec. 4A
 - [Hybrid-LTC] **does not include** life insurance policies that accelerate the death benefit specifically for ... terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and **where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.**

The definitions of Stand-Alone and Hybrid-LTC insurance can be found in the MCAS Data Call and Definitions. The Data Call and Definitions reference Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640). Stand-Alone LTC, per the Model Act, is “any insurance policy...designed to provide coverage ...for each covered person ... for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services” LTC-Hybrid products, per the MCAS Hybrid-LTC Data Call and Definitions are products in which LTC coverage is built into the life policy or annuity contract, or attached to them by a rider. The definitions for hybrid LTC also references Sec 4A of the LTC Model Act. Per the Model, Hybrid-LTC riders and policies would only qualify for reporting if the trigger for coverage is solely conditioned on the receipt of eligible long-term care. So if a life policy provides accelerated death benefits, but those benefits can be received for other conditions in addition to LTC needs, it would not be included in MCAS.

As the data elements for hybrid products and stand-alone products are basically the same, with one exception, we will discuss them all together. However, they must be reported separately.



Before we move on to the main data elements, it's important to point out that if there is any question regarding data reporting methodology, you should follow the same methodology used to report on the Financial Annual Statement.



In-Force & New Business

Long-Term Care General Information

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.		
20	Number of new business policies/contracts issued during the period.		
21	Number of free look cancellations during the period.		
22	Number of lapses during the period.		
23	Number of rescissions during the period.		
24	Number of policies/contracts in-force as of the end of the period.		
25	Number of internal replacements during the period.		
26	Number of external replacements during the period.		
27	Number of policies/contracts replaced where age of insured at replacement was < 65.		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.		
30	Number of complaints received directly from consumers.		

January 1, 2019 – December 31, 2019

Now we're ready to discuss the Long-Term Care MCAS questions. The first questions are about policies issued during the period:

Both the Stand-Alone and Hybrid LTC schedules ask for the

Total number of policies/contracts in-force at the beginning of the reporting period

And the

Total number of new business policies/contracts issued by the company during the period

As mentioned before, the reporting period only includes those policies issued between January 1 and December 31. If a policy was applied for on December 31 of the reporting period, but not finally issued until the middle of January, do not count it.

Free Looks

Long-Term Care General Information

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19			
20			
21			
22			
23			
24			
25			
26			
27		n/a	
28		n/a	
29		n/a	
30			

January 1, 2019 – December 31, 2019

Next you are asked to report the number of free look cancellations during the period. Note that, regardless of when the policy was issued, you should include only those free looks that occurred during the reporting period



Long-Term Care Data Call & Definitions

Free Looks

A free look is a set number of days provided in a policy or contract that allows time for the purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.

A free look is a set number of days provided in a policy or contract that allows time for the purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.

Free Looks

MCAS is not asking for the number of policies that have a Free Look provision; you are expected to provide the number of times the free look provision was exercised during the reporting period.



Policies with Free Look Provision



Policies where Free Look Provision was Exercised

MCAS is **not** asking for the number of policies that have a Free Look provision; you are expected to provide the number of times the free look provision was exercised during the reporting period.

Lapses

Long-Term Care General Information

	Stand-Alone LTC	Life LTC-hybrid	Annuity LTC hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.		
20	Number of new business policies/contracts issued during the period.		
21	Number of free look cancellations during the period.		
22	Number of lapses during the period.		
23	Number of rescissions during the period.		
24	Number of policies/contracts in-force as of the end of the period.		
25	Number of internal replacements during the period.		
26	Number of external replacements during the period.		
27	Number of policies/contracts replaced where age of insured at replacement was < 65.		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.		
30	Number of complaints received directly from consumers.		

January 1, 2019 – December 31, 2019

The next data element asks that you report the number of lapses during the period.

Long-Term Care Data Call & Definitions

Lapse

A termination of the entire policy or contract

OR

The termination of the LTC benefit of the policy or contract

DUE TO

Nonpayment of premium



A lapse is the termination of the entire policy or contract or the termination of the LTC benefit of the policy or contract due to nonpayment of premium.

Rescissions

Long-Term Care General Information

	Stand-Alone LTC	Life LTC-hybrid	Annuity LTC hybrid
19			
20			
21			
22			
23			
24			
25			
26			
27		n/a	
28		n/a	
29		n/a	
30			

January 1, 2019 – December 31, 2019

Then you are asked to report the number of rescissions during the period.

Long-Term Care Data Call & Definitions

Rescissions

The invalidation of a policy or contract

OR

The invalidation of the LTC benefit of the policy or contract by an insurer

In accordance with

NAIC Long-Term Care Insurance Model Act (#640)



A rescission is the invalidation of a policy or contract or invalidation of the LTC coverage portion of a policy or contract by an insurer, in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640).


Policies In-Force

Long-Term Care General Information

	Stand-Alone LTC	Life LTC hybrid	Annuity LTC hybrid
19			
20			
21			
22			
23			
24			
25			
26			
27		n/a	
28		n/a	
29		n/a	
30			

End of Reporting Period December 31, 2019

Next, you are asked to report the number of policies in-force at the end of the period. The number of policies in-force, is simply the number of in-force policies and contracts on the last day of the **reporting** period (which is December 31).



Replacements

Long-Term Care General Information

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.		
20	Number of new business policies/contracts issued during the period.		
21	Number of free look cancellations during the period.		
22	Number of lapses during the period.		
23	Number of rescissions during the period.		
24	Number of policies/contracts in-force as of the end of the period.		
25	Number of internal replacements during the period.		
26	Number of external replacements during the period.		
27	Number of policies/contracts replaced where age of insured at replacement was < 65.		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.		
30	Number of complaints received directly from consumers.		

January 1, 2019 – December 31, 2019

There is a series of questions addressing “replacement” activity during the reporting period. As we mentioned, the reporting period for the data year is January 1 through December 31. So, you would provide the number of replacements **issued** between January 1 and December 31. For all products (Stand-Alone LTC, Life LTC Hybrid and Annuity LTC Hybrid) you are asked to provide

- Number of internal replacements issued during the period, and the
- Number of external replacements issued during the period

Long-Term Care Data Call & Definitions

Replacements

- Stand-Alone LTC policies: The replacement of a policy or contract with LTC benefits already in force with a new stand-alone LTC policy.
- Hybrid LTC policies: The replacement of any life policy, annuity contract or LTC policy already in force with a new policy or contract with LTC hybrid insurance coverage.

The definition of a replacement policy as stated in the Long-Term Care Data Call & Definitions for Stand-Alone LTC policies is the replacement of a policy or contract with LTC benefits already in force with a new LTC policy. (Please note that new LTC policy means a stand-alone LTC policy.)

The definition for Hybrid LTC policies is the replacement of any life policy, annuity contract (that is, any life or annuity policy whether or not it already has LTC coverage) or LTC policy already in force with a new policy or contract with LTC hybrid insurance coverage.

Remember that you should report the replacement according to what type of product the new policy is.

Replacements



Reported as TWO Replacements

Note that if a person replaces two policies with one policy, this should be counted as two replacements.

Internal Replacement



An internal replacement is when the policy to be replaced was also issued by your company,



and an external replacement is when the policy to be replaced was issued by another company. The replacements reported **do not** include policies written by your company that are replaced by policies issued by another company.

Replacements

Long-Term Care General Information

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.		
20	Number of new business policies/contracts issued during the period.		
21	Number of free look cancellations during the period.		
22	Number of lapses during the period.		
23	Number of rescissions during the period.		
24	Number of policies/contracts in-force as of the end of the period.		
25	Number of internal replacements during the period.		
26	Number of external replacements during the period.		
27	Number of policies/contracts replaced where age of insured at replacement was < 65.		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.		
30	Number of complaints received directly from consumers.		

January 1, 2019 – December 31, 2019

In addition, *ONLY* for the Life LTC Hybrid and Annuity LTC Hybrid products you are asked to provide

The number of policies replaced where the age of insured at replacement was < 65 years old,

The number of policies replaced where the age of insured at replacement was between 65 years old and 80 years old, and the

Number of policies replaced where the age of insured at replacement was > 80 years old

Please note that if more than one person is insured on the policy, you would use the age of the oldest insured.

Complaints

Long-Term Care General Information

	Stand-Alone LTC	Life LTC-hybrid	Annuity LTC hybrid
19			
20			
21			
22			
23			
24			
25			
26			
27		n/a	
28		n/a	
29		n/a	
30			

January 1, 2019 – December 31, 2019

The next question asks for the number of complaints received directly from consumers. Please note that complaints should be counted separately for Stand-Alone LTC, Life-Hybrid LTC, and Annuity-Hybrid LTC.



Long-Term Care Data Call & Definitions

Complaint

Any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

A complaint is defined as “Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.”

Long-Term Care Data Call & Definitions

Complaints Include:


- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties
- Complaints that are **directly** received by the company through social media applications should be included if the complaint has enough specificity to meet the definition of a complaint

Complaints Do Not Include:

- Complaints received from the state department of insurance

Complaints should be included in the complaint count regardless of the subject of the complaint. So, whether it is regarding claims, underwriting, marketing, or another area, it should be included. Complaints received from third parties also should be included. Complaints that are **directly** received by the company through social media applications should be included if the complaint has enough specificity to meet the definition of a complaint. Please note that this does not include complaints that have been received via the department of insurance.

Now Tressa Smith will discuss the remaining Long Term Care MCAS data elements.



Claims

Long-Term Care Claimants and Claimant Requests Activity			
	Stand-Alone LTC	Life LTC hybrid	Annuity LTC hybrid
31	Number of claimants approved for benefits as of the beginning of period.		
32	Number of claimants with pending claimant request determinations as of the beginning of period.		
33	Number of new claimants during the period.		
34	Number of claimants with pending claimant request determinations as of the end of the period.		
35	Number of claimants approved for benefits as of the end of the period.		
36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).		
37	Number of claimant requests denied or not paid due to preexisting condition exclusions.		
38	Number of claimant requests denied or not paid due to elimination or waiting period not met.		
39	Number of claimant requests denied or not paid because services provided not covered under the policy.		
40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.		
41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.		
42	All other claimant requests denied or closed without payment.		
43	Number of claim request determinations made within 0-30 days.		
44	Number of claim request determinations made within 31-60 days.		
45	Number of claim request determinations made within 61-90 days.		
46	Number of claim request determinations made beyond 90 days.		

Long-Term Care Benefit Payment Requests Activity			
	Stand-Alone LTC	Life LTC hybrid	Annuity LTC hybrid
47	Number of benefit payment requests pending as of the beginning of the period.		
48	Number of benefit payment requests received during the period.		
49	Number of benefit payment requests denied or not paid during the period.		
50	Number of benefit payment requests pending as of the end of the period.		
51	Number of benefit payment requests paid within 0-30 days.		
52	Number of benefit payment requests paid within 31-60 days.		
53	Number of benefit payment requests paid within 61-90 days.		
54	Number of benefit payment requests paid beyond 90 days.		
55	Number of benefit payment requests denied or not paid within 0-30 days.		
56	Number of benefit payment requests denied or not paid within 31-60 days.		
57	Number of benefit payment requests denied or not paid within 61-90 days.		
58	Number of benefit payment requests denied or not paid beyond 90 days.		

The next two sections in MCAS deals with the claims activity. Please note that there are different sections for reporting claimant and claimant requests vs benefit payment requests. These differences are explained in further detail for each section. It is important to remember to report the experience for those policies or contracts with LTC hybrid benefits and report experience only for the LTC benefit portion of the policy or contract. For example, if the insured on a life LTC hybrid policy dies, you would not report this as a claim on the LTC MCAS. You only report experience the LTC benefit portion of the LTC hybrid product.

Claims

Claimant and Claimant Requests Activity

“Per claimant” basis: Counting each individual who makes one or a series of requests or demands for payment of benefits under a policy or contract

Long-Term Care Claimants and Claimant Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annually LTC Hybrid
31. Number of claimants approved for benefits as of the beginning of period.			
32. Number of claimants with pending claimant request determinations as of the beginning of period.			
33. Number of new claimants during the period.			
34. Number of claimants with pending claimant request determinations as of the end of the period.			
35. Number of claimants approved for benefits as of the end of the period.			
36. Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).			
37. Number of claimant requests denied or not paid due to preexisting condition exclusions.			
38. Number of claimant requests denied or not paid due to elimination or waiting period not met.			
39. Number of claimant requests denied or not paid because services provided not covered under the policy.			
40. Number of claimant requests denied or not paid because provider or facility not qualified under the policy.			
41. Number of claimant requests denied or not paid because benefits eligibility criteria not met.			
42. All other claimant requests denied or closed without payment.			
43. Number of claim request determinations made within 0-30 days.			
44. Number of claim request determinations made within 31-60 days.			
45. Number of claim request determinations made within 61-90 days.			
46. Number of claim request determinations made beyond 90 days.			

The first few questions deal with claimant requests and claimant request determinations. Reporting for this section is to be done on a “per claimant” basis which means that we are counting **each** individual who makes one or more requests for coverage under a policy or contract. It is **NOT** the actual benefit payment request. Those are reported in the Benefits section.



Long-Term Care Data Call & Definitions

Claimant

An insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests.

It may help to review the definition of claimant that is used in the MCAS LTC Data Call and Definitions. A claimant is an insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests.



Long-Term Care Data Call & Definitions

Claimant Request

A claimant request is a request or demand for payment made by an insured, or a representative of the insured, for a loss that may be included within the terms of coverage of the LTC policy or contract.

This does NOT include events that were reported by the insured for “information only” or an inquiry of coverage when a claim has not actually been presented (opened) for payment.

A claimant request is a request or demand for payment made by an insured, or a representative of the insured, for a loss that **may** be included within the terms of coverage of the LTC policy or contract. It does not, however, include events that were reported by the insured for “information only” or an inquiry of coverage when a claim has not actually been presented (opened) for payment.

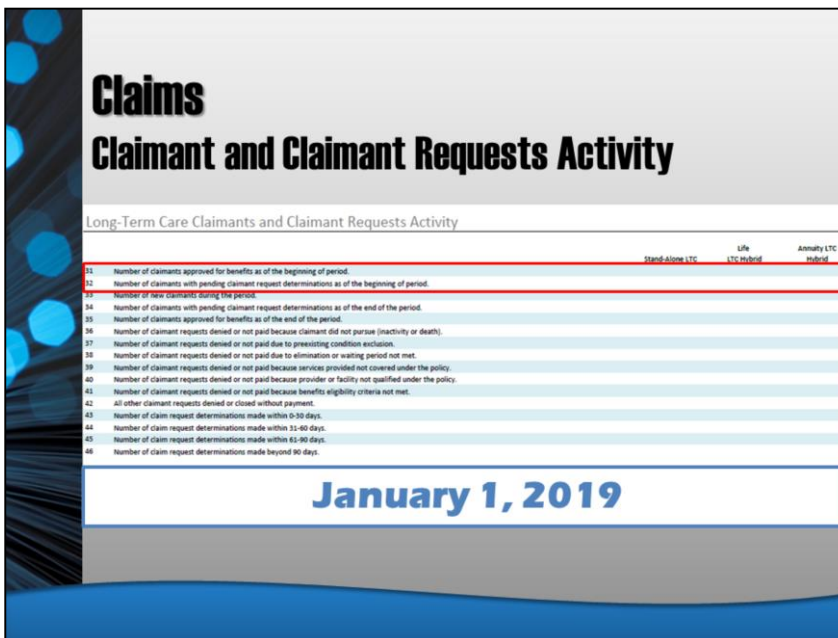


Long-Term Care Data Call & Definitions

Claim Request Determination

A claim request determination is a determination as to whether an insured has met a contractual provision of a LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity.

A claim request determination is a determination, by your company, as to whether an insured has met a contractual provision of a LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity.



Claims


Claimant and Claimant Requests Activity

Long-Term Care Claimants and Claimant Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
31	Number of claimants approved for benefits as of the beginning of period.		
32	Number of claimants with pending claimant request determinations as of the beginning of period.		
33	Number of new claimants during the period.		
34	Number of claimants with pending claimant request determinations as of the end of the period.		
35	Number of claimants approved for benefits as of the end of the period.		
36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).		
37	Number of claimant requests denied or not paid due to preexisting condition exclusions.		
38	Number of claimant requests denied or not paid due to elimination or waiting period not met.		
39	Number of claimant requests denied or not paid because services provided not covered under the policy.		
40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.		
41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.		
42	All other claimant requests denied or closed without payment.		
43	Number of claim request determinations made within 0-30 days.		
44	Number of claim request determinations made within 31-60 days.		
45	Number of claim request determinations made within 61-90 days.		
46	Number of claim request determinations made beyond 90 days.		

January 1, 2019

Now that we have defined these terms, there are varying types of data that we ask for regarding them. The first two questions are regarding what activity is pending as of the beginning of the reporting period (January 1st). The first question asks for the number of claimants approved for benefits as of the beginning of the period. The second asks for the number of claimants with pending claimant request determinations as of the beginning of the period.



Claims

Claimant and Claimant Requests Activity

Long-Term Care Claimants and Claimant Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
31	Number of claimants approved for benefits as of the beginning of period.		
32	Number of claimants with pending claimant request determinations as of the beginning of period.		
33	Number of new claimants during the period.		
34	Number of claimants with pending claimant request determinations as of the end of the period.		
35	Number of claimants approved for benefits as of the end of the period.		
36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).		
37	Number of claimant requests denied or not paid due to preexisting condition exclusion.		
38	Number of claimant requests denied or not paid due to elimination or waiting period not met.		
39	Number of claimant requests denied or not paid because services provided not covered under the policy.		
40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.		
41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.		
42	All other claimant requests denied or closed without payment.		
43	Number of claim request determinations made within 0-30 days.		
44	Number of claim request determinations made within 31-60 days.		
45	Number of claim request determinations made within 61-90 days.		
46	Number of claim request determinations made beyond 90 days.		

January 1, 2019 – December 31, 2019

Next we ask how many new claimants there are during the period. Please note that if a claim is re-opened, report the claim as new.

Claims


Claimant and Claimant Requests Activity

Long-Term Care Claimants and Claimant Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
31. Number of claimants approved for benefits as of the beginning of period.			
32. Number of claimants with pending claimant request determinations as of the beginning of period.			
33. Number of new claimants during the period.			
34. Number of claimants with pending claimant request determinations as of the end of the period.			
35. Number of claimants approved for benefits as of the end of the period.			
36. Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).			
37. Number of claimant requests denied or not paid due to preexisting condition exclusion.			
38. Number of claimant requests denied or not paid due to elimination or waiting period not met.			
39. Number of claimant requests denied or not paid because services provided not covered under the policy.			
40. Number of claimant requests denied or not paid because provider or facility not qualified under the policy.			
41. Number of claimant requests denied or not paid because benefits eligibility criteria not met.			
42. All other claimant requests denied or closed without payment.			
43. Number of claim request determinations made within 0-30 days.			
44. Number of claim request determinations made within 31-60 days.			
45. Number of claim request determinations made within 61-90 days.			
46. Number of claim request determinations made beyond 90 days.			

December 31, 2019

The next two questions are very similar to the first two in this section. However, these are regarding what activity is pending as of the **end** of the reporting period (December 31st). The first question asks for the number of claimants approved for benefits as of the end of the period. The second asks for the number of claimants with pending claimant request determinations as of the end of the period.



Claims

Claimant and Claimant Requests Activity

Long-Term Care Claimants and Claimant Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
31	Number of claimants approved for benefits as of the beginning of period.		
32	Number of claimants with pending claimant request determinations as of the beginning of period.		
33	Number of new claimants during the period.		
34	Number of claimants with pending claimant request determinations as of the end of the period.		
35	Number of claimants approved for benefits as of the end of the period.		
36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).		
37	Number of claimant requests denied or not paid due to preexisting condition exclusions.		
38	Number of claimant requests denied or not paid due to elimination or waiting period not met.		
39	Number of claimant requests denied or not paid because services provided not covered under the policy.		
40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.		
41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.		
42	All other claimant requests denied or closed without payment.		
43	Number of claim request determinations made within 0-30 days.		
44	Number of claim request determinations made within 31-60 days.		
45	Number of claim request determinations made within 61-90 days.		
46	Number of claim request determinations made beyond 90 days.		

January 1, 2019 – December 31, 2019

The next section of questions, in MCAS, deal with reasons that claimant requests could be denied. There are six reasons to choose from, and one “all other” category. We will quickly cover the reasons in the next few slides. Please note that if a denial could be reported under more than one of the categories, you should report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant’s request was denied, the denial should **NOT** be counted more than once.



Long-Term Care Data Call & Definitions

Claimant Request Denied/Not Paid Because Claimant Did Not Pursue

A claimant made a request or demand for payment for the purpose of receiving a claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again (inactivity could be the result of death.)

Claimant Request Denied/Not Paid Because Claimant Did Not Pursue—this would be if a claimant made a request or demand for payment for the purpose of receiving a claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again.



Long-Term Care Data Call & Definitions

Claimant Request Denied/Not Paid Because of Preexisting Condition Exclusion

A denial of coverage because benefits for the medical advice or treatment recommended by, or received from a provider of health care services are subject to a restriction as a pre-existing condition for a period of time following the effective date of the claimant's LTC coverage.

Claimant Request Denied/Not Paid Because of Preexisting Condition Exclusion—this is a denial of coverage if the benefits are subject to a restriction as a pre-existing condition.



Long-Term Care Data Call & Definitions

Claimant Request Denied/Not Paid Because Elimination/Waiting Period Not Met

A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract that the elimination/waiting period had not yet elapsed.

Claimant Request Denied/Not Paid Because Elimination/Waiting Period Not Met—this would be used if the elimination or waiting period had not yet elapsed.




Long-Term Care Data Call & Definitions

Claimant Request Denied/Not Paid Because Services Provided Not Covered

Expenses incurred for services and support which are not eligible for reimbursement under the LTC benefit of a policy or contract, such as an expense incurred for home health care when the policy or contract only provides benefits for nursing home confinements.

Claimant Request Denied/Not Paid Because Services Provided Not Covered—this would be chosen if the expenses incurred for services and support are not eligible for reimbursement under the LTC benefit of a policy or contract.



Long-Term Care Data Call & Definitions

Claimant Request Denied/Not Paid Because Provider/Facility Not Qualified

A long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract.

Claimant Request Denied/Not Paid Because Provider/Facility Not Qualified—this is for denials because the long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract.



Long-Term Care Data Call & Definitions

Claimant Request Denied/Not Paid because Benefit Eligibility Criteria Not Met

A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract, that a benefit trigger has not been met, or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided.

Claimant Request Denied/Not Paid because Benefit Eligibility Criteria Not Met—This is used if it is determined that the initial claimant request for coverage fails to meet any of the eligibility criteria or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided

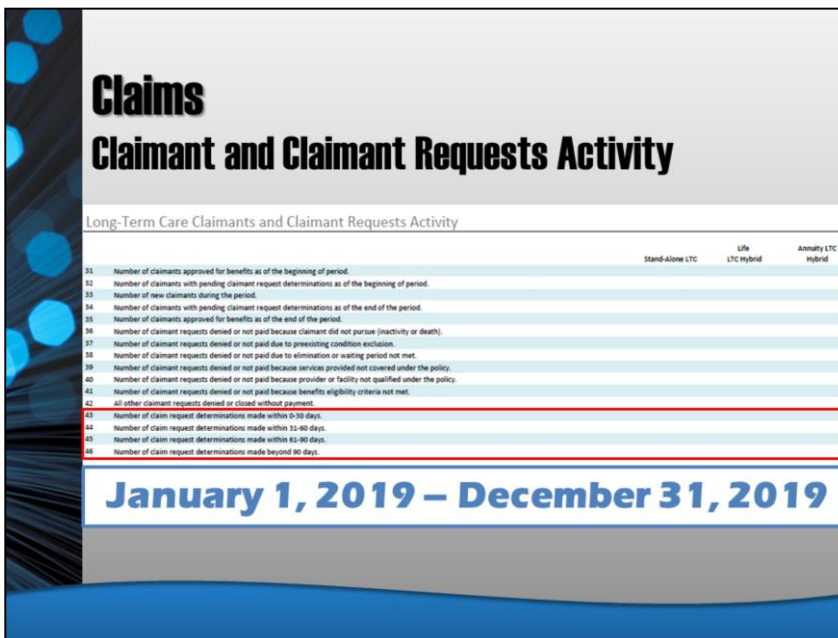


Long-Term Care Data Call & Definitions

All Other Claimant Requests Denied or Closed Without Payment

A claimant request that was denied or closed without payment for any reason other than those we have just discussed.

All Other Claimant Requests Denied or Closed Without Payment—this is a claimant request that was denied or closed without payment for any reason other than those specifically listed.



Claims

Claimant and Claimant Requests Activity

Long-Term Care Claimants and Claimant Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
31	Number of claimants approved for benefits as of the beginning of period.		
32	Number of claimants with pending claimant request determinations as of the beginning of period.		
33	Number of new claimants during the period.		
34	Number of claimants with pending claimant request determinations as of the end of the period.		
35	Number of claimants approved for benefits as of the end of the period.		
36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).		
37	Number of claimant requests denied or not paid due to preexisting condition exclusions.		
38	Number of claimant requests denied or not paid due to elimination or waiting period not met.		
39	Number of claimant requests denied or not paid because services provided not covered under the policy.		
40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.		
41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.		
42	All other claimant requests denied or closed without payment.		
43	Number of claim request determinations made within 0-30 days.		
44	Number of claim request determinations made within 31-60 days.		
45	Number of claim request determinations made within 61-90 days.		
46	Number of claim request determinations made beyond 90 days.		

January 1, 2019 – December 31, 2019

The next questions refer to the length of time that it took for a claim request determination to be made. To review, a claim request determination is a determination as to whether an insured has met a contractual provision of an LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity. For purposes of the MCAS, the term applies to the initial claimant request, and captures the period of time from the notice of claim to the claimant request determination date. For claimant requests that are denied or not paid, you should report the period of time from the date of notice of claim to the date the claimant was **notified** of the determination to deny or not pay the claim. These are broken out into time frames from 0-30 days, from 31-60 days, from 61-90 days and those beyond 90 days.

Long-Term Care Data Call & Definitions

Reporting Notes

- If a claim is re-opened:
 - Report the claim as a new claim.
 - The claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.

If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.

Claims

Benefit Payment Requests Activity

“per transaction” basis counts each benefit payment request pending and benefit payment paid or not paid/denied.

Long-Term Care Benefit Payment Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefit payment requests pending as of the beginning of the period.		
48	Number of benefit payment requests received during the period.		
49	Number of benefit payment requests denied or not paid during the period.		
50	Number of benefit payment requests pending as of the end of the period.		
51	Number of benefit payment requests paid within 0-30 days.		
52	Number of benefit payment requests paid within 31-60 days.		
53	Number of benefit payment requests paid within 61-90 days.		
54	Number of benefit payment requests paid beyond 90 days.		
55	Number of benefit payment requests denied or not paid within 0-30 days.		
56	Number of benefit payment requests denied or not paid within 31-60 days.		
57	Number of benefit payment requests denied or not paid within 61-90 days.		
58	Number of benefit payment requests denied or not paid beyond 90 days.		

The next section in MCAS deals with benefit payment requests activity. This is to be done on a “per transaction” basis (that is, you count each benefit payment request pending and benefit payment paid or not paid (or denied.)




Long-Term Care Data Call & Definitions

Benefit Payment Request

A benefit payment request is a request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request.

- Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment.

A benefit payment request is a request for benefits **after** the insurer has determined the insured is entitled to benefits following the initial claimant request. Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment. These are broken out into groupings of information requested.



Claims Benefit Payment Requests Activity

Long-Term Care Benefit Payment Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefit payment requests pending as of the beginning of the period		
48	Number of benefit payment requests received during the period		
49	Number of benefit payment requests denied or not paid during the period		
50	Number of benefit payment requests pending as of the end of the period		
51	Number of benefit payment requests paid within 0-30 days		
52	Number of benefit payment requests paid within 31-60 days		
53	Number of benefit payment requests paid within 61-90 days		
54	Number of benefit payment requests paid beyond 90 days		
55	Number of benefit payment requests denied or not paid within 0-30 days		
56	Number of benefit payment requests denied or not paid within 31-60 days		
57	Number of benefit payment requests denied or not paid within 61-90 days		
58	Number of benefit payment requests denied or not paid beyond 90 days		

January 1, 2019

Benefit payment requests pending as of the beginning of the reporting period – those requests that are pending as of January 1st.

Claims Benefit Payment Requests Activity

Long-Term Care Benefit Payment Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefit payment requests pending as of the beginning of the period.		
48	Number of benefit payment requests received during the period.		
49	Number of benefit payment requests denied or not paid during the period.		
50	Number of benefit payment requests pending as of the end of the period.		
51	Number of benefit payment requests paid within 0-30 days.		
52	Number of benefit payment requests paid within 31-60 days.		
53	Number of benefit payment requests paid within 61-90 days.		
54	Number of benefit payment requests paid beyond 90 days.		
55	Number of benefit payment requests denied or not paid within 0-30 days.		
56	Number of benefit payment requests denied or not paid within 31-60 days.		
57	Number of benefit payment requests denied or not paid within 61-90 days.		
58	Number of benefit payment requests denied or not paid beyond 90 days.		

January 1, 2019 – December 31, 2019

- Benefit payment requests received during the period – those requests that were received at any point during the reporting period.

- Benefit payment requests that were denied or not paid during the reporting period for any reason.


Claims Benefit Payment Requests Activity

Long-Term Care Benefit Payment Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefits payment requests pending as of the beginning of the period.		
48	Number of benefits payment requests received during the period.		
49	Number of benefits payment requests denied or not paid during the period.		
50	Number of benefits payment requests pending as of the end of the period.		
51	Number of benefits payment requests paid within 0-30 days.		
52	Number of benefits payment requests paid within 31-60 days.		
53	Number of benefits payment requests paid within 61-90 days.		
54	Number of benefits payment requests paid beyond 90 days.		
55	Number of benefits payment requests denied or not paid within 0-30 days.		
56	Number of benefits payment requests denied or not paid within 31-60 days.		
57	Number of benefits payment requests denied or not paid within 61-90 days.		
58	Number of benefits payment requests denied or not paid beyond 90 days.		

December 31, 2019

and benefit payment requests that are still pending as of the end of the reporting period – those requests that are still pending on December 31st.



Claims Benefit Payment Requests Activity

Long-Term Care Benefit Payment Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefit payment requests pending as of the beginning of the period.		
48	Number of benefit payment requests received during the period.		
49	Number of benefit payment requests denied or not paid during the period.		
50	Number of benefit payment requests pending as of the end of the period.		
51	Number of benefit payment requests paid within 0-30 days.		
52	Number of benefit payment requests paid within 31-60 days.		
53	Number of benefit payment requests paid within 61-90 days.		
54	Number of benefit payment requests paid beyond 90 days.		
55	Number of benefit payment requests denied or not paid within 0-30 days.		
56	Number of benefit payment requests denied or not paid within 31-60 days.		
57	Number of benefit payment requests denied or not paid within 61-90 days.		
58	Number of benefit payment requests denied or not paid beyond 90 days.		

January 1, 2019 – December 31, 2019

Lastly, this section asks for the time frames during which benefit payment requests were paid or denied (or not paid.)

- Benefit payment requests that were **paid** during the period are broken out into time frames from 0-30 days, from 31-60 days, from 61-90 days and those beyond 90 days.

Claims Benefit Payment Requests Activity

Long-Term Care Benefit Payment Requests Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefit payment requests pending as of the beginning of the period.		
48	Number of benefit payment requests received during the period.		
49	Number of benefit payment requests denied or not paid during the period.		
50	Number of benefit payment requests pending as of the end of the period.		
51	Number of benefit payment requests paid within 0-30 days.		
52	Number of benefit payment requests paid within 31-60 days.		
53	Number of benefit payment requests paid within 61-90 days.		
54	Number of benefit payment requests paid beyond 90 days.		
55	Number of benefit payment requests denied or not paid within 0-30 days.		
56	Number of benefit payment requests denied or not paid within 31-60 days.		
57	Number of benefit payment requests denied or not paid within 61-90 days.		
58	Number of benefit payment requests denied or not paid beyond 90 days.		

January 1, 2019 – December 31, 2019

Those benefit payment requests that were denied or not paid are also broken out into time frames from 0-30 days, from 31-60 days, from 61-90 days and those beyond 90 days.

Lawsuit Activity

LAWSUIT ACTIVITY Previous Summary

	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59 Number of lawsuits open as of the beginning of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
60 Number of lawsuits opened during the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
61 Number of lawsuits closed during the period -- Total.	<input type="text"/>	<input type="text"/>	<input type="text"/>
62 Number of lawsuits closed during the period with consideration for the consumer.	<input type="text"/>	<input type="text"/>	<input type="text"/>
63 Number of lawsuits open as of the end of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>

January 1, 2019 – December 31, 2019

The final section of the LTC MCAS relates to Lawsuit Activity. There are some specifics you will need to know regarding the way lawsuits are defined.



Long-Term Care Data Call & Definitions

A **lawsuit** is an action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

A **lawsuit** is an action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

Long-Term Care Data Call & Definitions

For purposes of reporting lawsuits for LTC products:

- For Life LTC Hybrid and Annuity LTC Hybrid, report experience for those policies or contracts with some form of LTC hybrid benefit. Report lawsuit experience for all lawsuits related to the LTC hybrid product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.
- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;

For purposes of reporting lawsuits for LTC products:

- For Life LTC Hybrid and Annuity LTC Hybrid, you report lawsuit experience for all lawsuits related to the LTC-hybrid product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.
- You would only include lawsuits brought by an applicant for insurance, a policyholder or a beneficiary;
- And you would include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- But you would not include arbitrations;

Long-Term Care Data Call & Definitions

For purposes of reporting lawsuits for LTC products (cont'd):

- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;

- If one lawsuit seeks damages under two or more policies or contracts, you would count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;

- And, if one lawsuit has two or more complainants, you would report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits.



Long-Term Care Data Call & Definitions

For purposes of reporting lawsuits for LTC products (cont'd):

- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;

Finally, you should report a lawsuit in the jurisdiction in which the policy or contract was issued;

Long-Term Care Data Call & Definitions

For purposes of reporting lawsuits for LTC products
(cont'd):

- Treatment of class action lawsuits:
 - Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
 - Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Regarding the treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuit Activity

LAWSUIT ACTIVITY Previous Summary

	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59 Number of lawsuits open as of the beginning of the period.	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
60 Number of lawsuits opened during the period.	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
61 Number of lawsuits closed during the period — Total.	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
62 Number of lawsuits closed during the period with consideration for the consumer.	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
63 Number of lawsuits open as of the end of the period.	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid

January 1, 2019

The information requested regarding lawsuits includes

- The number of lawsuits open at the beginning of the reporting period (January 1st),

Lawsuit Activity

LAWSUIT ACTIVITY Previous Summary

	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59 Number of lawsuits open as of the beginning of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
60 Number of lawsuits opened during the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
61 Number of lawsuits closed during the period — Total.	<input type="text"/>	<input type="text"/>	<input type="text"/>
62 Number of lawsuits closed during the period with consideration for the consumer.	<input type="text"/>	<input type="text"/>	<input type="text"/>
63 Number of lawsuits open as of the end of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>

January 1, 2019 – December 31, 2019

The number of lawsuits opened during the reporting period,

Lawsuit Activity

LAWSUIT ACTIVITY Previous Summary

	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59 Number of lawsuits open as of the beginning of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
60 Number of lawsuits opened during the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
61 Number of lawsuits closed during the period – Total.	<input type="text"/>	<input type="text"/>	<input type="text"/>
62 Number of lawsuits closed during the period with consideration for the consumer.	<input type="text"/>	<input type="text"/>	<input type="text"/>
63 Number of lawsuits open as of the end of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>

January 1, 2019 – December 31, 2019

- The total number of lawsuits closed during the reporting period (That is, all lawsuits), and
- The number of lawsuits closed during the period with consideration for the consumer



Long-Term Care Data Call & Definitions

Lawsuits Closed During the Period with Consideration for the Consumer is defined as a lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

The definition of **Lawsuits Closed During the Period with Consideration for the Consumer** is defined as a lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

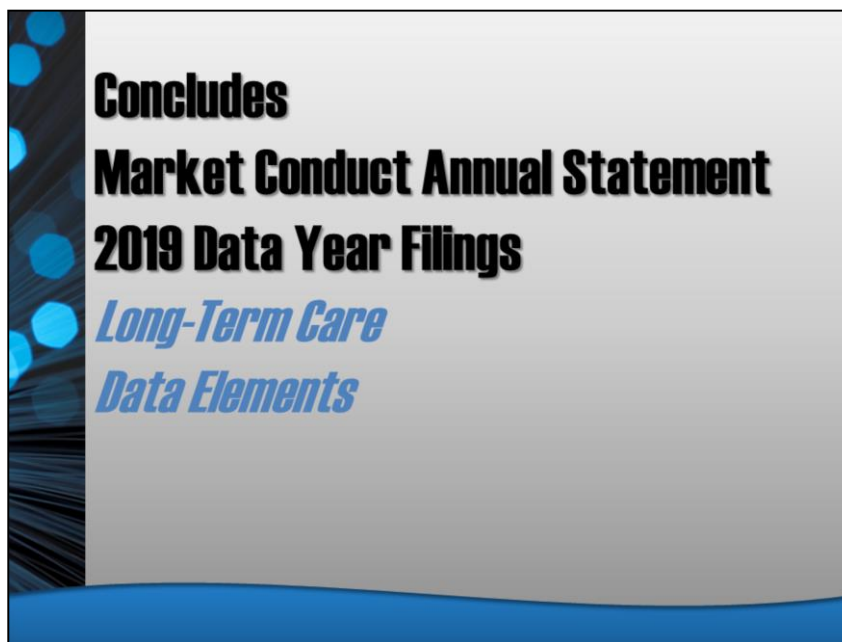
Lawsuit Activity

LAWSUIT ACTIVITY Previous Summary

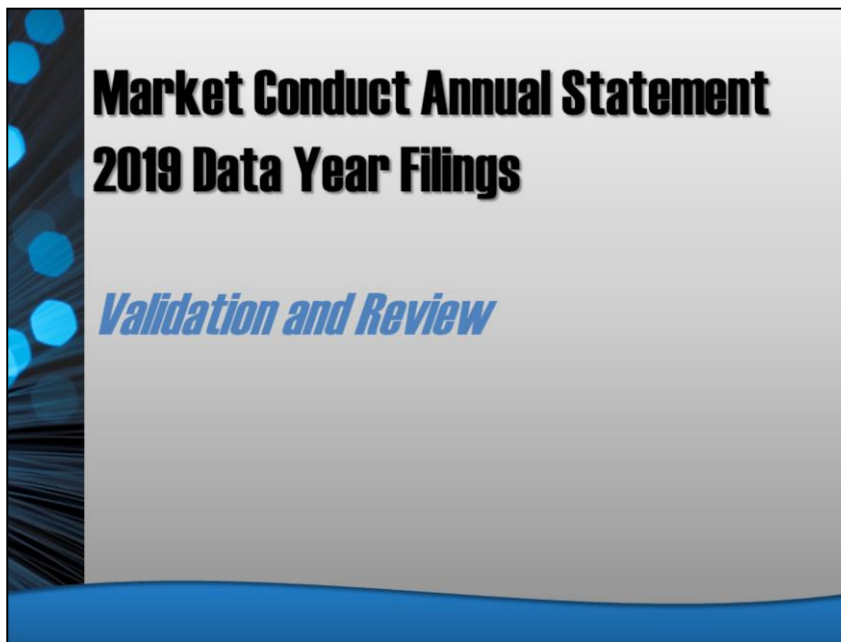
	Stand Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59 Number of lawsuits open as of the beginning of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
60 Number of lawsuits opened during the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>
61 Number of lawsuits closed during the period — Total.	<input type="text"/>	<input type="text"/>	<input type="text"/>
62 Number of lawsuits closed during the period with consideration for the consumer.	<input type="text"/>	<input type="text"/>	<input type="text"/>
63 Number of lawsuits open as of the end of the period.	<input type="text"/>	<input type="text"/>	<input type="text"/>

December 31, 2019

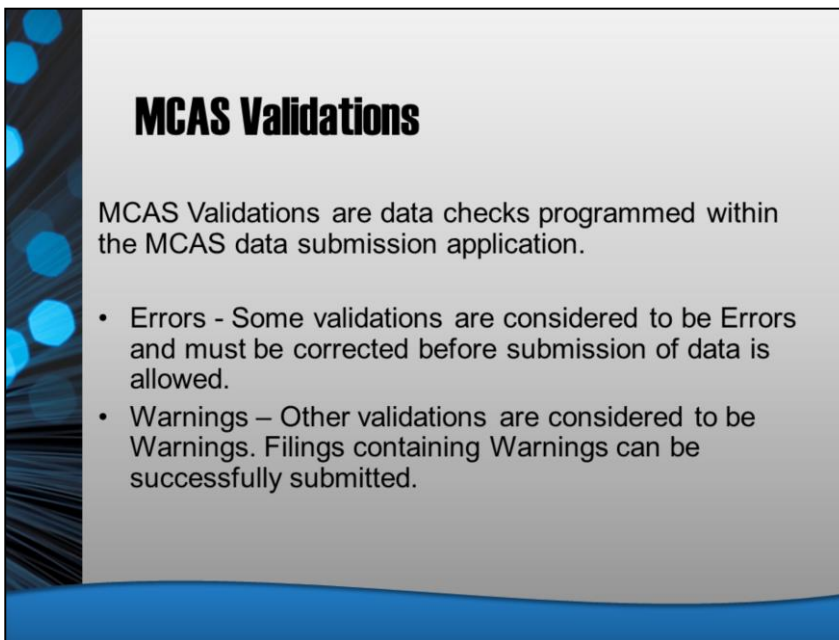
And lastly, the number of lawsuits open at the end of the reporting period (December 31st)



This concludes the data elements review portion of the tutorial. Now we'll discuss the MCAS data validations.



Hi, I'm Leana Massey, Market Regulation Trainer for the NAIC.

A slide graphic with a blue wavy border at the bottom and a vertical bar on the left containing blue circles and light rays. The main content is on a light gray background.

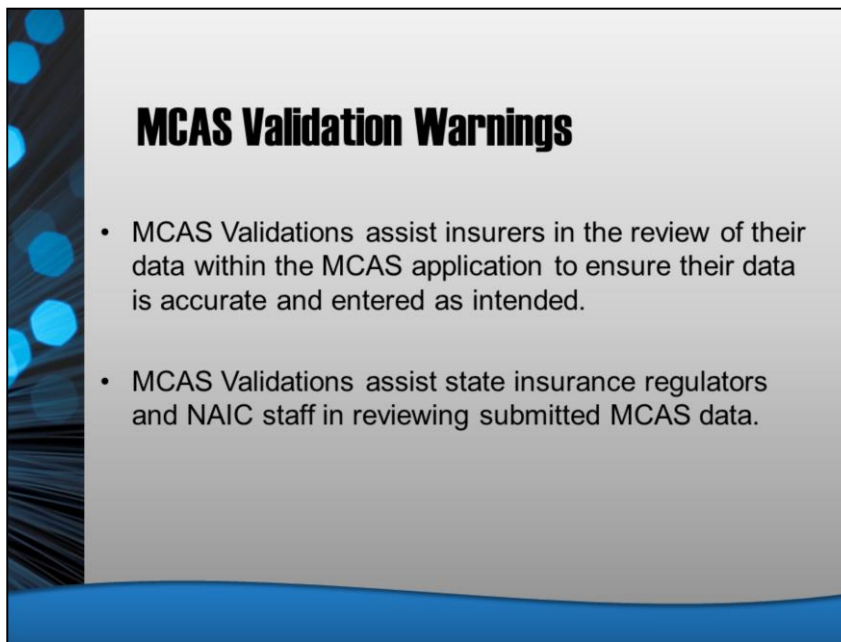
MCAS Validations

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

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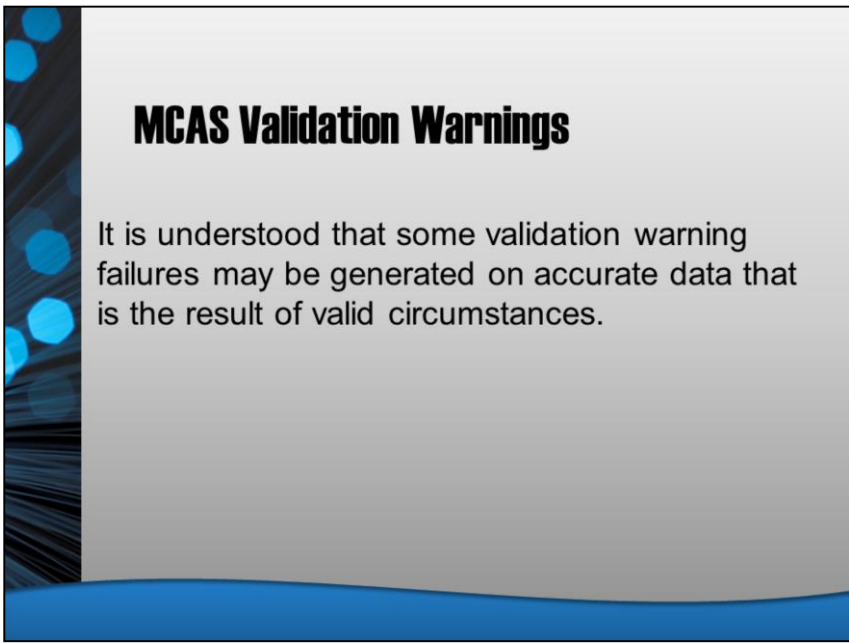
A graphic with a grey background and a blue wavy border at the bottom. On the left side, there is a vertical strip with a dark blue background and several glowing blue circles of varying sizes. The title "MCAS Validation Warnings" is centered at the top in a bold, black font. Below the title, there are two bullet points in a standard black font.

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 Validations have multiple purposes.

- They assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended. For example: The validations can point out data issues that are a result of data entry errors, or coding errors.
- And they assist state insurance regulators and NAIC staff in reviewing submitted MCAS data.

A slide with a grey background and a blue decorative border on the left and bottom. The title "MCAS Validation Warnings" is in bold black text. Below it, a paragraph explains that some validation warning failures may be generated on accurate data due to valid circumstances.

MCAS Validation Warnings

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

It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances; for example, companies with small amounts of business to report, or runoff business to report may trigger validation warning failures that are not concerning.

.

Filing Matrix for [Redacted] Company [Redacted] - 2018 Expand All

Total Warnings: 0					
	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Alaska					
Homeowners	Filed	0	0		
California					
Lender-Placed Insurance	Filed	0	0		
Maryland					
Lender-Placed Insurance	Filed	0	0		

The MCAS system filing matrix provides the MCAS user with information regarding their filings. The filing matrix displays the number of warnings found in submitted or started filings. Before a company submits each filing containing warnings, they are prompted to add comments regarding any outstanding warnings in the submission.

Filing Matrix for [Company] - 2018

Expand All

Alaska	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Homeowners	Filed	0	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		

Once a company has filed the MCAS data, the filing matrix will display a status of “filed” for each state and line of business submitted. At this point in the process, NAIC staff will begin a review of the data checking for data inconsistencies and anomalies.

Private Passenger Auto Interrogatories		Yes	No	Explanation
		Response		
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?		--	Comments
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):		--	

As NAIC analysts review company filings, they view comments found in the interrogatories

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 attestors 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

and in the attestation to determine if the warnings have been sufficiently addressed.

If a filing contains “warning messages,” and there are no comments entered by the company, it is more likely that the company will be contacted for an explanation by NAIC staff.

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

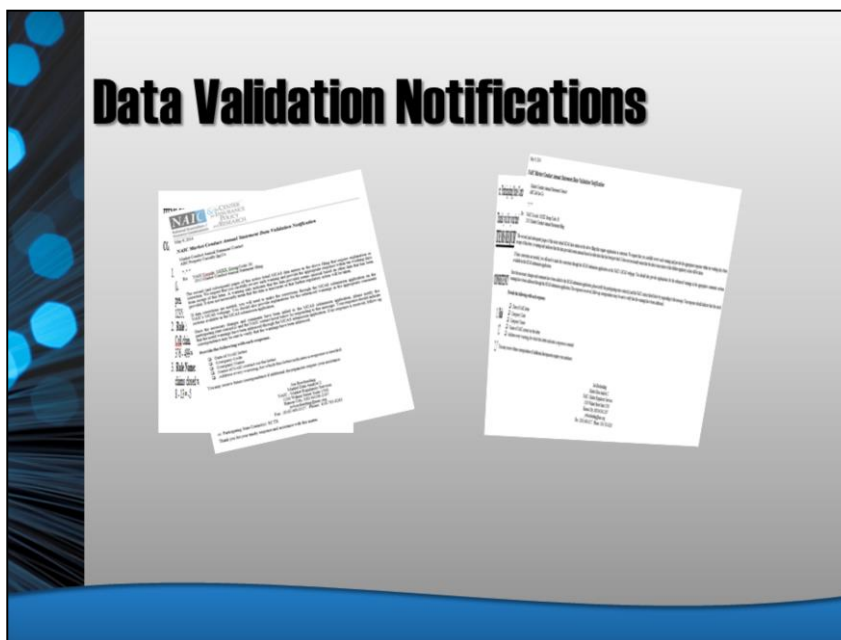
- [FAQ \(Frequently Asked Questions\)](#) - Contains both technical and definitional information not located in the other Help documents (located just under the MCAS "Log In" icon) You will find answers to questions regarding...

The MCAS User Guide, (found on the MCAS webpage) lists the data validation messages that may be encountered while validating data. This includes both “Error” and “Warning” messages. Use the listing to prepare data and to determine comments that will be needed to explain “Warning” messages received during the data validation process.

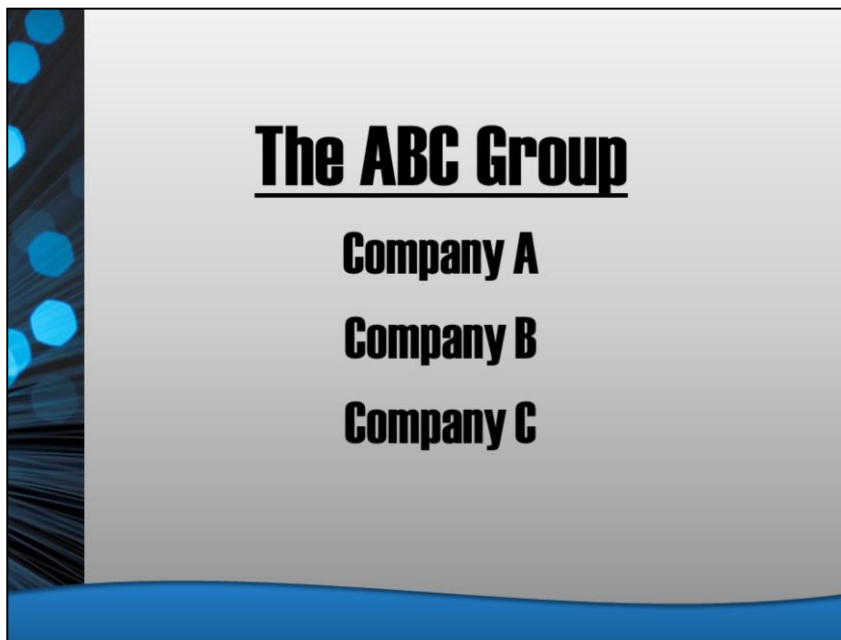
State Regulators have Oversight



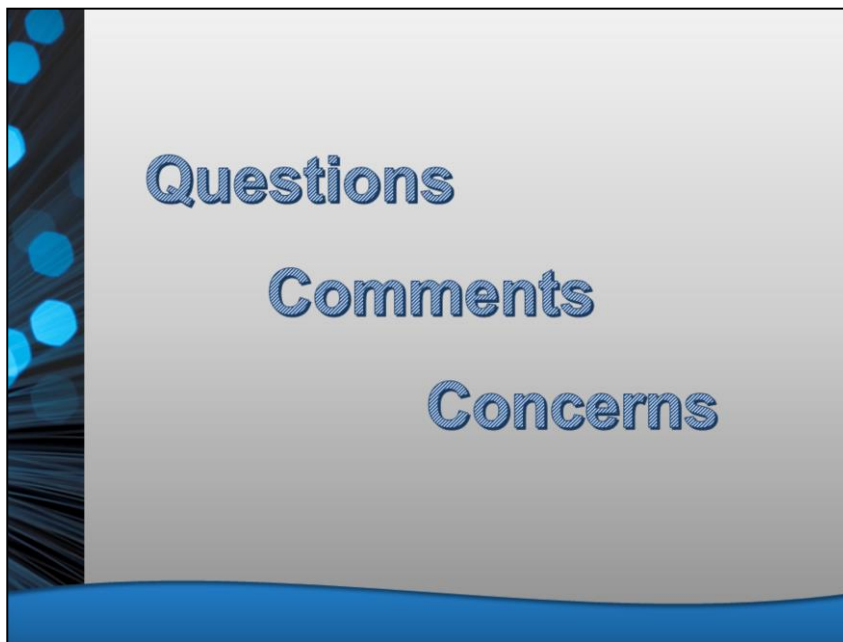
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within **multiple** states.



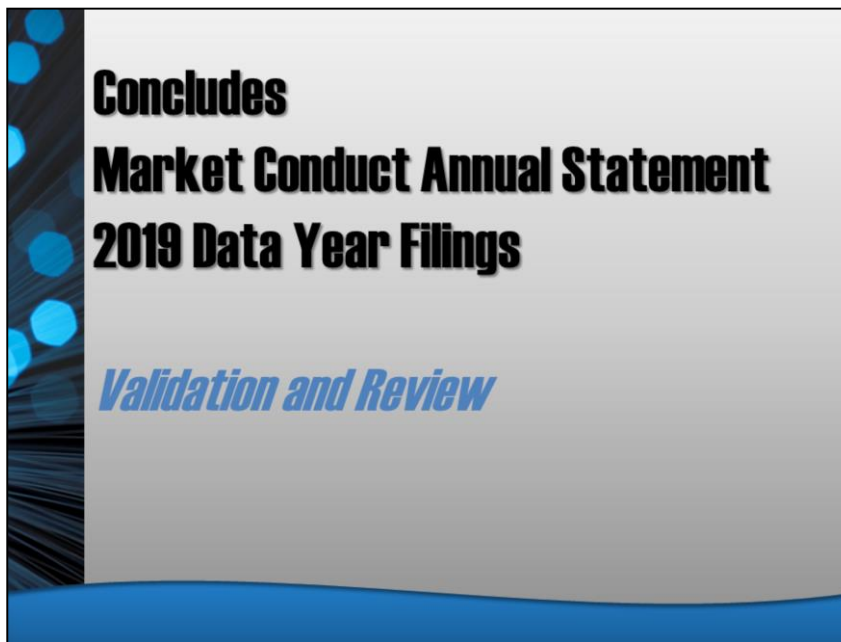
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence. If they have additional questions or concerns, they may also contact the company. However, keeping state regulators in the line of communication, should lessen the number of inquiries received for any particular data concern.



If company A is part of ABC group, and the same observations are made for other companies within the group, then separate correspondence will be sent to each company. It is important to respond to requests in a timely manner to avoid follow up from the NAIC or state regulators. In the company response to the NAIC, please include comments on what action the company will take.



If you receive correspondence from an NAIC analyst, we encourage you to reach out to the analyst with any questions, comments or concerns you may have regarding the correspondence, the validations, or other MCAS filing related issues.



This concludes the filing validation and review discussion.