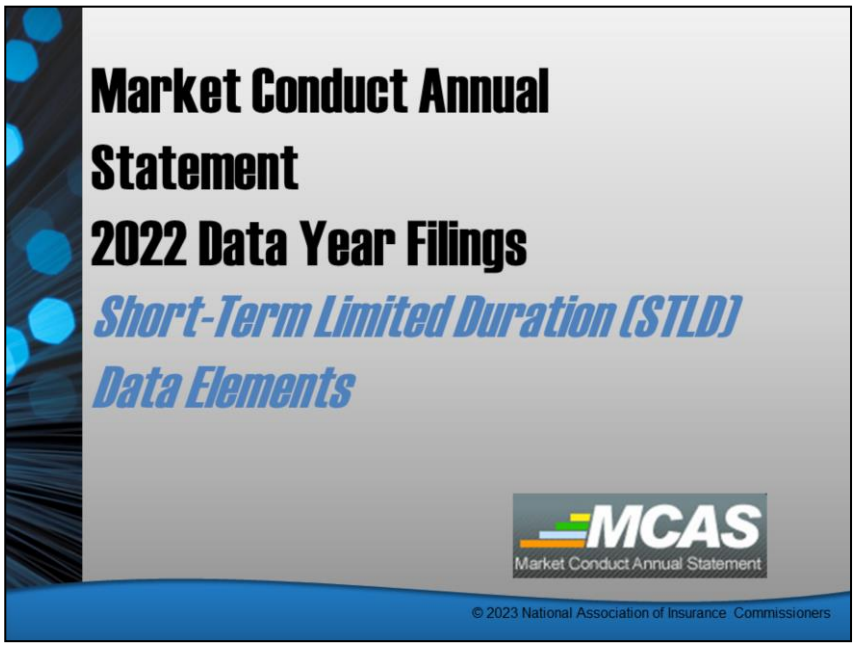

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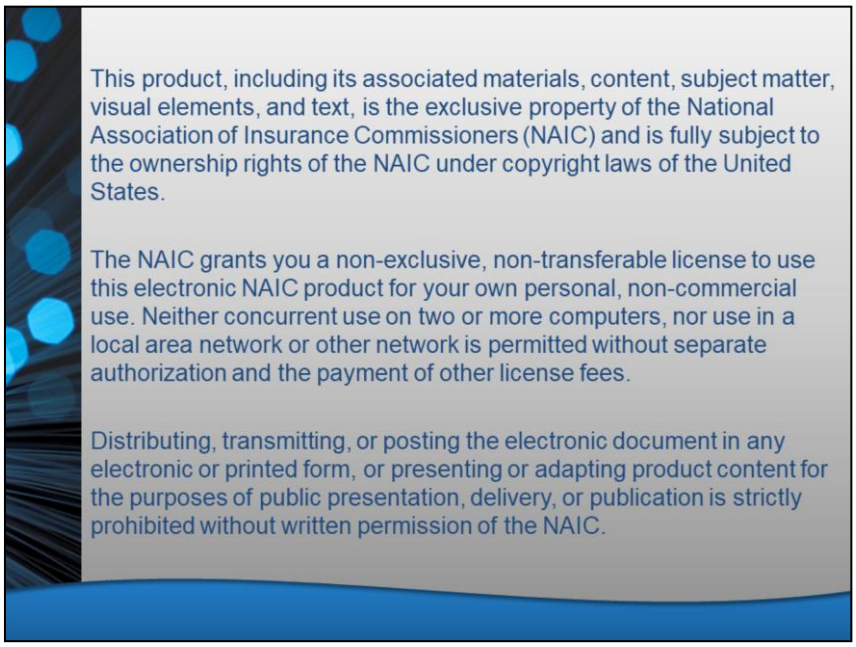

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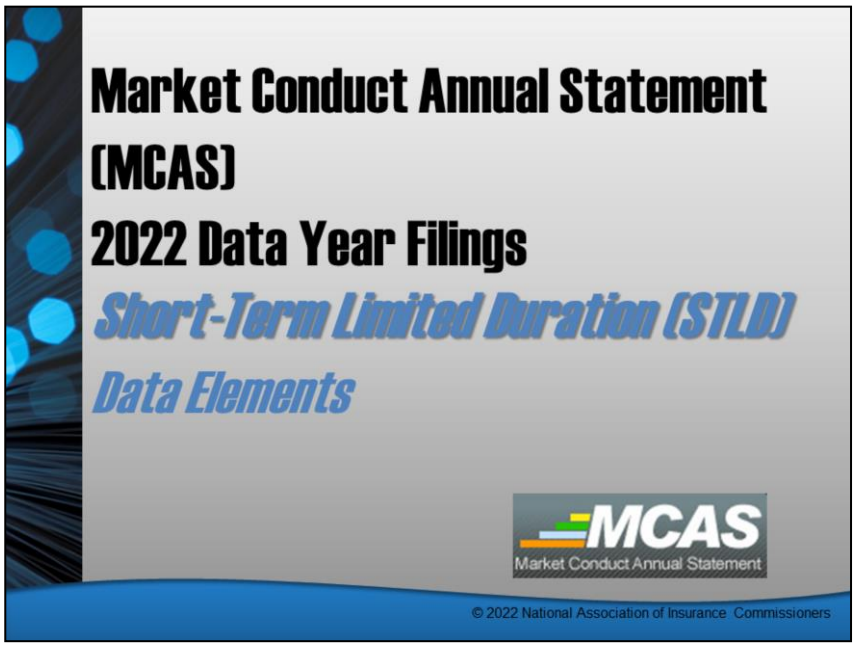

In this handout will be reviewing the data elements that must be provided for the Short-Term Limited Duration MCAS.

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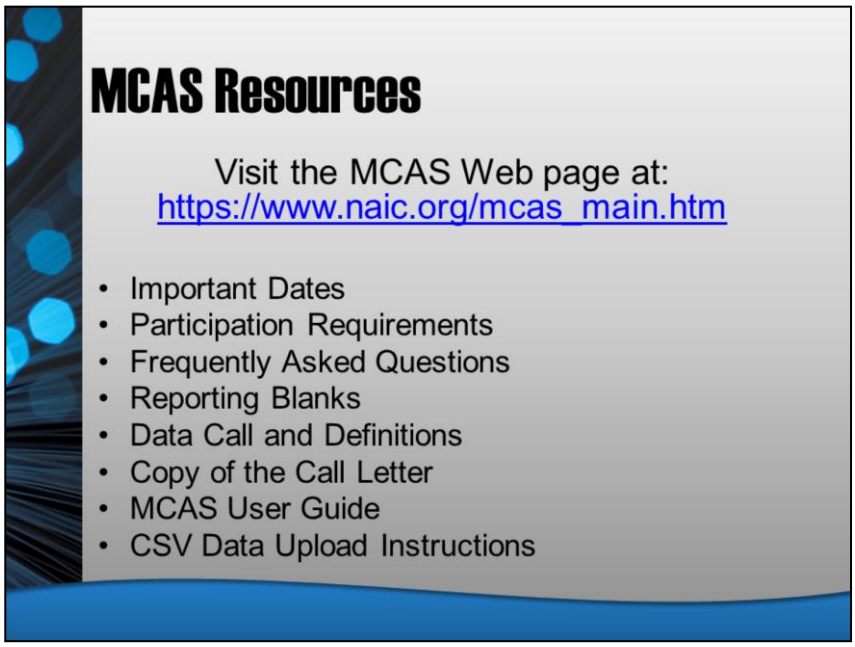

Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

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

You may find it helpful to pull up the STLD Data call and Definitions and Data Collection Worksheets or blanks documents on the MCAS web page to refer to as you go through this information.

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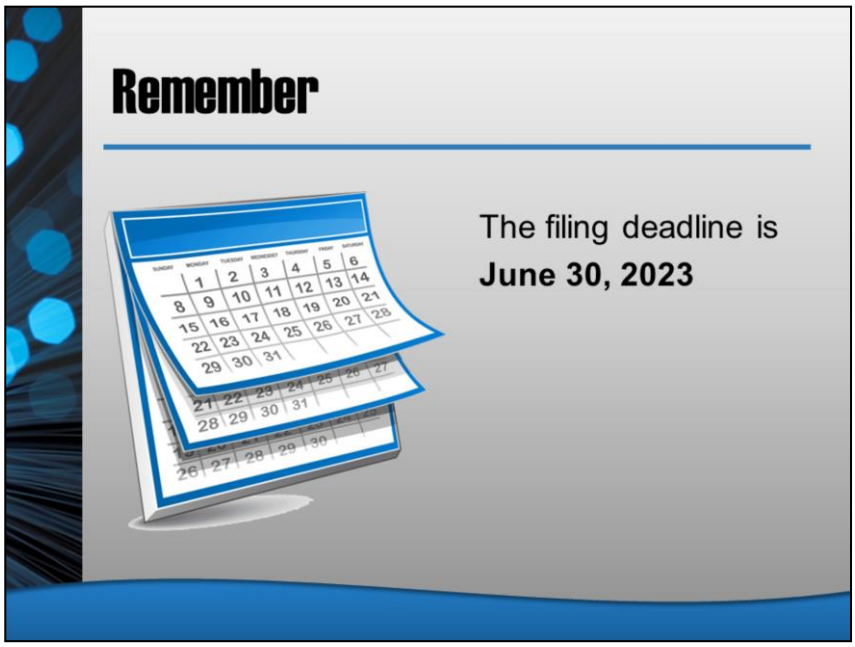

Before we begin, please be sure to remember the current year MCAS filing deadline is April 30th

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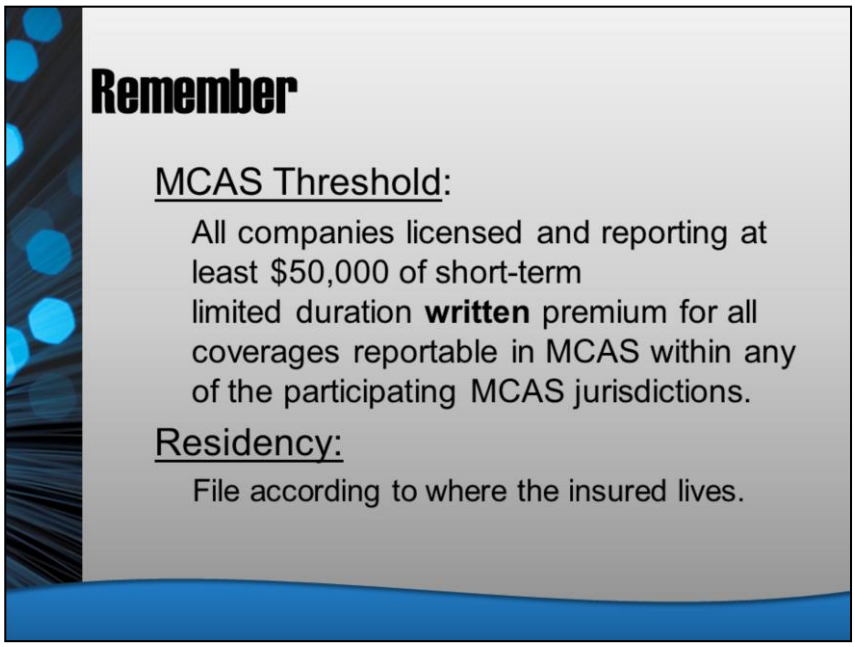

STLD MCAS reporting will begin for the 2022 data year and the first filing will be on June 30, 2023. All companies licensed and reporting at least $50,000 of STLD direct **written** premium, for all coverages reportable in MCAS within any of the participating MCAS jurisdictions, are required to report.

Also, the data must be reported according to the residency of the individual insured. For example, if an Association located in Arizona sells a policy to a resident of California, the MCAS data for the coverage on that insured would be reported to California, not Arizona.

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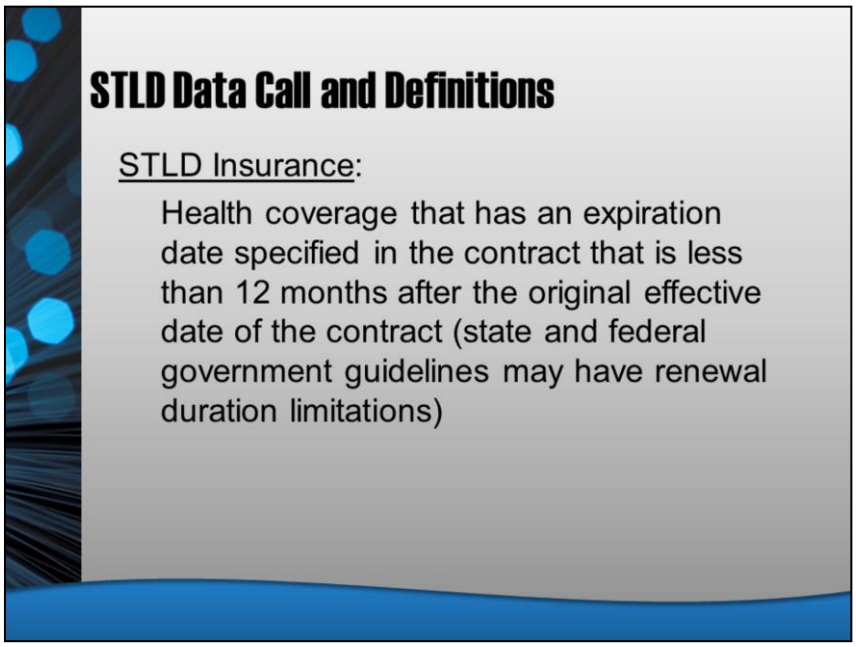

The definition of Short-Term Limited Duration Insurance can be found in the MCAS Data Call and Definitions. Per the Data Call and Definitions, Short-Term Limited Duration (or STLD) insurance is health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract.

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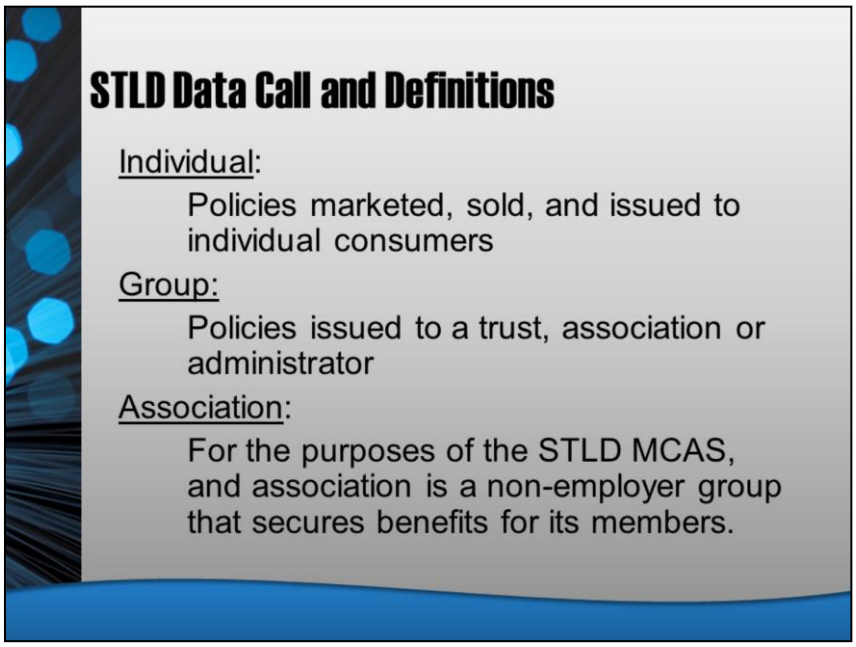

STLD policies can be sold directly to individuals, or they can be sold to groups, associations, or administrators who will then market the STLD product to individuals who are then issued a certificate of coverage. This MCAS asks for data on both policies sold to individuals and certificates issued by groups to individuals.

An Association is defined as a non-employer group that secures benefits for its members. An association may be located in the jurisdiction to which the MCAS is being filed (that is, situsedin the jurisdiction) or it may be located outside the jurisdiction (not situsedin).

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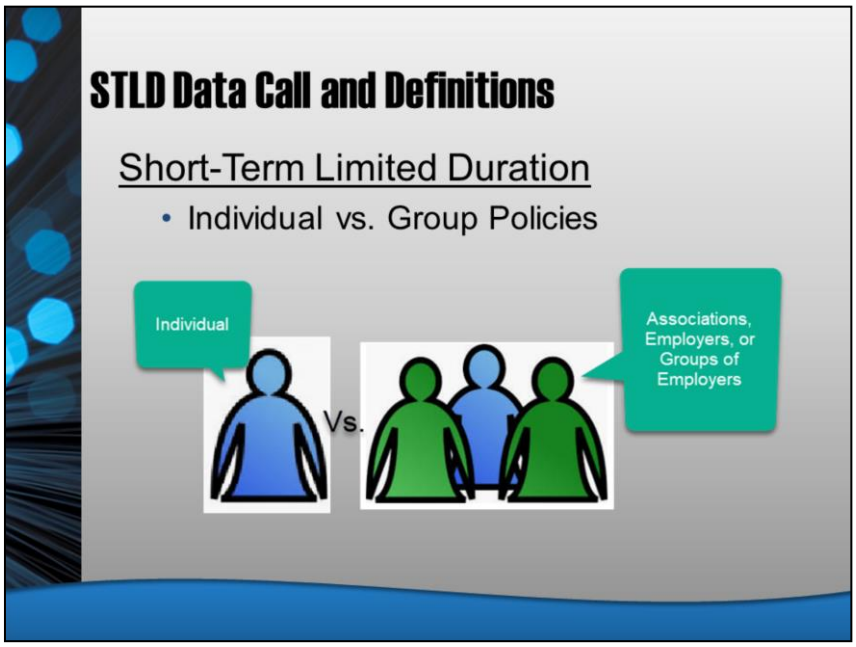

The difference between Individual and Group Policies, is that individual policies are marketed to, or purchased directly by individuals, and Group policies are sold and purchased by or through group sponsors such as associations, employers, or groups of employers. If purchased by or through a group the insured will be issued a certification of coverage by the group, association, trust or administrator.

For the purposes of the STLD MCAS, it does not matter if the policy form has been filed in with any Department of Insurance. If the policy provides STLD coverage it will be reported in the STLD MCAS.

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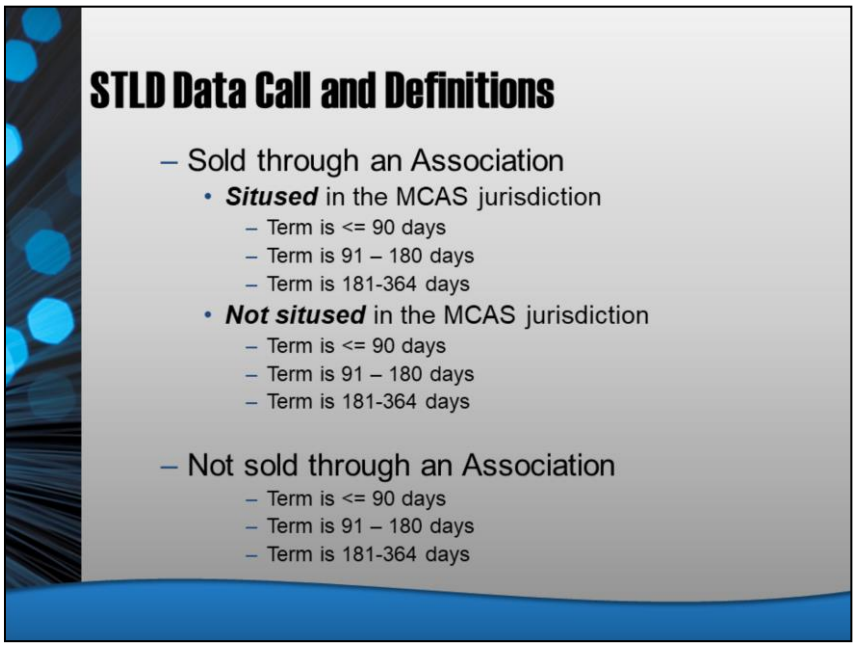

The STLD MCAS collects data based on how the STLD product is marketed (whether the STLD policy is sold through an association) and the length of the policy term of the product.

As noted earlier, an association is a non-employer group and the amount of business sold through associations is of special interest to the state insurance regulators. In addition to asking for the data to be reported based on whether it is through an association or direct to the individual, you will also be asked numerous questions in the interrogatory section of the MCAS blank to identify the associations and provide information on any contractual relationships with associations.

For each policy or certificate, in order to properly report it on the MCAS blank, you will need to know:

- Whether it was, or was not, sold through an Association;
- If through an Association, whether the Association is or is not sitused in the jurisdiction to which you are reporting; and
- The length of the term of the policy

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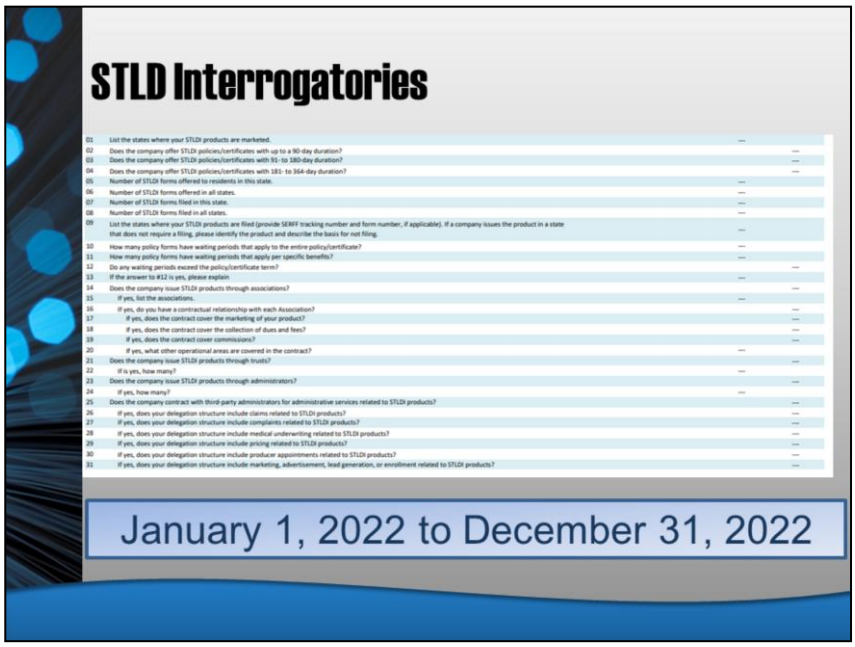

The first section of questions that you will see in the data entry screen is the interrogatories, which is schedule 1 of the STLD MCAS.

The interrogatories provide one location for all comments and questions that require a text response.

This allows reporting entities the opportunity to provide regulators with relevant information that helps them interpret the data and gives a general overview of the nature of a company's book of business.

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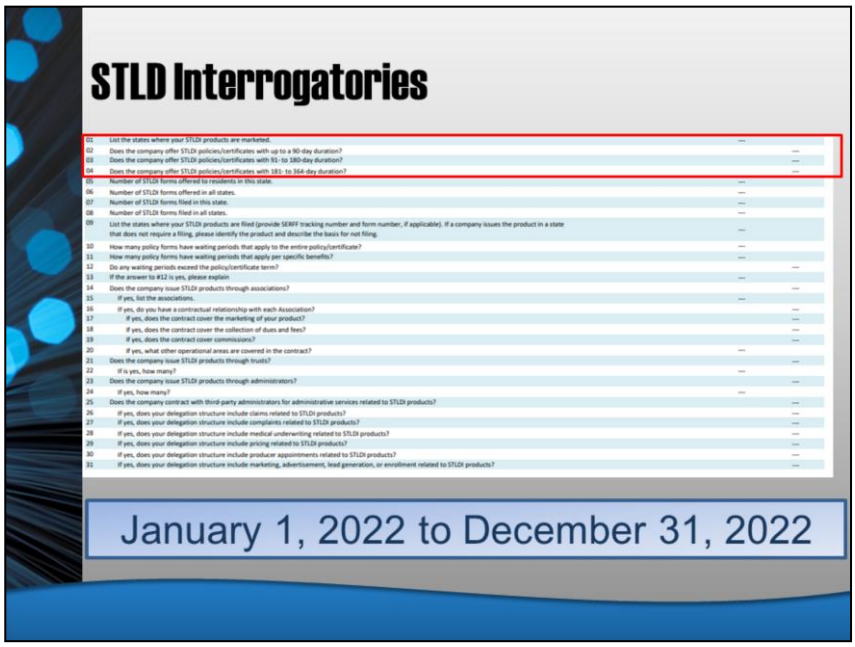

The first five interrogatories ask you to identify the states in which your products are marketed; and whether you offer policies for the any of the term lengths identified.

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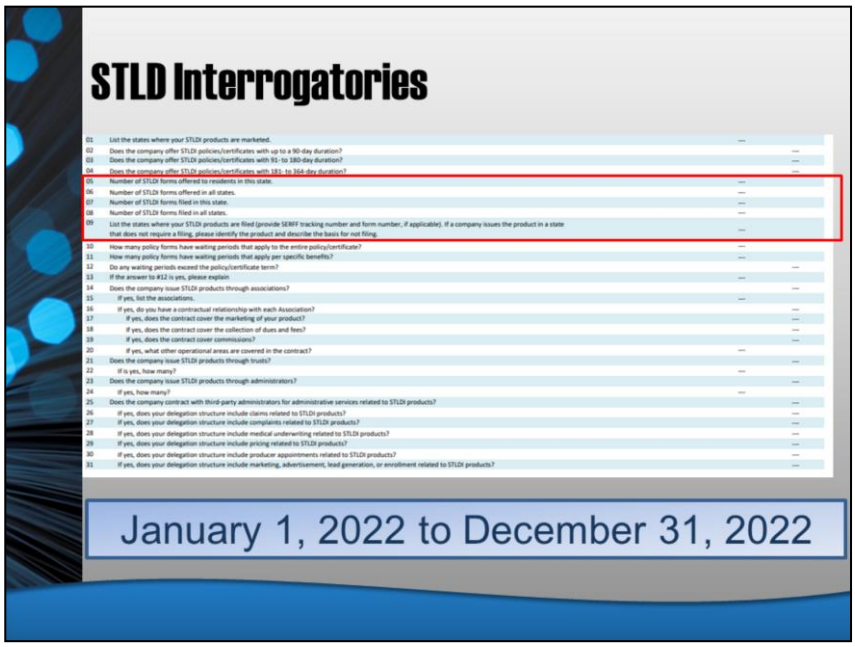

The next five interrogatories ask for information regarding the number of forms offered to residents; and the number forms actually filed.

You will need to provide these numbers for the specific state to which you are filing the MCAS, as well as the total in all states.

For products that are filed, you are asked to identify the states in which they are filed and any applicable SERFF tracking number.

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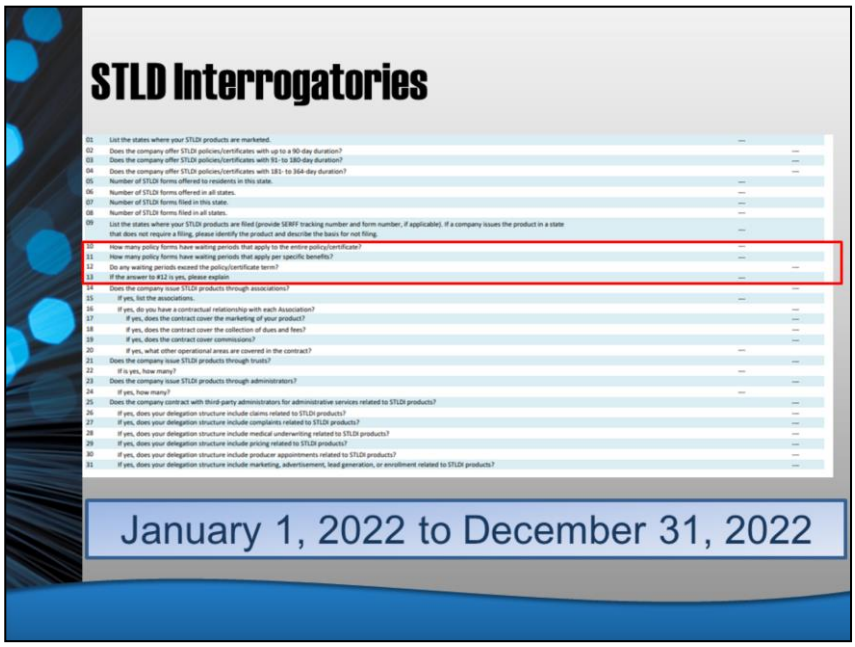

The next four interrogatories ask for information on waiting periods.

The waiting period is the time a covered person who is entitled to receive benefits for sicknesses must wait before coverage is provided.

This applies to waiting periods that are per policy or per condition. Also, in the interrogatories you are asked if any waiting periods are longer than the term length of the policy.

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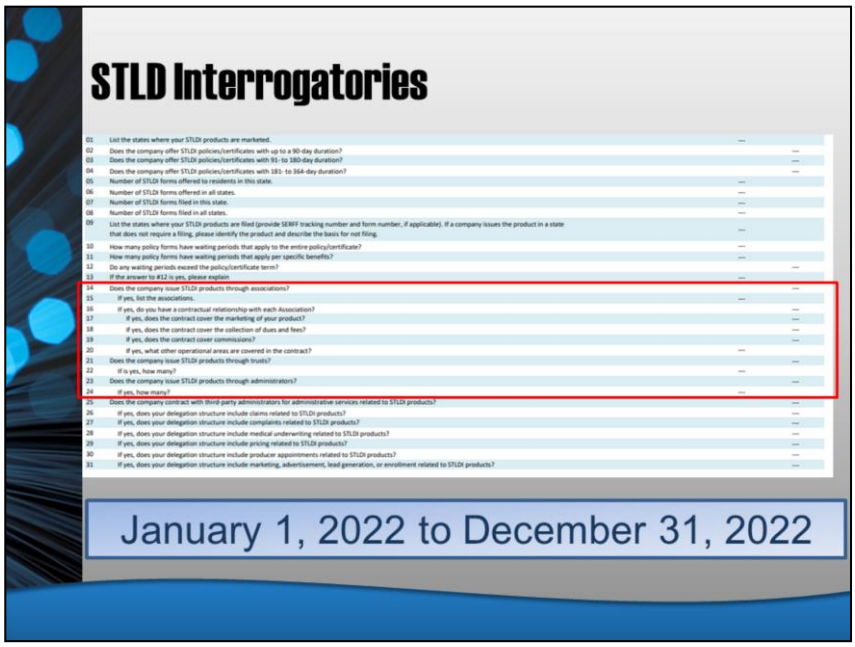

The next section of the interrogatories asks whether the company markets STLD products through associations, trusts, and administrators.

If the company does market through associations, they need to be identified and a series of questions need to be answered concerning what is included in the company's contracts with associations.

If the company markets through trusts or administrators, the interrogatories asks how many trusts or administrators.

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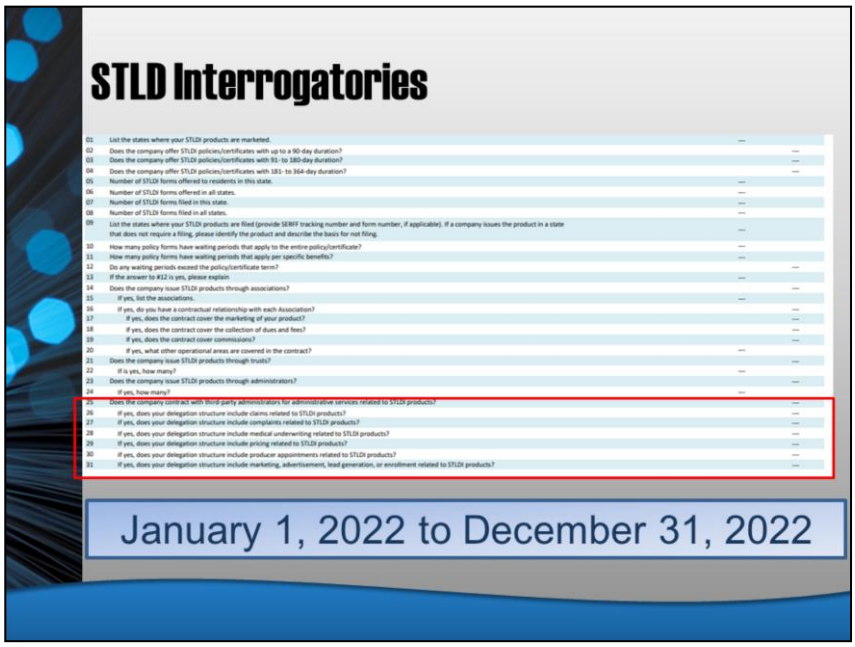

Next, there are a series of questions regarding whether the company uses third-party administrators and for which activities.

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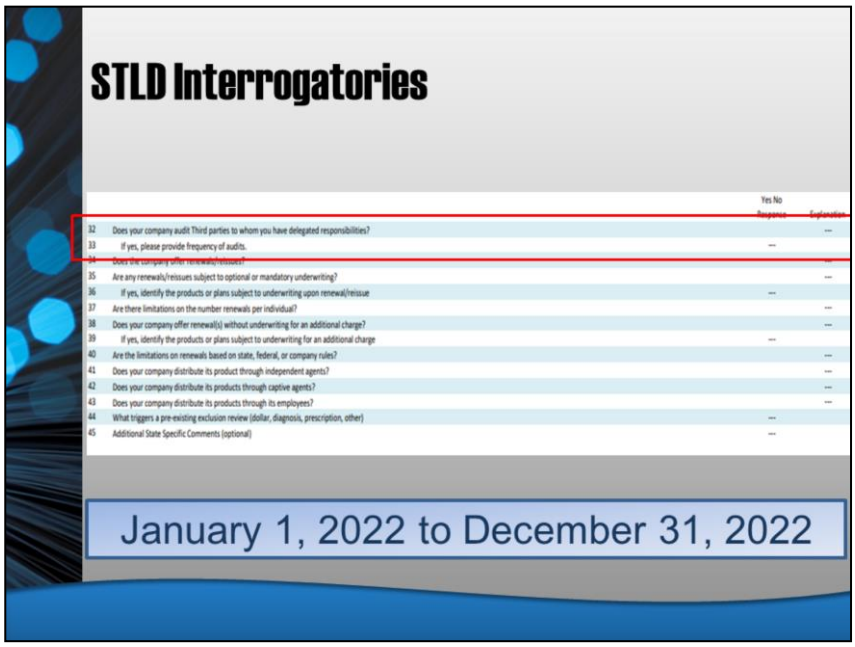

In addition to whether the company uses third-party administrator, MCAS also asks how frequently TPA's are audited.

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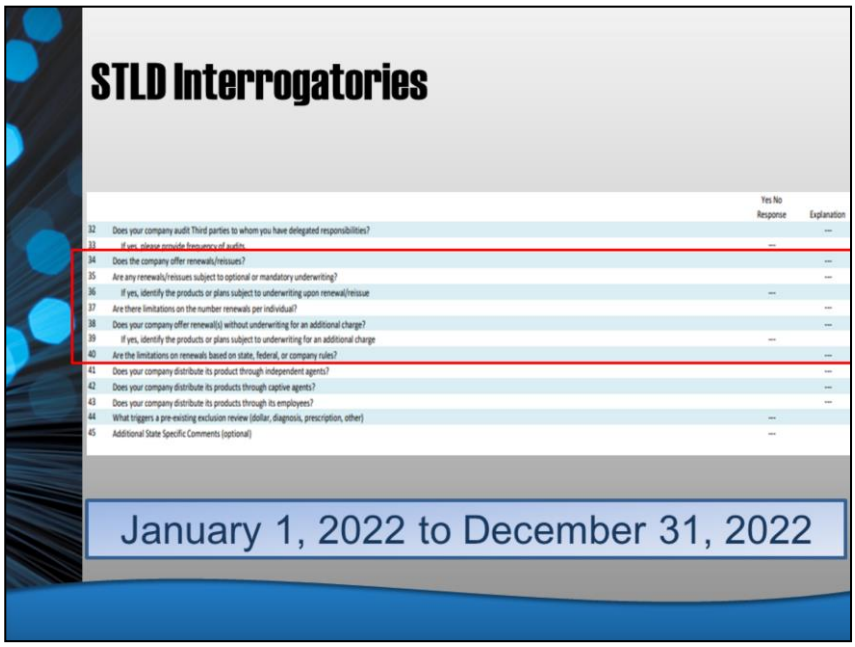

Next is a series of interrogatory questions about the company's rules surrounding the renewal (or re-issuance) of STLD products.

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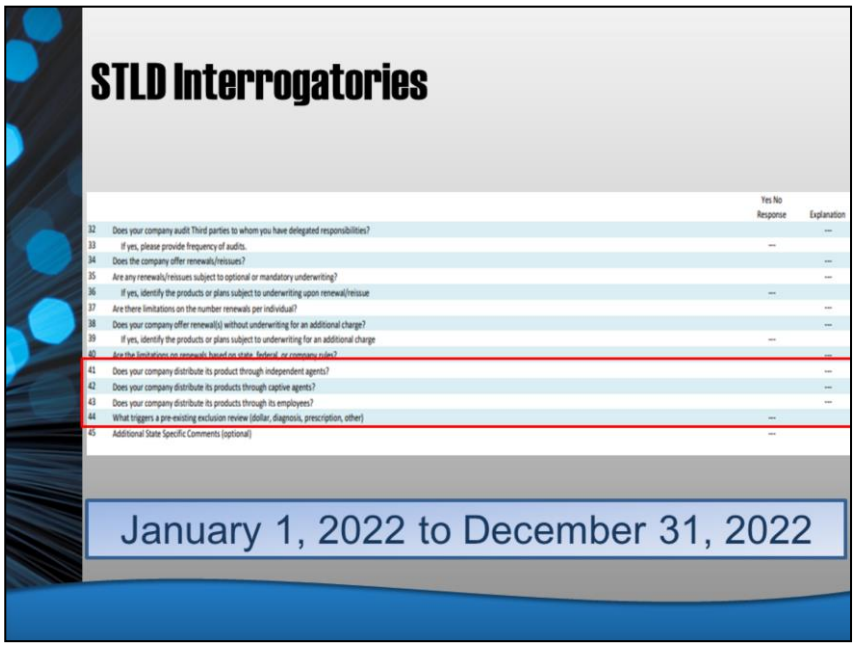

There are four interrogatory questions about who company uses to distribute it products – you only need to indicate whether or not you use independent agents, captive agents, or directly through employees.

There is also one question about what triggers a pre-existing exclusion review.

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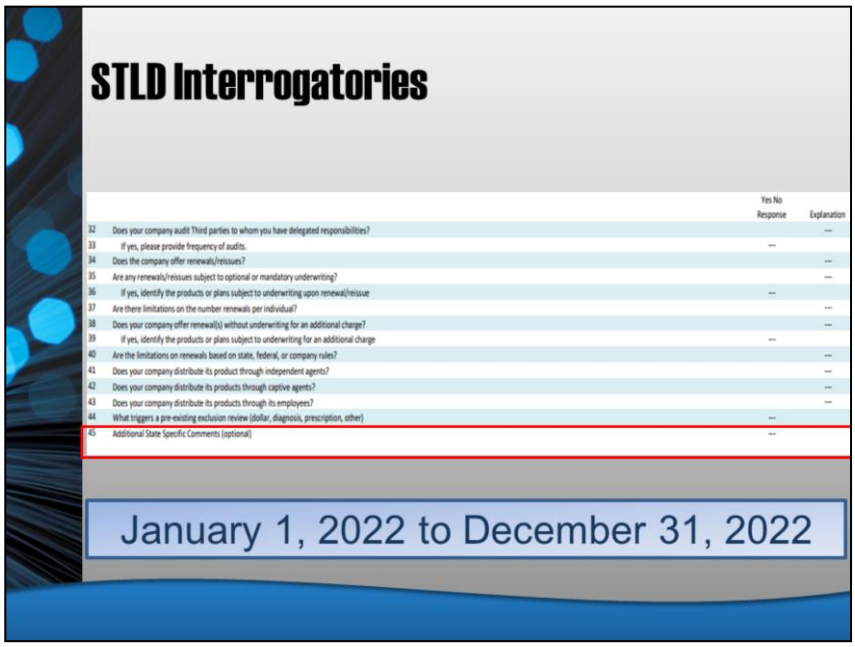

Finally, the interrogatories also provide space where you may enter any state specific comments.

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. Please review the MCAS validations in more detail along with the importance of using the comments sections.

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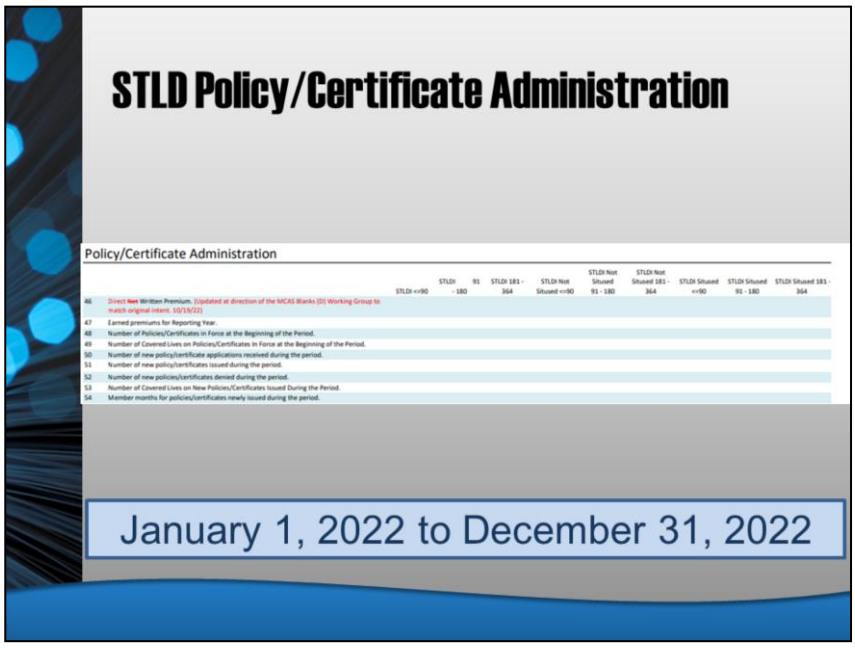

Schedule 2 of the STLD Blank concerns Policy and Certificate Administration.

On this slide you see the first 9 questions asked in this schedule.

You will also notice the columns along the top for the 9 types of products you are asked to report on.

The first three columns are for STLD products not sold through an association with term lengths of less than or equal to 90 days; term lengths of 91 to 180 days; and between 181 and 364.

The next three columns are for STLD products sold through associations **not** sitused in the state you are reporting to.

And the final columns for STLD products sold through associations sitused in the state you are reporting to.

The first 9 data elements provide the amount of business the company had on the books at the beginning of the reporting period, and the amount of business written during the reporting period. You will need to provide both the direct **written** premium and the earned premium for the year.

In addition to the number of policies or certificates in force at the beginning of the reporting period, MCAS also asks for the number of covered lives on those

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policies.

When providing information on the policies/certificates issued during the year, you will first be asked for the number of applications for STLD coverage you received, then how many were issued and how many were denied. Additionally on the new business issued during the year, you will be asked to provide both the covered lives and member months applicable to the newly issued policies/certificates.

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The next 8 questions are regarding renewals or reissues. For this MCAS a renewal and a reissue refer the to same event.

As with new business, we ask for the number of applications for renewal received; how many were approved, and how many denied. Of those approved, MCAS requires you also report the number of covered lives and member months on the renewals.

Question 59 asks for the number of renewals allowed. This is asking for the number of times your company will allow an STLD policy to be renewed. It can be zero if you do not renew STLD policies. Of course, if your answer is zero, you should also be reporting zero for the number of renewal applications that are approved.

The MCAS also asks about renewals that had an option to be renewed without underwriting. This needs to be reported in member months. This is a subset of the next question, which, though poorly worded, is simply asking you to report the member months on all renewed policies for the period.

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The next series of questions concern cancellations. As with the new and renewal questions, these questions ask for the number of cancelled policies and the number of covered lives impacted by the cancellations.

First, you are asked to provide the total number of cancellations, and covered lives impacted, for cancellations that were **initiated by the policyholder.** You will report these in total and then report the number that occurred during the free look period.

Then, you will need to report **insurer-initiated** cancellations and covered lives by the reason for the cancellation – non-payment of premium, any reason “other than non-payment of premium”, and finally the number of cancellations after a claim is filed or a prior authorization is requested.

You are then asked to report the number of rescissions and covered lives on the policies rescinded. A rescission, of course, is the termination of coverage by the reporting entity, retroactive to the beginning of the policy contract period. This would not include cancellations for non-payment of premium.

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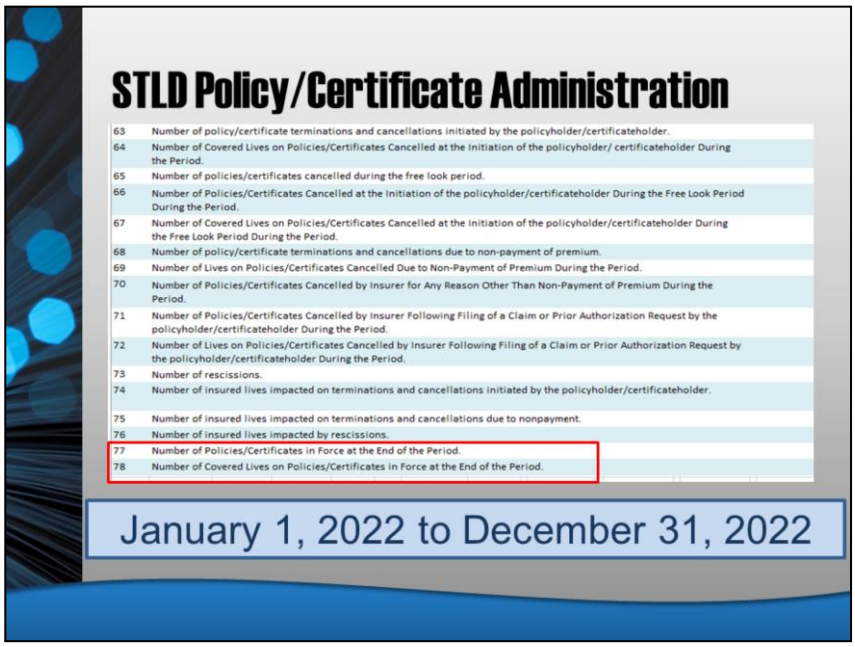

This schedule wraps up by asking for the number of policies/certificates, and covered lives, in force at the end of the period.

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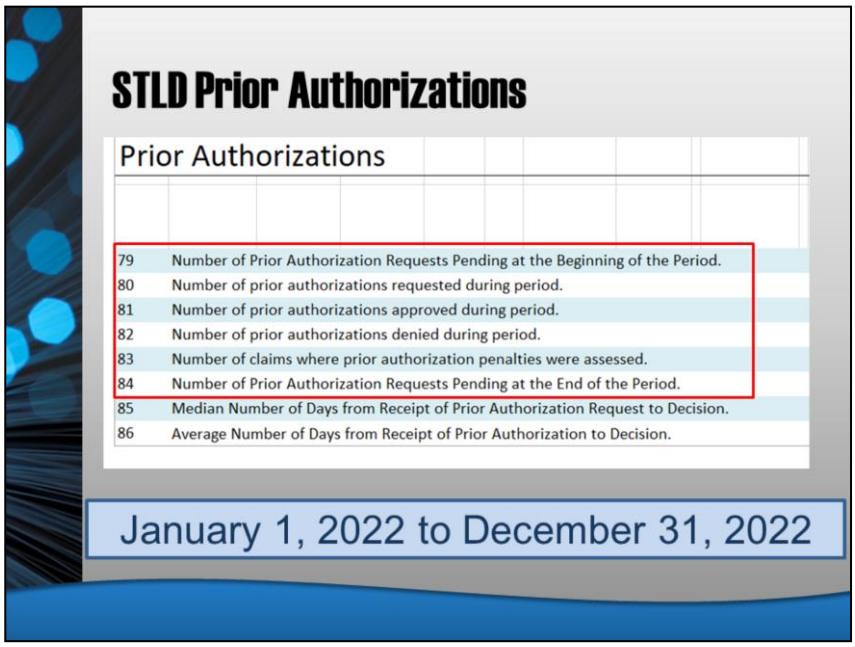

The STLD MCAS Blank also asks a series of questions regarding prior authorizations. Prior authorizations include notifications prior to treatment if notifications are required in the policy.

The first six questions in this schedule ask for the number of pending requests at the beginning and the end of the reporting period. Additionally, you are asked for the total number of prior authorizations received, the number approved, the number denied and, finally, the number of claims where prior authorization penalties were assessed.

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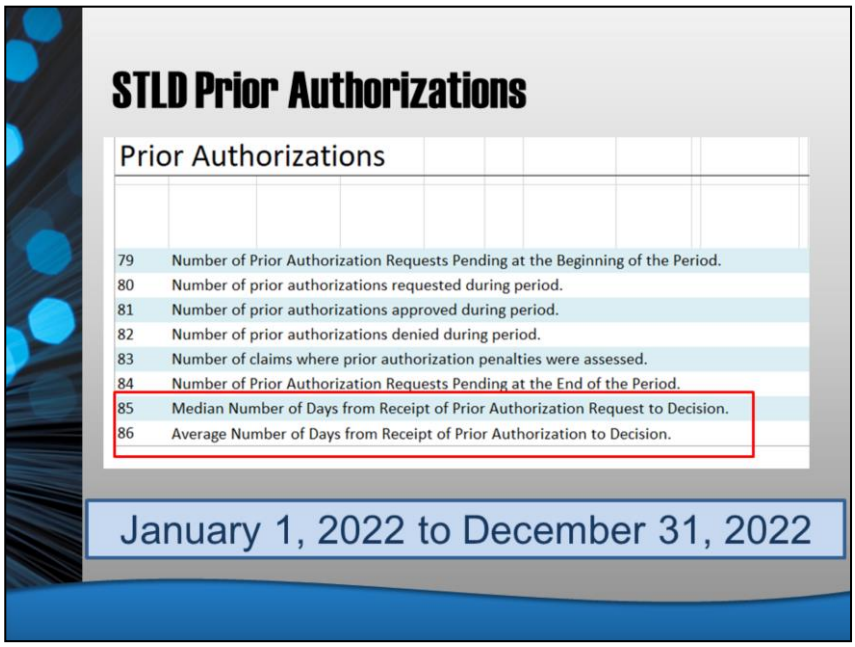

The final two questions in the “Prior Authorization” schedule cover the speed at which decision on prior authorizations are made. The MCAS ask for this in the form of the average number of days and the median number of days.

In the “Claims” section of this handout, we will cover the definition of median days and how it is derived.

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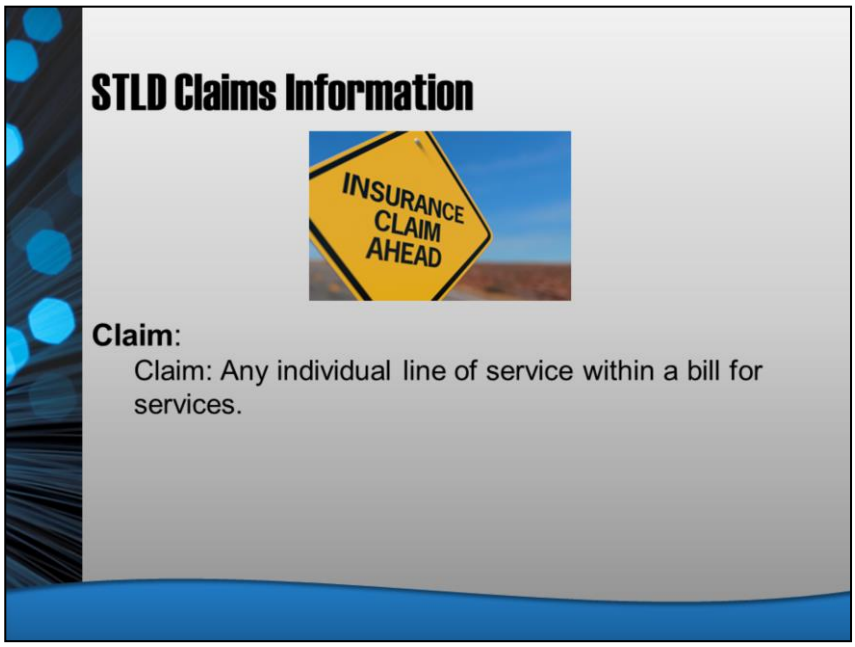

Next, we move on to the claims schedule of the STLD MCAS.

For purposes of this MCAS blank, a claim is any individual line of service within a bill of service. If a billing has multiple lines of service, and your company pays some lines, but deny the remainder, you will report each paid line and each denied line.

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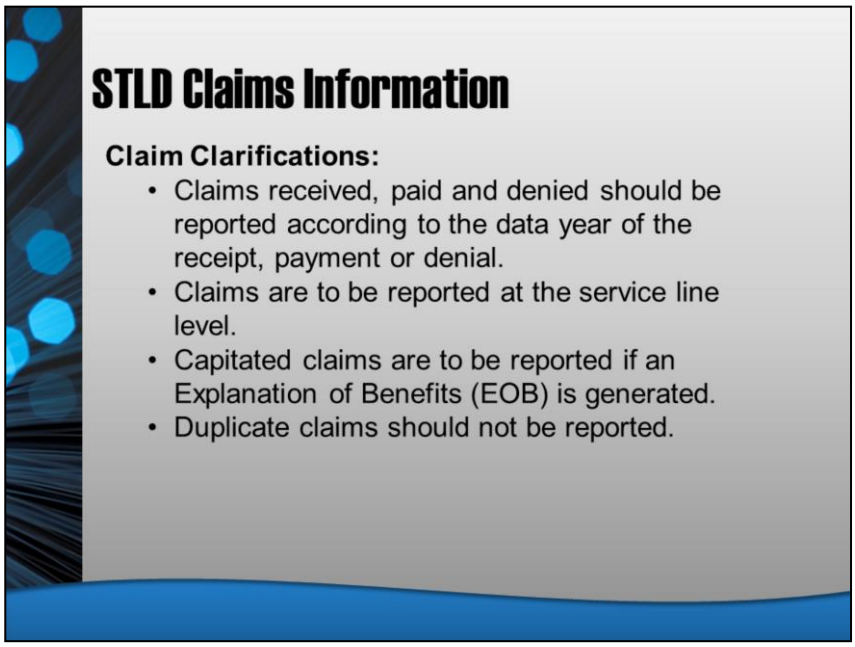

The definition of claim found in the “STLD Data Call and Definitions” provides guidance on how to report claims.

For any one claim, you will report the data on the MCAS covering the data year for the date of receipt, payment or denial. For example, if a claim is received on 12/30 of the data year being reported, but it was not yet paid in January of the following data year, you would report it as a received claim during that reporting year’s MCAS.

The claim’s payment or denial would be reported on the following data year’s filing. You would only report the payment (or denial) in the following reporting year, and not the receipt since that will have been reported on the prior data year filing.

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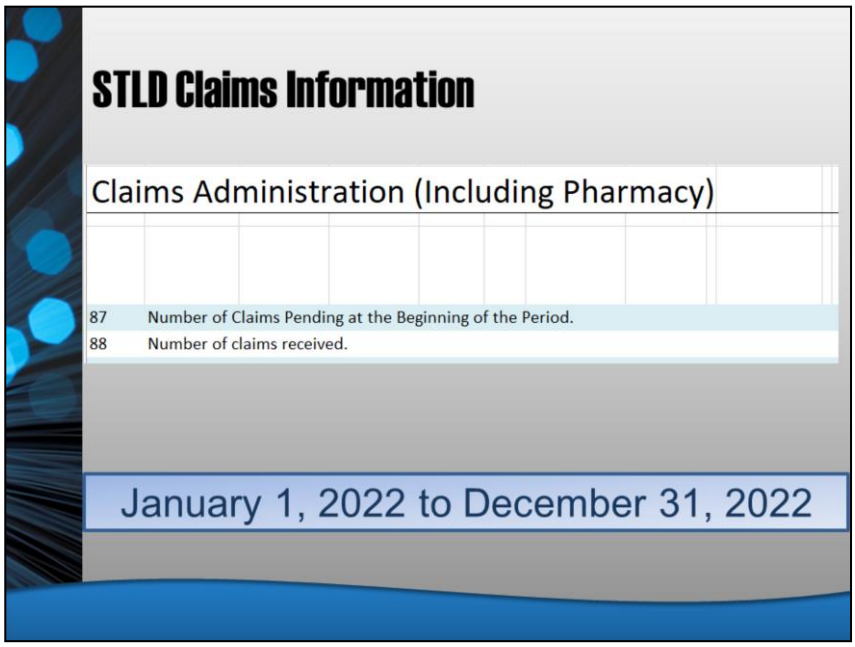

The first two questions regarding the STLD claims simply ask for the number of claims pending at the beginning of the year and how many were received during the year.

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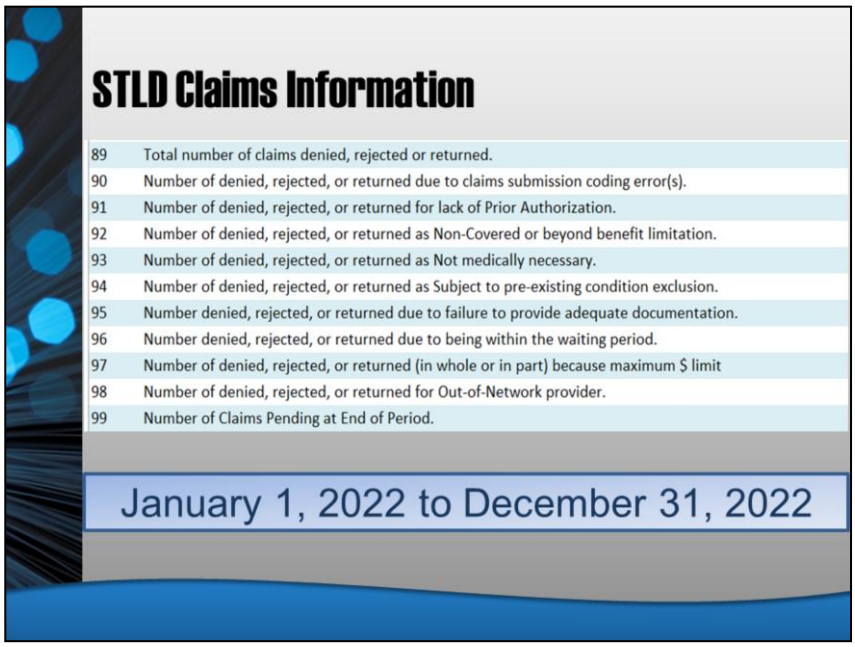

The next series of questions ask you to report on the number of claims denied, rejected, or returned according to the reason why. There are 9 reasons and they are not exhaustive. So, if you total lines 90 to 98, they will be less than or equal to the total entered on line 89.

The 9 reasons are broken out by line as:

- A claims submission coding error
- Lack of a prior authorization
- Not covered or beyond the benefit limitation
- Not medically necessary
- Subject to a pre-existing condition exclusion
- Failure to provide adequate documentation
- Claim is within the waiting period (this is either per policy or per condition)
- The maximum limit has been reached; or
- the use of an out-of-network provider

Finally, at the end of this section, you will provide the number of claims pending at the end of the reporting period.

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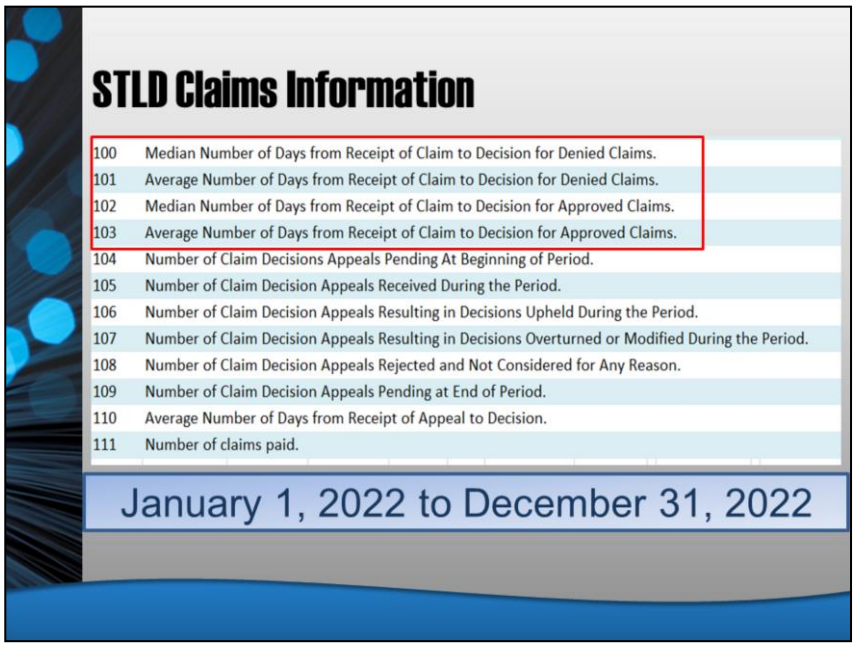

The next four claims questions are regarding how long it takes to approve or deny a claim. The MCAS blank ask for the median number of days and the average number of days. The average number of days is self explanatory, but the next two slides will describe how to calculate the median number of days.

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Briefly, the median is the value above which, and below which there are an equal number of values. For example, if you have “days to decision” of 30, 45 and 60, the median is 45 days.

So, to find your median days to decision, you will need to know the number of days to decision for each claim approved or denied. Organize them from the most days to the fewest days and find the “days to decision” value that falls right in the middle of all those values, then enter that amount.

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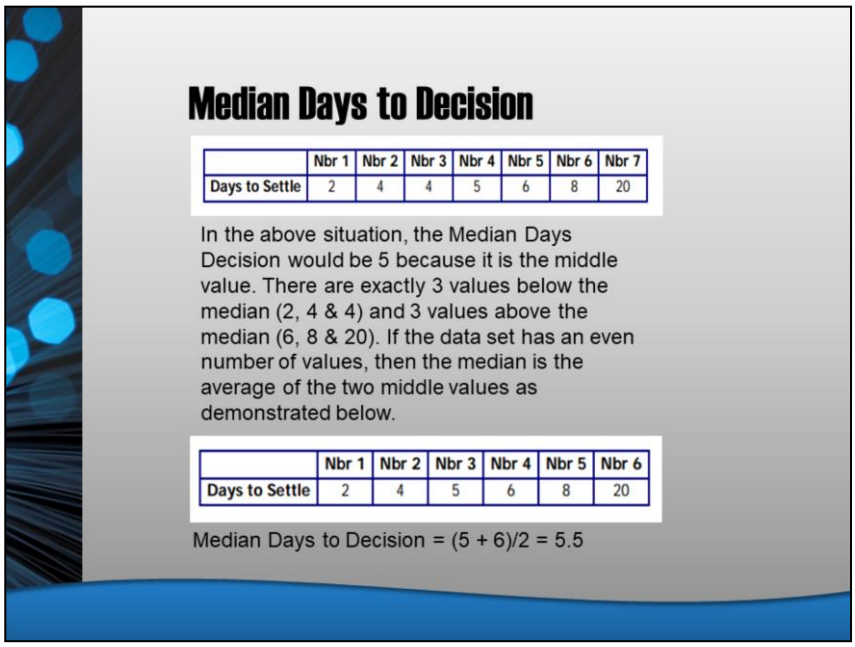

For further illustration, see the 1st data set shown here. In this situation, the Median Days to Decision would be 5 because it is the middle value.

There are exactly 3 values below the median (2, 4 & 4) and 3 values above the median (6, 8 & 20).

If the data set has an even number of values, then the median is the average of the two middle values as demonstrated in the 2nd data set.

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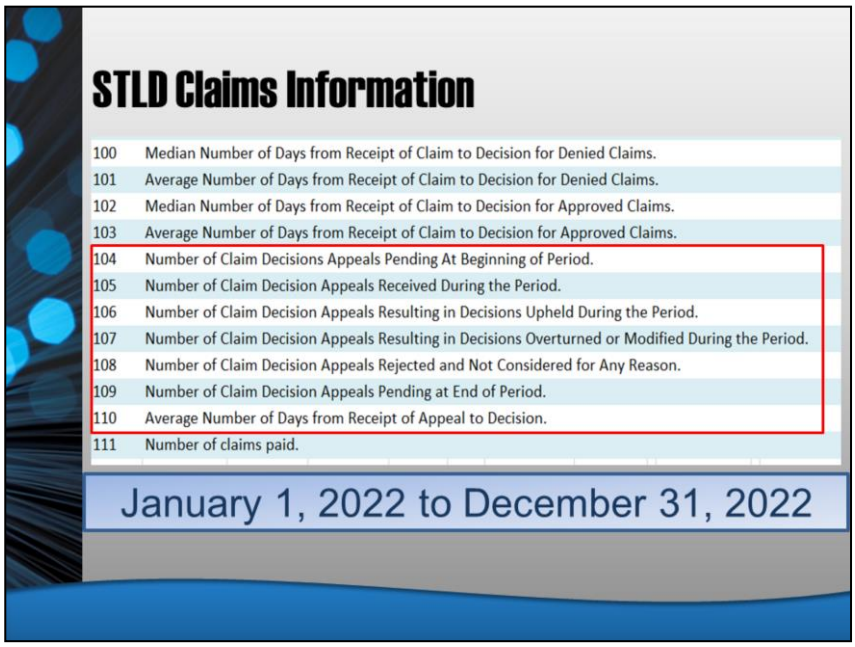

The next six question concern appeals of claim decisions. You will have to report on the number of appeals that were pending both at the beginning of the reporting period and at the end of the reporting period.

Additionally, you will need to provide data on the total number of appeals received during the year, how many decisions were upheld, how many decisions were overturned (or modified) and how many appeals were rejected or not considered.

Finally, you will also need to report on the average number of days from appeal to a decision on the appeal.

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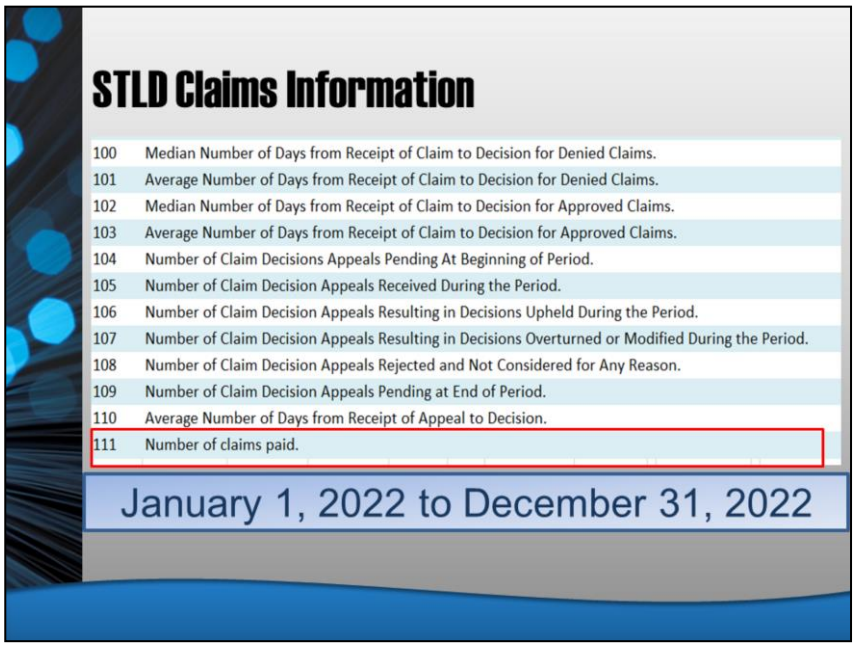

The last question in the claims schedule is for the total number of claims paid during the reporting period for individual policyholders and/or group certificateholders residing in the state for which reporting is being completed.

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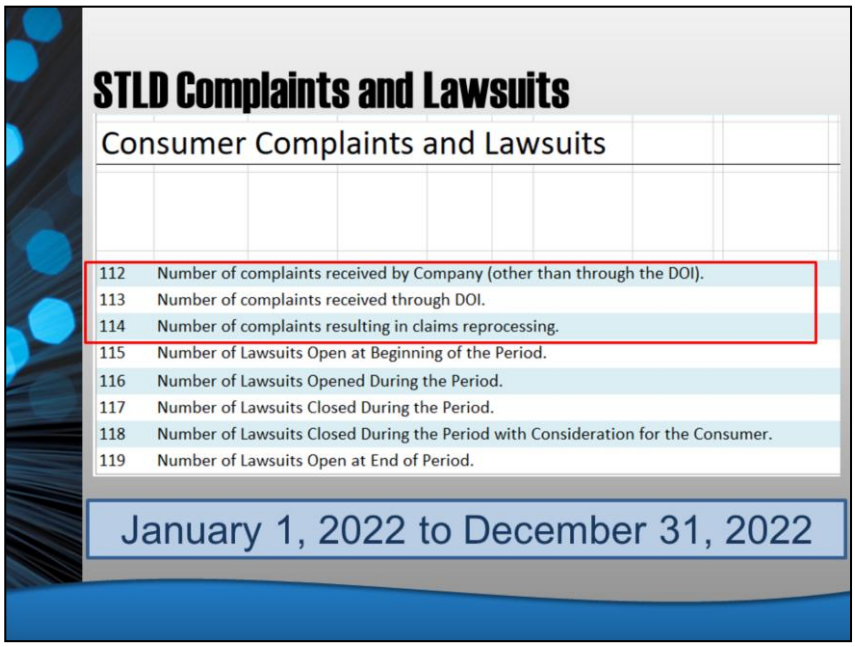

Following the Claims schedule is a series of questions regarding consumer complaints and lawsuits.

A consumer complaint is any written communication from a consumer that expresses dissatisfaction with a specific person, entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, is also a complaint for the purpose of this MCAS

The STLD blank asks you to provide the number of complaints received through the Department of Insurance and the number received from a source other than through the DOI. Additionally, you need to report how many of all the complaints led to the reprocessing of a claim or claims.

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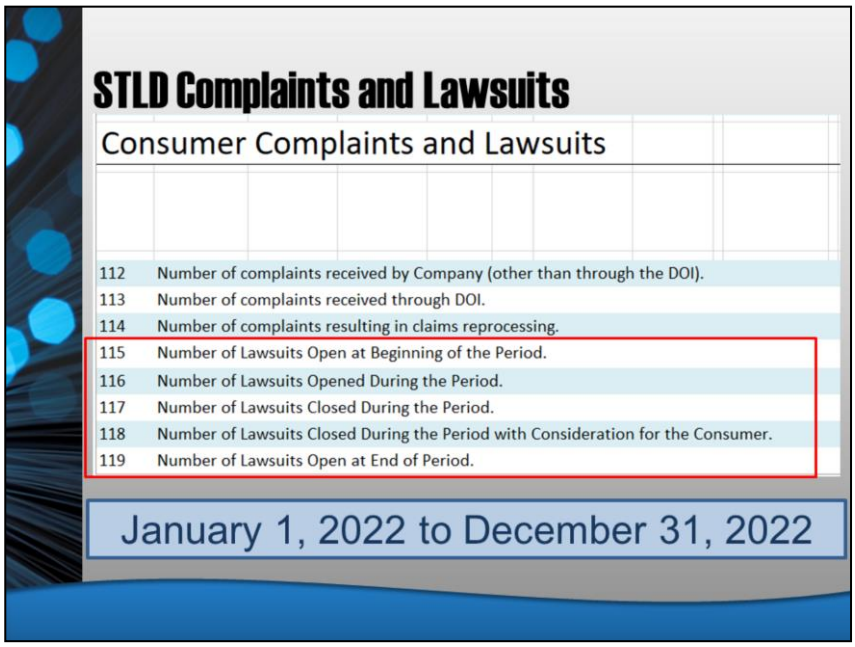

The STLD MCAS requests that you report the number of lawsuits open at the beginning and the end of the reporting period, as well as the number of lawsuits opened and closed during the reporting period.

The definition of lawsuit is lengthy, the next two slides will provide more detail and what is expected to be reported.

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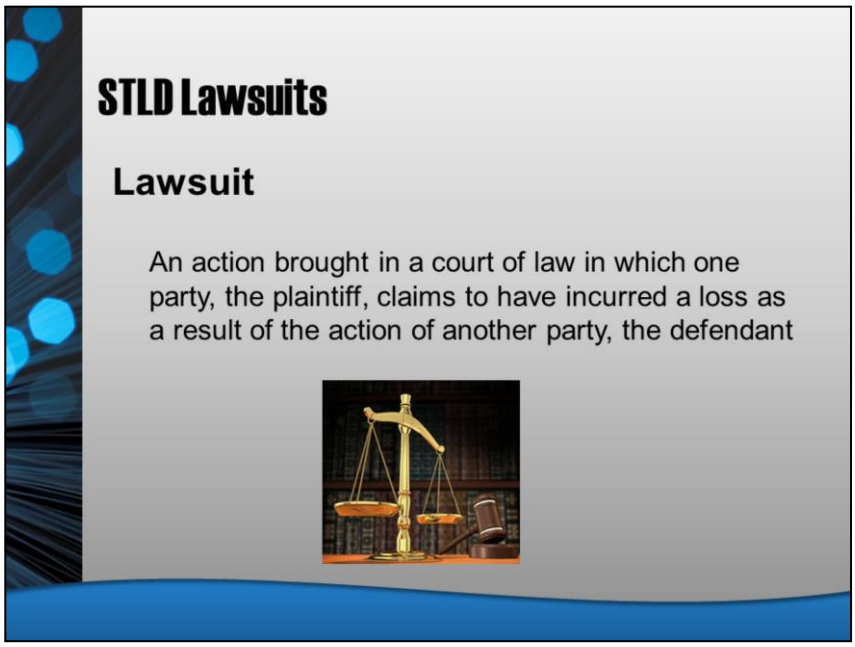

A lawsuit is an action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

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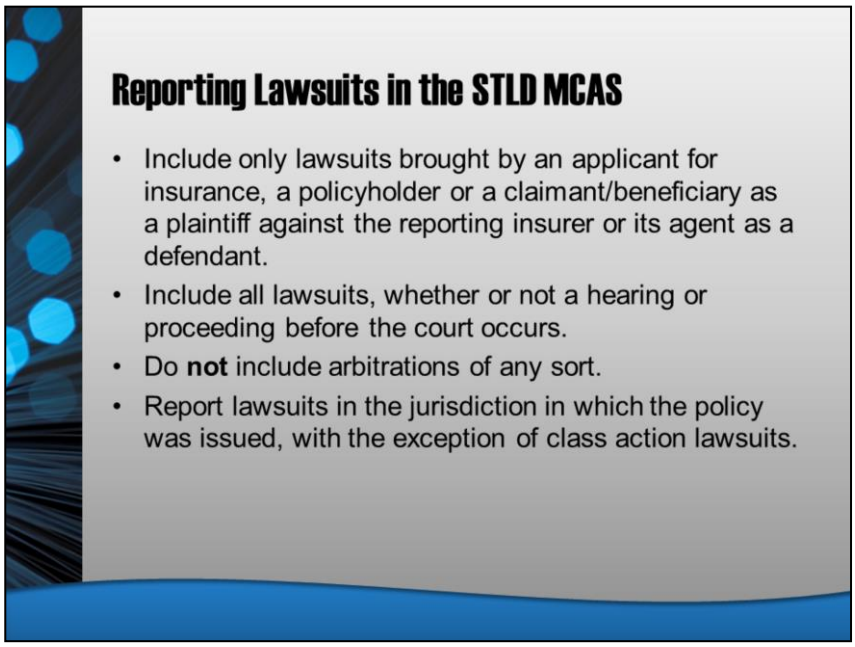

There are several things to consider for the purposes of reporting lawsuits in the STLD MCAS:

- 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
- Lawsuits must be reported in the jurisdiction in which the policy was issued, with the exception of class action lawsuits.

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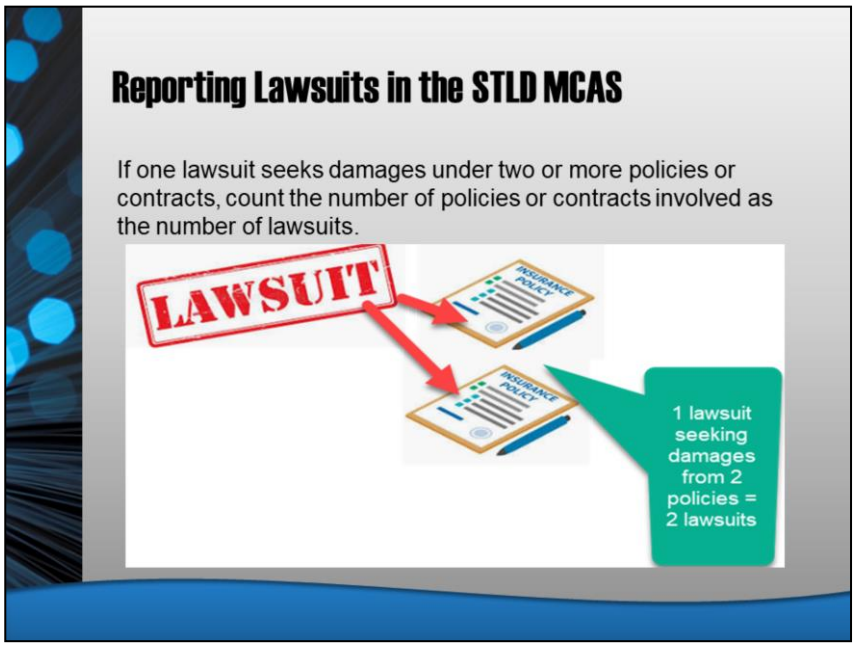

If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example: if one lawsuit seeks damages from two policies, count the action as two lawsuits.

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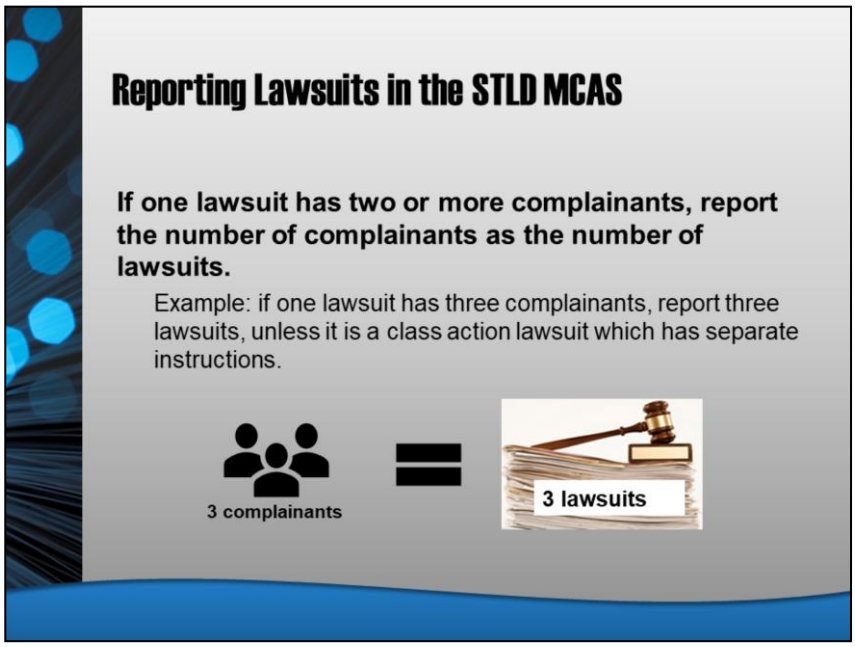

Similar to the previous slide, if one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits.

For example: if one lawsuit has three complainants, report three lawsuits. This does not include class action lawsuits.

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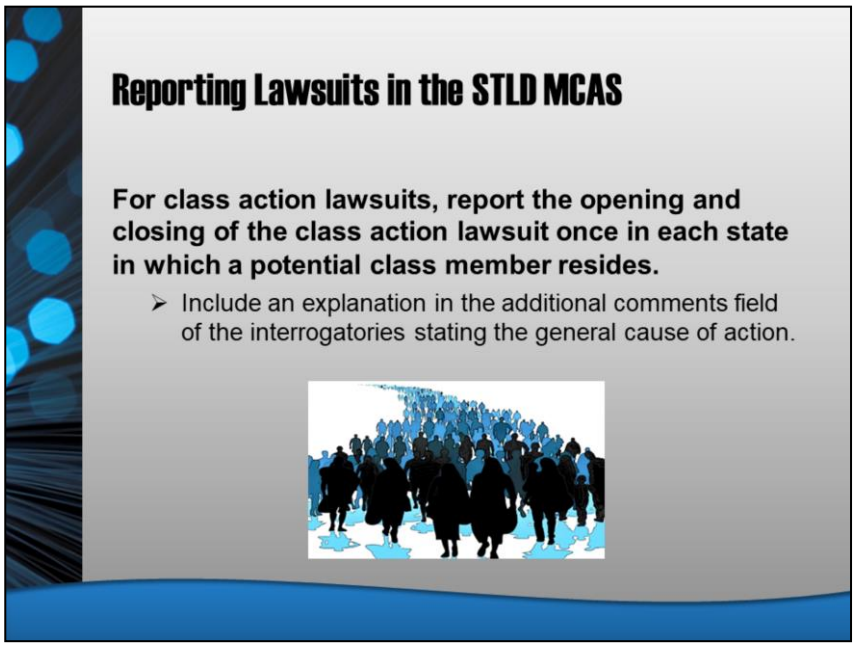

For class action lawsuits, report the opening and closing of the class action lawsuit once in each state where a potential class member resides. Include an explanation in the additional comments field, which is the final line of the Interrogatories, stating the general cause of action.

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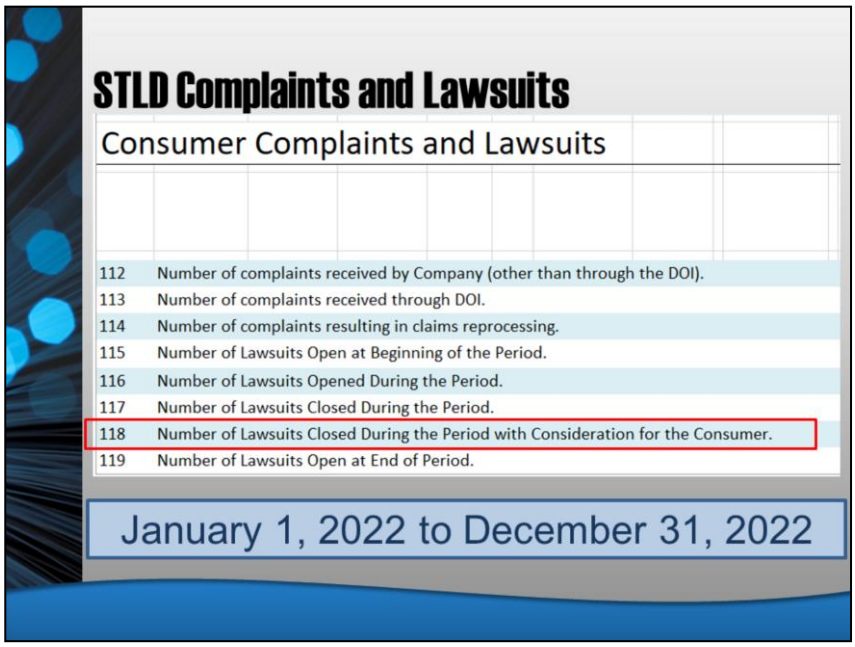

Finally, the STLD MCAS asks for the number of lawsuits that were closed with consideration for the consumer

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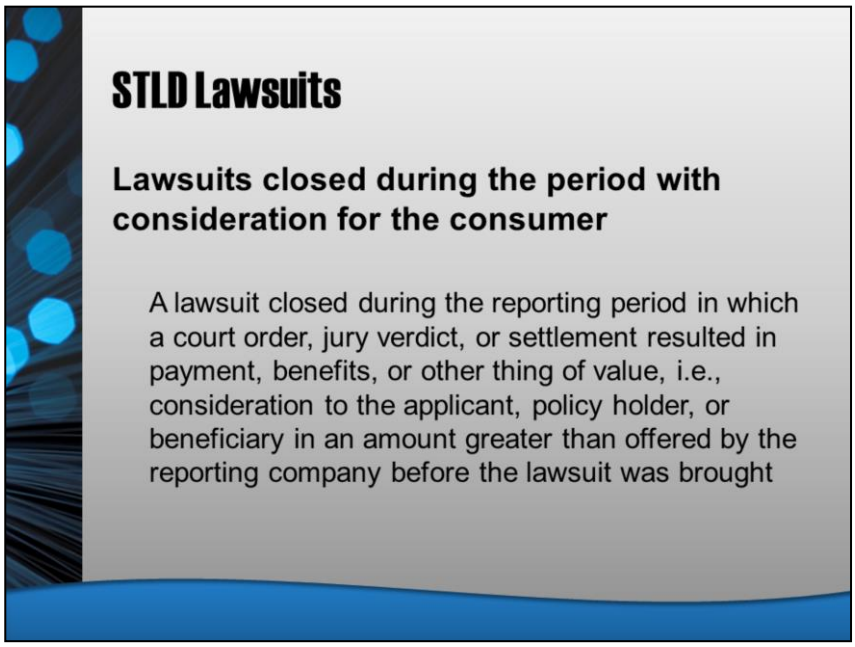

This line includes lawsuits closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, such as consideration to the applicant, policy holder, or beneficiary in an amount greater than the last offer by the reporting company before the lawsuit was brought.

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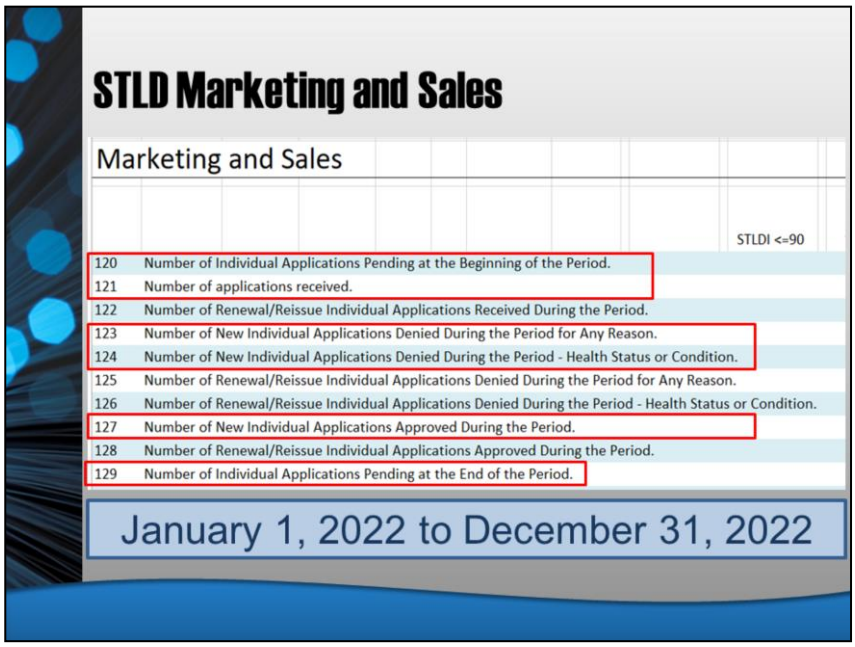

The final schedule in the STLD MCAS is all about Marketing and Sales.

It begins with a number of questions about applications for new policies and applications for renewals/reissues.

On this slide, we have highlighted all the questions referring to applications for new policies.

The first two questions apply to both new and renewals and simply asks for the total number of apps that were pending at the beginning of the reporting period and the number received. Of course, the last question asks for the total number of apps pending at the end of the reporting period.

Additionally, the blank asks about the number of new applications approved, and the number that were denied. Further, the MCAS asks you to report on the total number of new applications denied and the subset of applications denied due to health status or condition.

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On this slide, we have highlighted all the questions referring to applications for renewals or reissues.

As noted previously, the first two questions (120 and 121) apply to both new and renewals and simply asks for the total number of applications that were pending at the beginning of the reporting period and the number received. Of course, the last question asks for the total number of applications pending at the end of the reporting period.

Additionally, the blank asks about the number of renewal applications approved, and the number that were denied. Further, the MCAS asks you to report on the total number of renewal applications denied and the subset of applications denied due to health status or condition.

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The next series of questions in the Marketing & Sales section explore the methods for how the STLD policies were marketed and sold.

MCAS asks for the number of applications that were initiated and the number that were completed by:

- Phone,
- Face-to-face,
- Online,
- By mail, or
- By any other method.

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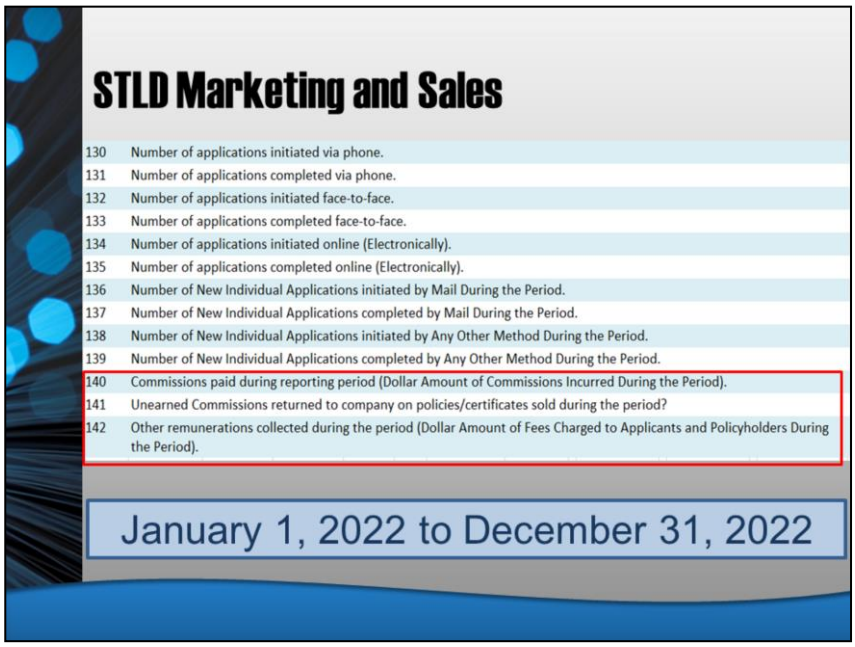

The last three questions on the STLD blank address commissions and other remunerations. These are measured in dollars.

For this MCAS commissions are defined as the total amount of compensation paid to any individual or entity for marketing, selling, and attracting potential insureds, by whatever means this compensation is provided.

You are not expected to include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money.

Also, for products not related to the actual sale of an STLD contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting.

Of course, MCAS is also interested in knowing the amount of unearned commissions returned to the company.

Other remunerations are any monetary consideration provided by the insurer through the course of the insurance transaction that are not commissions and are separate amounts paid for as a result of the insurance transaction.

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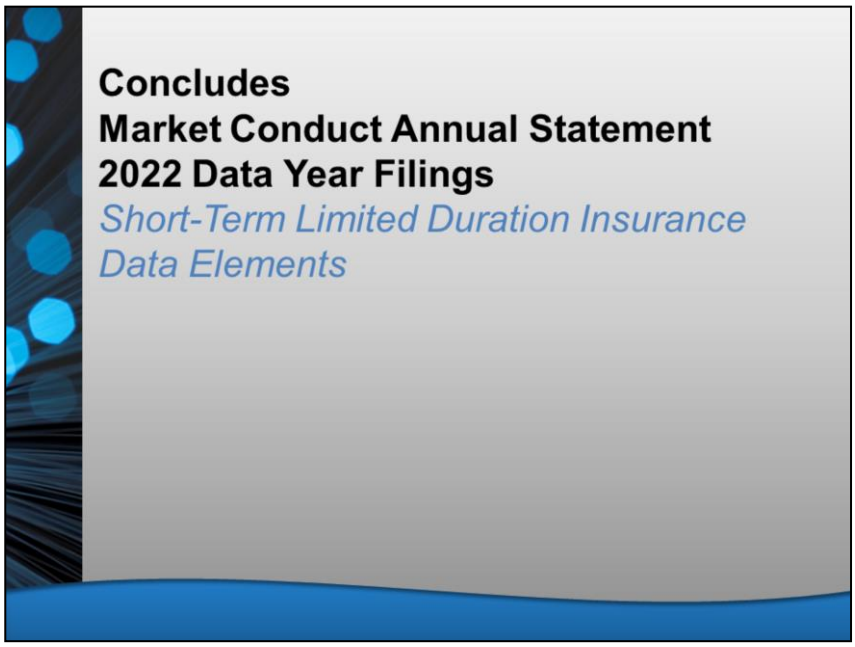

This concludes the data elements review portion of the Short-Term Limited Duration Data Elements.

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