NAIC National Association of Insurance Commissioners

Date: 6/19/2020

Conference Call

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP

Wednesday, June 24, 2020
2:00 p.m. ET / 1:00 p.m. CT / 12:00 p.m. MT / 11:00 a.m. PT

ROLL CALL

Rebecca Rebholz, Chair	Wisconsin	Paul Hanson	Minnesota
October Nickel, Vice Chair	Idaho	Brent Kabler/Teresa Kroll	Missouri
Maria Ailor	Arizona	Angela Dingus	Ohio
Jimmy Harris/Ryan James/ Russ Galbraith	Arkansas	Katie Dzurec	Pennsylvania
		Michael Bailes	South Carolina
Kurt Swan	Connecticut	Lisa Borchert/Ned Gaines/ John Haworth	Washington
Scott Woods	Florida		
Lori Cunningham	Kentucky	Letha Tate	West Virginia

NAIC Support Staff: Tressa Smith/Teresa Cooper

AGENDA

1. Consider Adoption of its May 28, May 27, May 21 and May 20 Minutes—*Rebecca Rebholz (WI)* Attachments 1-4

2. Consider Market Conduct Annual Statement (MCAS) Data Call and Definitions Clarifications Needed After Adoption of Changes to the Life, Annuity, Home and Auto MCAS Lines of Business —*Rebecca Rebholz (WI)* Attachments 5-7

3. Discuss Any Other Matters Brought Before the Working Group—*Rebecca Rebholz (WI)*

4. Adjournment

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Draft: 6/11/20

Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
May 20, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 20, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Jimmy Harris (AR); Sara Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Jeffrey Arnold (PA); Rachel Moore (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating was: Sarah Crittenden (GA); and Karen McCallister (NH).

1. Discussed Survey Results and Possible Edits to the Life MCAS Blank and Data Call and Definitions

Ms. Rebholz noted that in 2018, a survey was sent to state Market Analysis Chiefs and Market Conduct Annual Statement (MCAS) contacts to get their input regarding possible updates to the Life and Annuity MCAS. The results of the survey are posted on the Working Group's web page. In addition, a summary of the items in the survey for this discussion is included in materials for this call. The items highlighted in gray are related to the MCAS Market Analysis Prioritization Tool (MAPT) rankings and ratios, and they will need to be discussed by the Market Analysis Procedures (D) Working Group. These items are being passed along to Mr. Haworth for the Market Analysis Procedures (D) Working Group to discuss. Tomorrow, the Annuity MCAS Blank and Data Call and Definitions will be discussed.

The Working Group should come to a consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. Some issues discussed today may not be easily resolved, and they may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. Ms. Rebholz noted that Ms. Nickel would lead the discussions today, and she explained that time would be allowed for comments on each item discussed.

Ms. Nickel started by thanking the Center for Economic Justice (CEJ) and the American Council of Life Insurers (ACLI) for the comments submitted to the Working Group. Messages were also received in support of the CEJ comments. These letters of support were from Brendan Bridgeland (Center for Insurance Research—CIR), J. Robert Hunter (Consumer Federation of America—CFA), and Professor Ken Klein (California Western School of Law). Some CEJ comments were related to the frequency of MCAS data submissions. These comments will be shared with the Market Analysis Procedures (D) Working Group chair and vice chair for inclusion in its upcoming meetings. The CEJ, the ACLI, and other interested parties will be able to provide input on all edits discussed today.

During the last subject matter expert (SME) call, in which possible edits to the Life and Annuity MCAS were discussed, participants were asked to review the survey responses in detail and bring back their top three selections for changes to the next meeting. In the responses received from Working Group members, there was no consensus regarding the level of granularity needed. There was mention of adding some data elements to the Life MCAS blank.

a. The first item discussed was the level of reporting granularity for the Life blank. In Attachment 1 of the meeting materials are the survey results related to Life granularity. It is a percentage based on each different coverage line. There were comments made for additional areas that were not identified in that coverage by line of business or coverage type. The comments were related to credit and other products with no cash value, preneed, final expense, and funeral contracts. The ACLI provided a basic overview with differences related to those types of products, specifically for final expense and preneed products. Ms. Nickel asked if Working Group members had an interest in pulling out preneed and final expenses. She noted that the credit line was already rejected by the Market Analysis Procedures (D) Working Group for a new line of business for the Market Conduct Annual Statement Blanks (D) Working Group to work on. Therefore, this will also need to be brought back up with the Market Analysis Procedures (D) Working Group for it to be the Market Conduct Annual Statement Blanks (D) Working Group's charge to discuss the credit line of business.

   Tanya V. Sherman (INS Companies) noted that it is challenging when conducting analysis when these unique products are mixed in with other lines, and she felt that it would be nice to break these out. Ms. Nickel asked for clarification

about whether Ms. Sherman meant these products should be separated or they could be grouped into one. Ms. Sherman felt that they could be grouped into one category.

Birny Birnbaum (CEJ) noted that there are two reasons to segregate preneed and final expense. One would be because you have an interest in consumer outcomes for a specific product. The second is that you do not want consumer outcomes in a specific product line to muck up the data for other product lines that you have an interest in. Mr. Birnbaum noted that both instances for preneed and final expense warrant separation from the current overly aggregated categories of cash and non-cash values. He believes that during prior calls, industry stakeholders expressed that preneed was significantly different than final expense, and he felt that these comments should be reviewed so they are not aggregated together.

Ms. Nickel noted that it did not appear that there was a large consensus to make changes here, but it would be beneficial in some respects to pull apart the preneed and final expense. Based on the comments made, there does not appear to be enough interest to make these changes now. Ms. Rebholz agreed, and she asked if there was a motion from the Working Group members to break out individual preneed and final expense to the Life MCAS reporting blanks. There was no motion made.

Mr. Bridgeland noted that he has reviewed this and looked at what information can be gathered by consumers, academics and consumer organizations. It used to be that in the annual statement, you could gather some basic information about generally smaller face value life insurance policies because they fell into the industrial life policy category. Now, however, because of the way it is defined, there is no information reported and industrial life does not exist as its own category. Over the years there have been changes in terms of what information is available about certain types of life insurance products that you used to be able to segregate from the financial data, which you can no longer do because of the way industrial life has been defined and classified over the years. Mr. Bridgeland noted that there is a gap here because state insurance regulators used to be able to pick up information from annual statement reporting, but it is missing now. He feels that market conduct assessment would help because as a consumer advocate, when he hears from families or funeral service directors, it is commonly related to preneed and burial polices. From a consumer perspective, he believes it is important; and he wants to note that because of changes over the years, there is a gap in data available to state insurance regulators and consumers.

Monica Sole (Lincoln Heritage) noted that one of the problems Lincoln Heritage faces is that there is only one line of business for Lincoln Heritage and it is final expense. Final expense is not defined by the NAIC or any state insurance regulator, and it is not the same as preneed. Ms. Sole asked how bigger companies would report what a is final expense policy is and what is not since it is just a way of marketing a small face policy and there is no definition. She asked if large companies would report differently based on the face value of a policy. She feels that it should be separated from preneed, as it is its own line of business.

Mr. Birnbaum noted that the March 4 letter from the ACLI outlines the difference between final expense and preneed. Final expense is a whole life policy that is marked as final expense, and preneed is a whole life policy used to prepay a funeral on a contingent assignment. Preneed could be easily defined as a contractual relationship. To separate out final expense, you could segregate it as a whole life policy marketed for final expense. Mr. Birnbaum feels that this would be a straightforward way of doing it, as a company knows if they are marketing something as final expense or not.

Ms. Nickel agreed that companies generally would know what their different product lines are and how to properly file them. Ms. Rebholz asked if anyone from the Working Group wanted to make a motion to add this endowment coverage to the Life MCAS reporting. There was no motion made.

b. The next item of discussion was Individual Universal Life Insurance and Individual Variable Universal Life Insurance. There was no interest from the Working Group or any state insurance regulators to segregate Universal Life products.

Mr. Birnbaum noted that for most of these product lines, there is a different market and a different target population. There have been different types of market problems associated with that. If you look at traditional universal life, there have been problems with companies that promise vanishing premium, and now consumers are being faced with extraordinary premium. With indexed universal life (IUL), there is a different set of issues with unrealistic or misleading illustrations or hidden fees. If you aggregate all of this into cash value products, there is no way to distinguish what is happening with whole life versus universal life versus IUL versus variable life; as a result, the

market analysis is ineffective. A company that might be an outlier if you were looking at IUL does not show up as an outlier because that experience is hidden through aggregation with other products. Mr. Birnbaum believes that the pandemic illustrates why there is a problem. People are now being marketed certain products, claiming that they can be protected in the event if a market turndown; yet, there is no way to see what is going on in the marketplace in the aftermath of the pandemic. For those reasons, CEJ suggests not only a breakout for universal life separate from IUL, but also a break-out for variable life and whole life as part of the cash value breakouts. Ms. Nickel asked if anyone else has comments to add, and there were none. There was not enough interest here to make changes to Universal Life.

Ms. Nickel then asked for comments on Individual Variable Universal life. Mr. Birnbaum noted that he believes there should be a break-out here as well. Ms. Sherman noted that she was looking at Attachment 1 that has the survey notes for the Life MCAS, and she asked for clarification on the percentages. Tressa Smith (NAIC) noted that the survey results are on the webpage, and they are more than just the summaries for anyone that would like to review them in more detail. There were 32 responses; 19 of those answered that yes, they would like additional break outs for more granularity for the Life MCAS. The percentages shown are from the 19 people that answered yes as to what they would find beneficial. Mr. Birnbaum further expressed his support for breaking these lines out further to assist with a more detailed market analysis. Ms. Rebholz encouraged Working Group members to speak up on these matters to have a good understanding of how they feel about making changes to each item as the call progresses. She asked if there was a motion to make any changes to the Individual Universal Life and individual variable universal life, and there were none.

c. Ms. Nickel noted that the next topic to discuss is Individual Term Life Insurance with no Cash Value and Other Individual Life Insurance with no Cash Value. She asked if any Working Group members have an opinion or interest to include Individual Term Life Insurance with no Cash Value and Other Individual Life Insurance with no Cash Value as a separate line. Mr. Gaines noted that he does not feel that this needs to be broken down further. There were no comments by interested state insurance regulators or interested parties made on this topic. There was no motion to make changes here.

d. The next topic discussed was Individual Equity Indexed Life Insurance products. There were no comments from Working Group members, other state insurance regulators, or interested parties with an interest to break this product line out, so no motions were made to make changes here.

e. The next item discussed was whether there is an interest in separating Individual Whole Life Insurance and Individual Variable Life Insurance. Mr. Gaines noted that based on the survey, if there is a specific line that has a clear number of states in the majority, the group should consider making changes. Ms. Nickel noted that the 19 people who indicated that they would like to see changes represented 15 states, which did not seem to represent a significant enough interest from the majority. She explained that in future surveys, it may need to be a requirement for the states to answer these kinds of questions to have a better understanding of all the states. There were no other comments from Working Group members, other state insurance regulators, or interested parties on this topic, and no motion to make changes was made here.

f. Ms. Nickel noted that the next item of discussion is regarding comments received on surrenders. She asked if any Working Group members want to discuss surrenders being broken out by years and how that would be useful. She asked what the current options are, and Teresa Cooper (NAIC) noted that the options are contracts surrendered under two years of issuance, between two and five years of issuance, and between six and 10 years of issuance. Ms. Nickel asked if there was any interest in modification to these timeframes.

Mr. Birnbaum suggested adding an option for 10 years or longer. Ms. Crittenden noted that she supports adding the option for 10 years or longer, and she expressed interest in knowing about surrender fees. Ms. Nickel asked if she had a proposal regarding surrender fees. Ms. Rebholz noted that there was a suggestion in the survey that suggested adding a data element to collect the number of policies surrendered where a surrender fee was applied. She noted that the questions for the Working Group to decide are: 1) whether it would be useful to know how many policies were surrendered; and 2) of those surrendered, how many had a surrender fee applied.

After some discussion among Working Group members, Mr. Haworth made a motion, seconded by Ms. Nickel, to collect the number of policies surrendered where a surrender fee was charged. The motion passed unanimously.

Mr. Haworth asked if adding the option for contracts surrendered past 10 years is going to be discussed further. After some discussion, Ms. Nickel made a motion, seconded by Mr. Woods, to add the option for contracts surrendered beyond 10 years. The motion passed unanimously.

g. Ms. Nickel noted that there was feedback received for in-force contracts and definitions needing more clarity. There was dialogue in the survey regarding policies taken and not taken. Ms. McCallister noted that she was the one that made this comment, as she had several companies that were not including their non-taken, and she found it odd that some companies are including non-taken while some are not. She believes that since it is a formal offer, they should be included, and she is looking for clarity here. There was no interest from other call participants to make changes here, so this subject has been tabled for future discussions if filing discrepancies continue to be a concern. Ms. McCallister noted that the next matter up for discussion on adding data elements to both Individual Cash Value Policies and Individual Non-Cash Value Policies could be disregarded, as she was referring to the financial annual statement and the comment does not apply here, so there is no need to discuss it.

h. Ms. Nickel noted that the next item to discuss is the Individual Cash Value Policies related to nonforfeiture. She noted that this relates to the surrender topic discussed earlier on this call, and even though the surrender and nonforfeiture options are different, this could be clearer with the changes being made to the surrender data. She asked if additional separation here is necessary or if the surrender changes agreed on would suffice. Mr. Haworth agreed that with the changes being made regarding surrender fee data, clarity for nonforfeiture is also gained. There were no additional comments here, so no changes will be made.

i. Ms. Nickel noted that the next topic to discuss is the comment made regarding the Life interrogatories and whether it would be valuable information to include third-party administrator (TPA) information. The comment suggested requesting whether the company utilizes a TPA for the line of business, the name(s) of the TPA, and what the TPA does. Mr. Haworth noted he could see merit with this request because this also came up in the short-term limited-duration (STLD) data call as a topic people wanted to be aware of. He advised it would probably need to be an interrogatory that says whether a TPA is utilized to list the name and for what function.

   Mr. Haworth made a motion, seconded by Ms. Nickel, to collect TPA information on an interrogatory and the functions that they carry out. The motion passed unanimously.

   Mr. Birnbaum noted that the reporting here is limited to individual coverages, as group coverages are not provided. He asked whether the question about TPAs is intended to relate to the use of TPAs for individual coverages or if it is a broad application question. Mr. Haworth noted that for this context, it would just be for individual business; however, by being able to track it this way, they can see who these companies work with.

j. The next item discussed was for a comment received that stated the following: "We find that most companies do not have comments about being a potential outlier because they do not have any basis for comparison to state and national averages at the time of their filing." Ms. Nickel asked if the person who made the comment was on the call and available to elaborate on this. There was no response. Ms. Nickel noted that the score cards are available for everyone to review, including insurance companies and consumers; and even at an individual state level, carriers have the ability to review where they fall and review trends over periods of time to determine what kind of outliers they may have. She asked if anyone else had comments. Mr. Haworth noted that he believes this is more of an educational comment, as he has had to assist various parties by showing them the tools available to find information on potential outliers. There were no changes to be made here.

k. Ms. Nickel noted that the final comment regarding the Life MCAS interrogatories supports the incorporation of illustration certification fields. She asked that Working Group members interested in this topic provide further clarification on this request by email to Randy Helder (NAIC) or other NAIC staff to get a better idea of what is being asked for.

l. Ms. Nickel noted that there were some questions on definitions for data being reported by a resident state or an issue state. She advised that this should fall in line with what is used in the Financial Annual Statement (FAS). For example, if you issue a policy to a resident of the state of Idaho, then it is an Idaho policy. Ms. Nickel asked that anyone interested in elaborating on this topic further email their comments and feedback to her, Mr. Helder, Ms. Smith or Mr. Haworth.

m. The next item discussed was the proposal from the CEJ. Mr. Birnbaum has suggested edits to the MCAS related to lawsuit questions that are asked within the Life, Annuity, Home and Auto MCAS blanks. His suggestion is to make the lawsuit questions consistent across all lines of business. The current life and annuity lines of business do not contain information related to lawsuits. The other lines of business include the number of lawsuits open as of the end of the period, the number of lawsuits open as of the beginning of the period, the number of lawsuits opened during the period, and the number of lawsuits closed during the period in total. With exception of Homeowner and Private Passenger Auto, the other lines also include a data element to collect the number of lawsuits closed during the period with consideration for the consumer. It needs to be determined whether lawsuit data collection is an addition that should be made to the Life MCAS Blank.

   Mr. Birnbaum noted that all MCAS blank lines have data elements related to lawsuits except life and annuity, and all recent MCAS blanks have five lawsuit data elements: 1) the number of lawsuits open at the beginning of the period; 2) the number of lawsuits opened during the period; 3) the number of lawsuits closed during the period; 4) the number of lawsuits closed during the period with consideration for the consumer; and 5) the number of lawsuits open at the end of the period. He suggested that these data elements be added to the life blanks. Ms. Nickel made a motion, seconded by Mr. Arnold, to add these lawsuit elements to the life MCAS. The motion passed unanimously.

n. Ms. Nickel noted that Mr. Birnbaum has also suggested new data elements to address accelerated life underwriting. With accelerated life underwriting, insurers use credit scores, facial analytics, and other non-medical data to underwrite applicants and price policies. Mr. Birnbaum has suggested a definition of accelerated underwriting and several interrogatory questions asking whether a company utilizes accelerated underwriting, on what products, and what data sources and vendors they use, to replicate the underwriting questions to answer specifically for accelerated underwriting. For example, in addition to asking for the total number of policies issued, we would also ask for the total policies issued utilizing accelerated underwriting. Ms. Nickel said she sees the benefits with this.

   David Leifer (ACLI) asked if there is a definition of accelerated underwriting that would be used. Mr. Birnbaum stated that they proposed a definition and explained that historically, life insurers have relied on information provided by consumers and medical information through blood tests, family histories, and things of that nature. In the last five years, life insurers have started predictive modeling, and they are projecting mortality using non-medical third-party data sources. The reason the CEJ is making these suggestions is that this is a qualitatively different approach to underwriting and sales than has been done in the past. In some ways, it is an almost completely digital process as opposed to a traditional, in-person and hands-on process. There may be different consumer outcomes when there is information being used that the consumer is not aware of and has no idea how that information is being used. There is not much information that state insurance regulators have about accelerated underwriting outcomes in the marketplace right now.

   The suggestion from the CEJ is that there be some additions to the life blank related to accelerated underwriting, starting with the definition of accelerated underwriting meaning underwriting and pricing of life insurance in whole or in part on non-medical data obtained from other than the applicant or policy holder and includes, among other things, facial analytics, social media, and consumer credit information. The CEJ also suggests adding interrogatories: 1) whether the company uses accelerated underwriting for life insurance; 2) whether the company uses accelerated underwriting for life insurance and for what product categories it is used; and 3) whether the company uses accelerated underwriting for life insurance and a list of the date sources used and vendors supplied, the data, or the algorithm. The CEJ also suggests that the specific underwriting data elements have an addition for the total number of new policies issued by the company during the period utilizing accelerated underwriting, so state insurance regulators could get some sense of how much accelerated underwriting is being used and what portion of the book of business is developed using accelerated underwriting.

   Mr. Haworth asked if this information could be reviewed as possible data elements to see what this looks like when trying to capture this information, as he believes that there is some merit to this request. Ms. Rebholz asked if he was suggesting a mock set of blanks for review. Mr. Haworth confirmed that that is what he is suggesting. Ms. Rebholz agreed. Mr. Birnbaum noted that he would provide the mock set of data elements related to accelerated underwriting for review if that would be helpful. Ms. Nickel agreed.

   Mr. Leifer noted they are not allowed to change rates after policies are issued, nor do they generally use rating models. He stated that there is no good definition of accelerated underwriting, and life insurance companies have used things like credit and other non-medical information for decades. He believes that this is an extremely complicated topic,

and he noted that the NAIC has a working group dedicated to looking at life insurance and accelerated underwriting. He feels that this level of granularity could be premature. Ms. Nickel noted that reviewing the mock set of data elements and then having further discussion about it would be a good place to start, but it may need to be tabled for another year. Ms. Rebholz agreed and explained that the working group already working on this topic may need to be consulted once this is reviewed further.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Draft: 6/11/20

Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
May 21, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 21, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sara Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Teresa Kroll (MO); Angela Dingus (OH); Katie Dzurec (PA); Michael Bailes and Rachel Moore (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating was: Sarah Crittenden (GA).

1. Discussed Annuity MCAS Survey Results and Possible Edits to the Blanks and Data Call and Definitions

Ms. Rebholz noted that the focus of this call is possible edits to the Annuity MCAS Blanks Data Call and Definitions. The results of the 2018 survey results are posted on the Working Group web page. In addition, a summary of items in the survey for this discussion is included in the materials for this call. The items highlighted in gray are related to the Market Conduct Annual Statement (MCAS) Market Analysis Prioritization Tool (MAPT) rankings and ratios, and they will be discussed by the Market Analysis Procedures (D) Working Group. These items are being passed along to Mr. Haworth for the Market Analysis Procedures (D) Working Group to discuss.

The Working Group should come to consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. Some issues may not be easily resolved, and they may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. Ms. Rebholz noted that Ms. Nickel would lead the discussions today, and she explained that time would be allowed for comments on each item discussed.

Ms. Nickel noted that many of the topics discussed yesterday for the Life MCAS would also apply to the Annuity portion of the MCAS and would be discussed to see if similar changes should be made. The survey results and possible edits specific to the Annuity MCAS will then be reviewed.

a. The first item discussed was to review the changes made to the Life MCAS on yesterday’s call and determine if the same changes should apply to the Annuity MCAS.

    i. The first change discussed was adding a data element requesting the number of policies surrendered with a surrender fee. Mr. Haworth expressed an interest in making this change. Ms. Crittenden agreed. Mr. Swan asked if the same 10 year and over methodology would be applied here. Ms Nickel explained that the number of policies surrendered greater than 10 years from policy issue date was added to the Life MCAS, and she asked if there was also an interest in making this change on the Annuity line, explaining that this would be two separate additions. One addition would be for the number of policies surrendered with a surrender fee and one would be for the number of policies surrendered greater than 10 years from the policy issue date.

    ii. The next item of discussion was to add an interrogatory asking the company to identify all third-party administrators (TPAs) the company uses and their function.

    iii. The next suggestion was to add the following data elements related to lawsuits: 1) the number of lawsuits open at the beginning of the period; 2) the number of lawsuits opened during the period; 3) the number of lawsuits closed during the period; 4) the number of lawsuits closed during the period with consideration for the customer; and 5) the number of lawsuits open at the end of the period.

    Ms. Nickel asked if there were any comments regarding the above changes being made to the Life MCAS and applying them all to the Annuity MCAS. Birny Birnbaum (Center for Economic Justice—CEJ) asked whether the intent was to add the interrogatory about TPAs for both Life interrogatories and Annuity interrogatories or to get one set of interrogatories regarding TPAs. Randy Helder (NAIC) noted that there would be a TPA question for the Life blank and then a separate TPA question for the Annuity blank in the interrogatories for both.

Mr. Haworth made a motion, seconded by Ms. Nickel, to add the data elements and interrogatory additions discussed here that were added to the Life MCAS yesterday to the Annuity blank. The motion passed unanimously.

b. The next item discussed was having internal and external replacements further defined, and possibly adding another category for external replacements for those that are replaced by another company within the same group of companies. Tanya Sherman (The INS Companies) asked for clarification on this topic.

Mr. Birnbaum noted that the blank defines internal replacement as being issued by your company and an external replacement as being issued by another company. There probably needs to be some clarification on what "another company" means. It can mean another insurer outside of your group, or it can mean another company within your group if you have multiple companies issuing annuities. Mr. Birnbaum would not want to categorize a replacement by another company within the group as an external replacement, as that appears misleading. He noted that it may be helpful to break down external replacements into two data elements; one could be when a policy or annuity is replaced and was issued by a company unaffiliated with your company, and the other could be an external replacement issued by another company that is affiliated with your company. The internal replacement would stand.

Ms. Rebholz noted that one of the suggestions along this line was to add a separate field to report a sister company replacement to help identify if churning may be occurring. Ms. Nickel asked if anyone wanted to move to add an additional level of detail regarding affiliated or unaffiliated company relationships on replacements. Mr. Haworth asked whether a motion made here would be consistent for the Life MCAS too. Ms. Nickel said that would be appropriate.

Mr. Haworth made a motion, seconded by Mr. Swan, to make the changes as discussed and clarify the external versus internal replacements including affiliated companies.

Mr. Birnbaum noted that the definition for internal replacement is described as a replacement by your company, and the current definition for external replacement is described as being issued by another company. He asked if the proposal is to retain the current definition of internal replacement and then to create two data elements for external replacement where one refers to another company affiliated with your company and then the second definition would be issued by another company unaffiliated with your company. Mr. Helder noted that his understanding of Mr. Haworth's motion is to add a separate field to identify external replacements to an affiliated company, and he believes Mr. Birnbaum is asking if there would be a commensurate definition in the data call and definitions. Mr. Haworth confirmed that the definitions would have to be added, as there is a data field that will need to be explained and clarified. Ms. Nickel asked for clarification about whether external would be broken out into two separate definitions and internal would remain the same as a replaced policy. Mr. Helder said that is correct, and one more data element for external replacements would be added for affiliated companies and the definitions would be revised to explain what that means.

Ms. Phelps asked if all companies would understand what the term affiliated means. Mr. Birnbaum noted that the term affiliated is standard in the insurance industry, and when companies file their annual statement, they complete an organizational chart showing any affiliations. He believes that it is a straightforward term.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add these additional data element and definition pieces clarifying the external versus internal replacements to the Life MCAS blank as well. The motion passed unanimously.

c. The next item of discussion was the granularity of annuity reporting. Mr. Gaines expressed an interest in pulling out the variable annuity product data.

Mr. Birnbaum noted that the current MCAS breaks annuities into fixed and variable categories. The fixed category includes immediate fixed, deferred, qualified longevity annuity contract, and indexed annuities. The data includes experiences for very different product types sold to different types of consumers, sold by different types of producers in different markets. Variable annuities currently include variable; traditional variable; fixed variable; indexed

variable, now called buffered annuities; and contingent deferred annuities. Mr. Birnbaum suggested breaking out the annuities into more granular categories to assist in a more useful and detailed market analysis.

Mr. Haworth noted that it looks like only 10 people responded to this topic on the survey and 22 people did not respond, and he asked if that was correct. Tressa Smith (NAIC) confirmed that as correct, and she said survey participants were not required to respond to these questions. The first part of the survey had a question that asked if it would be beneficial to have data broken down into a more granular level. Eleven people said yes, and 11 people said no. Of the 11 people that indicated that they would like more granularity, 10 of those then said they would like more granularity on this category. Mr. Haworth asked if Working Group members would like more granularity here. Mr. Gaines noted that he is interested in additional data on the variable side, specifically variable indexed annuities, and not as much on the fixed side. Mr. Birnbaum suggested categories for variable annuities of indexed variable and all variable annuities other than indexed. Then, the same thing could be done for fixed, having fixed-indexed annuities and all fixed annuities other than fixed-indexed annuities. This would add two additional categories.

After some discussion among the Working Group, Ms. Rebholz asked if there was a motion to make changes here. She explained that currently all fixed annuities are in one bucket and all variable annuities are in the other. The idea is to break out fixed annuities into fixed-indexed and all other fixed annuities, and then break out the all variable bucket into indexed variable and all other variable.

Mr. Haworth made a motion, seconded by Mr. Swan, to add the additional lines as discussed. The motion passed unanimously.

Ms. Nickel asked if there was any interest from the Working Group regarding adding additional levels of granularity here, such as immediate fixed annuities and deferred fixed annuities. There were no comments expressed to make additional changes here.

d. The next topic discussed was the suggestion of adding a definition of in-force. There was no interest in making this addition to the Annuity MCAS.

e. The next topic discussed was a comment regarding death claims closed with payment that does not fit for annuities, so this was not discussed.

f. The next item discussed was the suggestion to collect information based upon contract state and resident state. There was no interest in making this addition to the Annuity MCAS.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Draft: 6/11/20

Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
May 27, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 27, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating were: Sarah Crittenden (GA); and Jill Huisken (MI).

1. Adopted its May 6 Minutes

The Working Group met May 6 and took the following actions: 1) adopted its Feb. 26 minutes; 2) received an update on existing market conduct annual statement (MCAS) reviews and the other health MCAS development; and 3) adopted a $50,000 premium threshold for the private flood MCAS reporting.

Mr. Gaines made a motion, seconded by Mr. Arnold, to adopt the Working Group's May 6 minutes (Attachment __). The motion passed unanimously.

2. Discussed and Adopted Edits to the Homeowners MCAS Blanks Data Call and Definitions

Ms. Rebholz said the Working Group should come to consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. She said some issues may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. She said the survey results and a summary of items in the survey for this discussion are posted on the Working Group web page. The items highlighted in gray are related to the MCAS Market Analysis Prioritization Tool (MAPT). Ms. Rebholz said the Market Analysis Procedures (D) Working Group will forward rankings and ratios to Mr. Haworth for discussion.

a. Policies in Force

The first item discussed was a suggested interrogatory change dealing with policies in force. The suggestion was to add a question to the interrogatories where a company could provide an explanation for any significant difference between the number of policies in force at the end of the prior year and the number reported in force for the beginning of the current reporting period. The other related suggestion is to add a data element to report the number of total, in-force policies by coverage type in the interrogatories. There was no interest expressed to make changes here.

b. Renters and Tenant Policies

The next suggestion to the interrogatories was to break out reporting for renters and tenant policies. Working Group members discussed this suggestion. Birny Birnbaum (Center for Economic Justice—CEJ) advised if the Working Groups want to get the information on the number of renters policies, it should ask about the number of homeowners policies in force at the end or beginning of the period, how many dwelling fire policies were in force and how many renter/tenant/condo policies grouped together were in force.

Ms. Rebholz said the next suggestion to the interrogatories along this subject is to break out renters policies and homeowner coverage separate from dwelling since there is a separate definition within the data call and definitions.

Teresa Cooper (NAIC) said another option is to add the reporting of these values to the underwriting section since data is already collected for policies in force in that section for homeowners, renters and dwelling. Mr. Haworth and Mr. Arnold said they agree. Mr. Birnbaum stated the NAIC *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) outlines how residential properties groups are categorized. The groups are: 1) dwelling fire, which is HO1; 2) homeowners, which is HO3 and HO5; and 3)

renters/condo/co-op, which are HO4 and HO6. He suggested using the same three categories if adding them to the underwriting section.

Mr. Gaines made a motion, seconded by Mr. Arnold, to create three additional categories in the underwriting section: 1) dwelling fire; 2) homeowners; and 3) renters/condo/co-op. The motion passed unanimously

c. Interrogatories

The next item of discussion was to make a change to question 12 and question 13 in the interrogatories. The question currently asks: "Has all or part of this block of business been sold, closed or moved to another company during the year?" The suggestion is to change the end of the question to ask for information during the "last three data years."

Ms. Ailor asked if this is data that could be obtained from the dashboard. Tressa Smith (NAIC) confirmed the interrogatories will be available in the dashboard and that information on a current year would be available, as well as information up to five years back to see how responses have varied over time.

Ms. Crittenden said the three-year question seems to go outside of the MCAS annual reporting for the data year. Ms. Rebholz asked if it would be better to change the wording to: "Has all or part of this block of business been sold, closed or moved to another company during this reporting period?" with the understanding that the dashboard can provide information three years back. Mr. Haworth supported this idea.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she agrees with Ms. Crittenden and Mr. Haworth in that the companies have been reporting this data for quite a while on an annual basis and if the information can be obtained off the dashboard, the APCIA would support just changing the wording as suggested.

Ms. Nickel made a motion, seconded by Ms. Ailor, to edit the wording in the end of the question from "during the year" to "during this reporting period." The motion passed unanimously.

d. Private Flood Coverage

The next item discussed was to add an interrogatory asking if the company writes private flood coverage outside the National Flood Insurance Program (NFIP). Mr. Haworth said if he wants to know this information, he reviews the private flood MCAS. After discussion among Working Group members and interested parties, there was no motion made to make this change.

e. Claims Closed Without Payment

The next topic discussed was to add a data element to the Claims category for reporting claims closed without payment for those that are below the deductible. Currently, claims that are for amounts below the insured's deductible are reported as claims closed without payment, but they are not separated out from other claims closed without payment. If a data element is added, it might be necessary to exclude these from the current reporting of claims closed without payment. There was no motion to add this data element.

f. Phantom Claims

The next suggestion was a concern related to phantom claims. The current definition of a claim and the clarification instructing the insurer what to exclude was discussed. There was no motion to make edits here.

g. Claims Closed With Payment Beyond 90 Days

The next suggestion discussed was to remove claims question 26, question 27 and question 28. This would eliminate the reporting of claims closed with payment beyond 90 days. NAIC staff use the numbers reported in lines 23 through 28 to determine if the value reported on line 22 (median days to final payment) is reasonable. If elements 26 through 28 are removed, this check can no longer be done. After discussion among Working Group members and interested state insurance regulators, there was no motion to make changes here.

h. Separate Reporting for Each MGA

The next suggestion discussed was for reporting to be done separately for each managing general agent (MGA) to allow state insurance regulators to focus more attention on the MGAs that are potentially causing issues. During previous life and annuity discussions, the Working Group decided that an interrogatory would be added to ask for a listing of third-party administrators (TPAs) that the company uses and each TPA's function.

Mr. Gaines said that being able to identify which MGAs a company is using would be helpful.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add an interrogatory to list the names of MGAs that a company is using. The motion passed unanimously.

i. Complaints Questions in the Underwriting Section

The next suggestion discussed is to entirely remove the complaints questions in the underwriting section because companies do not seem to report the complaint counts correctly. Mr. Haworth, Mr. Arnold and Ms. Brown said they do not think it should be removed. Ms. Ailor said the location of the complaints question being in the underwriting section could be causing confusion. Mr. Birnbaum advised the complaints data and lawsuit data in other lines of business are broken out in different categories and suggested doing the same here to eliminate confusion that may exist.

Ms. Nickel made a motion to create a new category for complaints and lawsuit information and move the question that currently exists for complaints to that new category. Ms. Smith pointed out that currently the number of complaints received directly from any person or entity other than the department of insurance (DOI) is under the underwriting section, but that section is not broken out by coverage type. Data for complaints is not collected separately for dwelling, personal property, liability, medical payments and loss of use. Currently, complaints are collected as a whole, and lawsuits are collected by coverage type, so data collected for complaints and lawsuits are collected in different manners. Ms. Nickel then made a motion to move the complaint question out of the underwriting section and to the interrogatory section. Mr. Haworth asked if the data could still be pulled if the complaints were in the interrogatory section and expressed concern with consistency among other lines.

Mr. Birnbaum said if there is concern about having this question in the interrogatory section in terms of ease of access to the data, it could be kept as a data element. He said a reporting instruction could be added to report all complaints in the dwelling coverage and block out the other coverage boxes for that particular data element. Ms. Rebholz asked NAIC staff what would be the easiest option and if that was an option. Ms. Smith advised leaving the question in the underwriting section and said that adding some clarification would be the easiest solution, especially when considering looking at past data. The past data would still be in the underwriting section, and the new data would be in interrogatories if the question was moved, which is something to be aware of in considering changes here and future analysis. Ms. Brown asked if it would be easier to change the category name to "Underwriting and Total Complaints." Mr. Birnbaum said he thinks there is a benefit to pulling out the lawsuits and the complaints data into a separate schedule as it has been done in other categories, so it is clearer that it is all complaints and all lawsuits.

Ms. Nickel made a motion to pull the two elements out for complaints and lawsuits and make one new section for complaints and lawsuits with all related questions into that category. There was no second and no changes or edits were made regarding that suggestion at this time. Ms. Rebholz advised this can be discussed in the future.

j. Fire Protection Classes

The next suggestion discussed was to add a data element to capture fire protection classes used and to collect information regarding fire protection classes that are used. Mr. Gaines said the Washington Insurance Examination Bureau conducts exams on companies for this, so Washington would not benefit from this addition. There was no interest expressed in collecting this information.

k. Terminations Triggered by Nonsufficient Funds and the Insured's Request

The next suggestion discussed was to separate reporting of terminations triggered by nonsufficient funds and the insured's request. There is also a suggestion to separate reporting of terminations triggered by nonsufficient funds and the insured's request. Currently, there are two data elements for this information: 1) the number of cancellations for non-pay or non-sufficient funds; and 2) the number of cancellations at the insured's request. There was no interest expressed in making changes here.

l. MD&A Section

The next suggestion discussed is for the addition of a Management Discussion & Analysis (MD&A) section to the MCAS. The suggestion is to add the submission of an MD&A. Insurers currently submit an MD&A document with their financial annual statement filings. Ms. Nickel said she made this recommendation and explained why she supports this. Ms. Huisken asked if this information would be reported on a state-by-state basis. Ms. Nickel said she envisions the reporting would be on a national basis. Ms. Brown asked if there would be a different MD&A for market versus financial or if it would be a replication of what is done on financial. Ms. Nickel said it would focus on areas that would primarily affect the market, such as closed books of business and moving/shifting products from indexed annuities to variable products, use of TPAs and other general questions. Ms. Brown said she thinks this should be a separate market report on a national basis, separate from MCAS reporting since MCAS data is reported by state. Ms. Rebholz asked if Mr. Haworth could discuss this with the Market Analysis Procedures (D) Working Group to see if there was an interest there. He agreed to do so and said he does not believe it is suitable for MCAS reporting.

m. Lawsuits Closed With Consideration for the Consumer

The next suggestion discussed was to add a fifth data element to reflect lawsuits closed with consideration for the consumer and adjust wording of lawsuits to make it consistent across all lines of business. The MCAS lines of business of long-term care (LTC), disability, private flood and lender-placed have a data element for: "number of lawsuits closed with consideration for the consumer." These were just added, along with: "number of lawsuits open at the beginning of the period," "number of lawsuits opened during the period," "number of lawsuits closed during the period" and "number of lawsuits open at the end of the period." The current home and auto blanks do not have the "number of lawsuits closed with consideration for the consumer" and also refer to lawsuits as "suits."

Ms. Brown said companies have indicated that this data is not easily captured. She said they would have to manually look at what offer was made prior to litigation in the settlement, and what payment or other thing of value would need to be added and defined to the claims handling process. Mr. Birnbaum said that in addition to the data element, the data definitions used in the other blanks should be updated to have consistency with other lines on the data elements and definitions. He also said this information is useful and can eventually be programmed into company systems.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add a data element for "number of lawsuits closed with consideration for the consumer" and to update the language from "suits" to "lawsuits" for consistency purposes. Ms. Cooper asked if the motion includes the definitions for the other lines, and Ms. Nickel said it does. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Draft: 6/15/20

Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
May 28, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 28, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Maria Ailor (AZ); Mark Duffy (CT); Scott Woods (FL); Lori Cunningham (KY); Angela Dingus and Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV).

1. Discussed and Adopted Edits to the PPA MCAS Blanks Data Call and Definitions

Ms. Rebholz said that the survey results and a summary of items in the survey for this discussion are posted on the Working Group's web page. A summary of the decisions made during the Working Group's May 27 conference call for the homeowners Market Conduct Annual Statement (MCAS) was provided.

a. Exclusions

The first item discussed was to change the granularity of the private passenger auto (PPA) reporting to exclude reporting for uninsured motorist bodily injury (UMBI), uninsured motorist property damage (UMPD), medical payments, combined single limit (CSL) and personal injury protection (PIP). This would mean going forward, the MCAS would focus only on collision, comprehensive, liability and property damage (PD). The Working Group did not express interest in making this change.

b. Policies in Force

The next suggestion discussed was to require companies to report the number of policies in force by coverage type within the interrogatories. The Working Group did not express interest in making this change.

c. Update to Question 16 and Question 17

The next item of discussion was to make a change to question 18 in the interrogatories to include "last three data years." It appears the intent was to update question 16 and question 17 similarly to the update suggested for homeowners. The decision made for homeowners was to change the wording in question 12 and question 13 from "Has all or part of this block of business been sold, closed or moved to another company during the year?" to "Has all or part of the this block of business been sold, closed or moved to another company during the reporting period?"

Ms. Nickel made a motion, seconded by Mr. Haworth, to update the wording in question 16 and question 17 of the PPA MCAS to match the reporting for question 12 and question 13 in the homeowners MCAS. The motion passed unanimously.

d. Telematics or Usage-Based Data

The next item discussed was the suggestion to add two interrogatories for: "offers a transportation network company (Uber, Lyft) or similar rideshare endorsement" and "offers or uses telematics or usage-based products." Working Group members, interested state insurance regulators and interested parties discussed the suggestion.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add the interrogatory "Does the company use telematics or usage-based data?" with a "yes" or "no" response. The motion passed unanimously.

e. Reporting Claims Closed Without Payment That Are Below the Deductible

The next topic discussed was to add a data element for reporting claims closed without payment that are below the deductible. Ms. Nickel and Ms. Cunningham expressed interest in adding this data element.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said this does not seem to provide information on a company's market activity and stated a better approach may be redefining claims closed without payment to exclude those that were closed because the claim was below the deductible. Ms. Nickel said some carriers report these claims incorrectly and explained this could be an indication of a company's procedural or compliance issue. Further discussion took place.

Ms. Nickel made a motion, seconded by Ms. Cunningham, to add a data element for reporting claims closed without payment that are below the deductible and to remove claims closed because the amount claimed is below the insured's deductible from the reporting of the claims closed without payment data element. The motion passed unanimously.

f. Phantom Claims

The next suggestion was to edit the claim definition to avoid phantom claims. Mr. Self said an event reported for information only and coverage inquiries are not supposed to be included in claim counts. Ms. Brown said many states have statutes indicating an insurer cannot open a claim file based solely on an inquiry from a policyholder based on the potential of a claim. After discussion among Working Group members, there was no motion to make changes regarding this suggestion.

g. Claims Closed With Payment Beyond 180 Days

The next suggestion discussed was to remove data elements for claims closed with payment beyond 180 days. It was explained that removing these data elements removes the ability of NAIC staff to determine if the median days to final payment is reasonable. Mr. Arnold said he thinks these questions should remain due to the long tails that can take place on bodily injury (BI) claims. Ms. Ailor also supported keeping these data elements as PD claims can also last a long time and can be problematic if there are unnecessary delays in paying claims. There was no interest in removing these data elements.

h. Separate Reporting for Each MGA

The next suggestion was for reporting to be done separately for each managing general agent (MGA) to allow state insurance regulators to focus more on the MGAs that are potentially causing issues. During the Working Group's May 27 conference call related to the homeowners MCAS, it was decided to add an interrogatory question to ask if the company uses any MGAs and if so, to list them by name.

Mr. Gaines made a motion, seconded by Ms. Nickel, to add the interrogatory question asking if the company uses any MGAs and if so, to list them by name. The motion passed unanimously.

i. Company-Initiated Cancellations

The next suggestion discussed was to break out the reporting of company-initiated cancellations after effective date in the underwriting section, excluding rewrites to a related company, to 0–29 and 30–59 days. Currently, the breakouts for this data element are 0–59 days, 60–90 days and beyond 90 days. This suggestion would add an extra bucket to separate those within the first 59 days. The Working Group did not express interest in making this change.

j. Reporting of Terminations Triggered by Nonsufficient Funds

The next suggestion discussed was to separate reporting of terminations triggered by nonsufficient funds and the insured's request. Ms. Rebholz explained this data is already broken out by number of cancellations for non-pay or nonsufficient funds and number of cancellations at the insured's request. There was no further discussion raised in making changes here.

k. MD&A Section

The next suggestion discussed was to add the submission of a management discussion and analysis (MD&A) section. This was discussed during the Working Group's May 27 conference call, and the Working Group decided this suggestion would be passed to the Market Analysis Procedures (D) Working Group.

l. Lawsuits Closed With Consideration for the Consumer

The next suggestion discussed was to add a data element to reflect lawsuits closed with consideration for the consumer and adjust wording of lawsuits to make it consistent across all lines of business. The decision was made to add a question for

lawsuits closed with consideration for the consumer for the homeowners line and to change the wording of lawsuits questions to use "lawsuits" versus "suits" and consistent definitions across the lines of business.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add the "number of lawsuits closed with consideration for the consumer," to adjust the wording to say "lawsuits" instead of "suits" and to keep the definitions consistent to the other lines of business. The motion passed unanimously.

m. Non-Renewals and Digital Claims

The next topic discussed was the letter received from Birny Birnbaum (Center for Economic Justice—CEJ). Mr. Birnbaum said that the auto and homeowners blanks have data elements for company-initiated non-renewals during the period. He said it would be useful to get more granular information on the cause of non-renewals to see what is driving them and suggested four buckets: 1) non-renewals based in whole or in part on claims history; 2) non-renewals based on catastrophe risk exposure; 3) non-renewals based on changes in credit score other algorithm using non-insurance personal consumer information; and 4) all other company-initiated non-renewals. The proposal has definitions for each bucket to ensure they are mutually exclusive and to avoid overlap.

Ms. Nickel asked the NAIC if this would change any of the current ratios being used. Teresa Cooper (NAIC) said it would not cause any issues with any current ratios.

Ms. Brown said the insurers she communicated with on this suggestion indicated they do not capture this information in their systems. They said they do not code the reasons for non-renewals as outlined in this suggestion. Mr. Birnbaum advised the MCAS timeline is set up the way it is to give companies time to prepare their systems to collect the data being requested in the future. After further discussion among Working Group members and interested parties, it was suggested that this suggestion would be tabled for future discussion and review. There was no motion to make changes here.

Ms. Rebholz advised there was also a suggestion by Mr. Birnbaum regarding breaking claims elements into digital claims versus other than digital claims. Mr. Birnbaum said unless there was a member of the Working Group that has an interest in this, it can also be tabled for future discussion. Ms. Nickel said she likes the idea and agrees it should be reviewed in the future. She expressed interest in knowing about inspections on structures for homes, specifically regarding claims and whether adjusters are looking at the damages. She asked how this would apply to personal property. Mr. Birnbaum advised it would apply in the same way as it would to structural damage—for example, if your home was hit by a hurricane and you sent pictures of the damage, and the claim was settled based on the pictures.

Ms. Brown said that homeowners and auto writers she discussed this with indicated they have a lot of claims that would have aspects of both, where initially they would accept a drone assessment of the policyholder's loss but then later an adjuster is sent to inspect the damage. The same thing happens with auto claims, where initially the policyholder sends photos and then goes to a body shop, and then subsequent damage is found at the body shop. She said having these things be a part of the future discussion would be appreciated. Ms. Nickel said she sees a lot more of the drone use or use of Google images of homes before they are damaged. Carriers sometimes assess damage based on an older image that was taken years prior to the loss. Mr. Birnbaum said the definitions address some of the issues raised. He also said the National Insurance Crime Bureau (NICB) has a database of aerial photography. The NICB has planes flying over the country taking high-resolution photographs of properties that show resolution within two to three inches of every part of the country. It can use this to show the condition before a hurricane, and then a drone can look at the condition afterwards. This topic was tabled for future discussion.

2. Adopted Edits to the LPI MCAS Regarding Blanket VSI

Ms. Rebholz said that a subject matter expert (SME) group has discussed the lender-placed insurance (LPI) auto and home reporting issue for vendor single interest (VSI) products. The meeting material attachments four and five show redline copies of the LPI blank and data call and definitions that the SME group proposed. The proposal is to add separate reporting for blanket VSI auto and blanket VSI home. Mr. Birnbaum pointed out that the mock-up of the data call and definitions should be updated to have the new interrogatory wording consistent with those added in the blank. Each should say "Blanket Vendor" Single Interest.

Mr. Haworth said several different parties and state insurance regulators have reviewed and provided input on these proposed changes. Ms. Brown said the APCIA supports the proposal. Tom Keepers (Consumer Credit Industry Association—CCIA)

said that while the CCIA was a part of the SME group and appreciated the collaboration on defining the data elements and being able to contribute to the process, the CCIA is still not supportive of reporting VSI.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add separate reporting for blanket VSI auto and blanket VSI home, with interrogatory questions to be added for each additional coverage and additional columns to be added for the reporting of data. The motion passed unanimously.

3. Adopted a Motion to Add an Interrogatory for the Homeowners and Auto MCAS

Tanya Sherman (INS Companies) said that during the life and annuity conference calls last week, the Working Group agreed that third-party administrators (TPAs) would be added to the interrogatories. She said that during the conference calls today and yesterday, the Working Group agreed to add MGAs for property/casualty (P/C). She asked if also adding TPAs and not just MGAs to the P/C reporting would be appropriate. Ms. Nickel said she does not see a lot of TPA usage in Idaho Mr. Haworth said Washington sees a lot of TPA use, and it has companies that contract out a lot of services either for underwriting or claim handling.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add an interrogatory for the homeowners and auto MCAS asking if the company uses a TPA, and if so, to list the name and function. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Lines of Business: Individual Life Cash Value Products
Individual Life Non-Cash Value Products
~~Individual Fixed Annuities~~
Individual Indexed Fixed Annuities
Individual Other Fixed Annuities
~~Individual Variable Annuities~~
Individual Indexed Variable Annuities
Individual Other Variable Annuities

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Life and Annuity Product Types

Product Identifiers	Explanation of Product Identifiers
ICVP	Individual Life Cash Value Products (Includes Variable Life, Universal Life, Variable Universal Life, Term Life with Cash Value, Whole Life, & Equity Index Life)
INCVP	Individual Life Non-Cash Value Products (Any life insurance policy that does not contain a cash value element)
~~IFA~~	~~Individual Fixed Annuities (Includes Equity Index Annuity Products)~~
IIFA	Individual Indexed Fixed Annuities
IOFA	Individual Other Fixed Annuities
~~IVA~~	~~Individual Variable Annuities~~
IIVA	Individual Indexed Variable Annuities
IOVA	Individual Other Variable Annuities

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Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Schedule 1A—Life Interrogatories

ID	Description	Comments
1A-01	Individual Life Cash Value – Does the company have data to report for this product type?	Yes/No
1A-02	Individual Life Non-Cash Value – Does the company have data to report for this product type?	Yes/No
1A-03	Is there a reason that the reported Individual Life Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
1A-04	If yes, add additional comments	Comment
1A-05	Is there a reason that the reported Individual Life Non-Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
1A-06	If yes, add additional comments	Comment
1A-07	Does the company use third party administrators (TPAs) for purposes of supporting the individual life business being reported?	Yes/No
1A-08	If yes, provide the names and functions of each TPA.	Comment
1A-09	Individual Life Cash Value comments	Comment
1A-10	Individual Life Non-Cash Value comments	Comment

Schedule 1B—Individual Life Cash Value (ICVP) and Non-Cash Value (INCVP) Products

ID	Description
1B-11	Number of New Replacement Policies Issued During the Period (Include only the number of replacement insurance policies issued)
1B-12	Number of Internal Replacements Issued During the Period
	~~Number of External Replacements Issued During the Period~~
1B-13	Number of External Replacements of Unaffiliated Company Policies Issued During the Period.
1B-14	Number of External Replacements of Affiliated Company Policies Issued During the Period.
1B-15	Number of Policies Replaced Where Age of Insured at Replacement was <65 (Only applies to ICVP)
1B-16	Number of Policies Replaced Where Age of Insured at Replacement was Age 65 and Over (Only applies to ICVP)
1B-17	Number of Policies Surrendered Under 2 Years from Policy Issue (Only applies to ICVP)

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Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

1B-18	Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue (Only applies to ICVP)
1B-19	Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue (Only applies to ICVP)
1B-20	Number of Policies Surrendered More Than 10 Years from Policy Issue (Only applies to ICVP)
1B-21	Total Number of Policies Surrendered During the Period (Only applies to ICVP)
1B-22	Number of Policies Surrendered with a Surrender Fee (Only applies to ICVP)
1B-23	Number of Policies Issued During the Period where age of insured at issue was <65 (Only applies to ICVP)
1B-24	Number of Policies Issued During the Period where age of insured at issue was Age 65 and over (Only applies to ICVP)
1B-25	Total Number of New Policies Issued by the Company During the Period
1B-26	Number of Policies Applied for During the Period
1B-27	Number of Free Looks During the Period
1B-28	Number of Policies In-Force at the End of the Period (The number of active policies that the company has outstanding at the end of the reporting period)
1B-29	Dollar Amount of Direct Premium During the Period
1B-30	Dollar Amount of Insurance Issued During the Period (Face Amount)
1B-31	Dollar Amount of Insurance In-Force at the End of the Period (Face Amount)
1B-32	Number of Complaints Received Directly from Any Person or Entity Other than the DOI
1B-33	Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the claim was received)
1B-34	Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the claim was received)
1B-35	Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the claim was received)
1B-36	Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the date of due proof of loss occurred)
1B-37	Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the date of due proof of loss occurred)
1B-38	Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the date

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	of due proof of loss occurred)
1B-39	Number Of Death Claims Denied, Resisted or Compromised During The Period
1B-40	Number of Death Claims Closed With Payment During the Period, Which Occurred Within the Contestability Period
1B-41	Number of Death Claims Denied During the Period, Which Occurred Within the Contestability Period
1B-42	Total Number of Death Claims Received During the Period (Include any claim received during the period as determined by the first date the claim was opened on the company system)
1B-43	Number of Lawsuits Open At the Beginning of the Period
1B-44	Number of Lawsuits Opened During the Period
1B-45	Number of Lawsuits Closed During the Period
1B-46	Number of Lawsuits Closed During the Period with Consideration for the Customer
1B-47	Number of Lawsuits Open at the End of the Period

Schedule 2A—Annuity Interrogatories

ID	Description	Comments
	~~Individual Fixed Annuities – Does the company have data to report for this product type?~~	~~Yes/No~~
2A-01	Individual Indexed Fixed Annuities – Does the company have data to report for this product type?	Yes/No
2A-02	Individual Other Fixed Annuities – Does the company have data to report for this product type?	Yes/No
	~~Individual Variable Annuities – Does the company have data to report for this product type?~~	~~Yes/No~~
2A-03	Individual Indexed Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-04	Individual Other Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-05	Is there a reason that the reported Individual (Indexed or Other) Fixed Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
2A-06	If yes, add additional comments	Comment
2A-07	Is there a reason that the reported Individual (Indexed or Other) Variable Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No

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2A-08	If yes, add additional comments	Comment
2A-09	Does the company use third party administrators (TPAs) for purposes of supporting the individual annuity business being reported?	Yes/No
2A-10	If yes, provide the names and functions of each TPA.	Comment
2A-11	Individual Fixed Annuities comments	Comment
2A-12	Individual Variable Annuities comments	Comment

Schedule 2B—~~Individual Fixed Annuity (IFA) and Individual Variable Annuity (IVA) Products~~—Individual Indexed Fixed Annuities (IIFA), Individual Other Fixed Annuities (IOFA), Individual Indexed Variable Annuities (IIVA), and Individual Other Variable Annuities (IOVA)

ID	Description
2B-13	Number of New Replacement Contracts Issued During the Period (Include only the number of replacement annuity contracts issued)
2B-14	Number of Internal Replacement Contracts Issued During the Period
	~~Number of External Replacement Contracts Issued During the Period~~
2B-15	Number of External Replacements of Unaffiliated Company Contracts Issued During the Period.
2B-16	Number of External Replacements of Affiliated Company Contracts Issued During the Period.
2B-17	Number of Contracts Replaced Where Age of Annuitant at Replacement was < 65
2B-18	Number of Contracts Replaced Where Age of Annuitant at Replacement was 65 to 80
2B-19	Number of Contracts Replaced Where Age of Annuitant at Replacement was > 80
2B-20	Number of New Immediate Contracts Issued During the Period
2B-21	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was < 65
2B-22	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
2B-23	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
2B-24	Total Number of New Deferred Contracts Issued By the Company During the Period
2B-25	Number of Contracts Surrendered Under 2 Years from Issuance
2B-26	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
2B-27	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance
2B-28	Number of Contracts Surrendered Over 10 Years from Issuance
2B-29	Total Number of Contracts Surrendered During the Period
2B-30	Total Number of Contracts Surrendered with a Surrender Fee
2B-31	Number of Contracts Applied for During the Period
2B-32	Number of Free Looks During the Period
2B-33	Number of Contracts In-Force at the End of the Period (The number of active

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	contracts that the company has outstanding at the end of the reporting period)
2B-34	Dollar Amount of Annuity Considerations During the Period
2B-35	Number of Complaints Received Directly From Any Person or Entity Other than the DOI
2B-36	Number of Lawsuits Open At the Beginning of the Period
2B-37	Number of Lawsuits Opened During the Period
2B-38	Number of Lawsuits Closed During the Period
2B-39	Number of Lawsuits Closed During the Period with Consideration for the Customer
2B-40	Number of Lawsuits Open at the End of the Period

Definitions:

External Replacement - An external replacement is when the policy and/or annuity to be replaced was issued by another company.

External Replacement of Affiliated Company Policies – An external replacement of an affiliated company policy is when the policy and/or annuity to be replaced was issued by a company affiliated to the MCAS reporting company.

External Replacement of Unaffiliated Company Policies – An external replacement of an unaffiliated company policy is when the policy and/or annuity to be replaced was issued by a company not affiliated to the MCAS reporting company.

Individual Indexed Fixed Annuity – A fixed annuity whose accumulation or policy value is, in whole or in part, linked to an index or indices and offers principal protection. Indexed fixed annuities include equity indexed annuities or fixed indexed annuities that offer principal protection through a 0% floor feature.

Individual Indexed Variable Annuity – A variable annuity whose accumulation or policy value is, in whole or in part, linked to an index or indices and offers some principal protection. Variable indexed annuities include buffer annuities or registered index-linked annuity that offer some principal protection but do not provide a guaranty against loss of principal.

Internal Replacement - An internal replacement is when the policy and/or annuity to be replaced was also issued by your company.

Lawsuit—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.

For purposes of reporting lawsuits for Life & Annuities products:

- 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;

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

Lawsuits Closed During the Period with Consideration for the Consumer—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.

Replacement Policy – A policy and/or annuity contract application received by your company that is intended to replace an existing policy and/or annuity contract according to each states definition of a replacement. This may include both external and internal replacements according to each state's replacement law.
Include:

- loan purchases, if the original policy is surrendered,
- surrenders, if a replacement policy is issued in conjunction with the surrender
- 1035 exchanges

Do not include:

- policy conversions
- exchanges of a group policy for an individual policy

Surrendered Policy/Contract – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as "surrenders" for this statement.

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Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Line of Business: Homeowners

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1—Interrogatories

ID	Description	Comment
1-01	Were there policies in-force during the reporting period that provided Dwelling coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Personal Property coverage?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Liability coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Loss of Use coverage?	Yes/No
1-06	Was the Company still actively writing policies in the state at year end?	Yes/No
1-07	Does the Company write in the non-standard market?	Yes/No
1-08	If yes, what percentage of your business is non-standard?	Comment
1-09	If yes, how is non-standard defined?	Comment
1-10	Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No	Yes/No
1-11	If yes, add additional comments	Comment
1-12	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-13	If yes, add additional comments	Comment
1-14	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment
1-15	Does the company use Managing General Agents (MGAs)?	Yes/No
1-16	If yes, list the names of the MGAs.	Comment
1-17	Does the company use Third Party Administrators (TPAs)?	Yes/No

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Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

1-18	If yes, list the names of the TPAs.	Comment
1-19	Claims Comments	Comment
1-20	Underwriting Comments	Comment

Coverages

Dwelling (includes – Other Structures)
Personal Property
Liability
Medical Payments
Loss of Use

Schedule 2—Homeowners Claims Activity, Counts Reported by Claimant and by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two liability claimants, two medical payment claims, one dwelling claim for the insured, and one personal property claim for the insured, you would report as follows: Dwelling – 1; Personal Property – 1; Liability – 2; Medical Payments – 2. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

ID	Description
2-21	Number of claims open at the beginning of the period
2-22	Number of claims opened during the period
2-23	Number of claims closed during the period, with payment
2-24	Number of claims closed during the period, without payment
2-25	Number of claims open at the end of the period
2-26	Median days to final payment
2-27	Number of claims closed with payment within 0-30 days
2-28	Number of claims closed with payment within 31-60 days
2-29	Number of claims closed with payment within 61-90 days
2-30	Number of claims closed with payment within 91-180 days
2-31	Number of claims closed with payment within 181-365 days
2-32	Number of claims closed with payment beyond 365 days
2-33	Number of claims closed without payment within 0-30 days
2-34	Number of claims closed without payment within 31-60 days
2-35	Number of claims closed without payment within 61-90 days
2-36	Number of claims closed without payment within 91-180 days

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2-37	Number of claims closed without payment within 181-365 days
2-38	Number of claims closed without payment beyond 365 days
2-39	Number of lawsuits open at beginning of the period
2-40	Number of lawsuits opened during the period
2-41	Number of lawsuits closed during the period
2-42	Number of lawsuits open at end of period
2-43	Number of lawsuits closed with consideration for the consumer.

Schedule 3—Homeowners Underwriting Activity

ID	Description
3-44	Number of dwellings which have policies in-force at the end of the period
	~~Number of policies in-force at the end of the period~~
3-45	Number of dwelling fire policies in force at the end of the period.
3-46	Number of homeowner policies in force at the end of the period.
3-47	Number of tenant/renter/condo policies in force at the end of the period.
3-48	Number of all other residential property policies in force at the end of the period.
3-49	Number of new business policies written during the period
3-50	Dollar amount of direct premium written during the period
3-51	Number of Company-Initiated non-renewals during the period
3-52	Number of cancellations for non-pay or non-sufficient funds
3-53	Number of cancellations at the insured's request
3-54	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-55	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-56	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-57	Number Of Complaints Received Directly From Any Person or Entity Other than the DOI

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Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

Definitions:

Dwelling Fire ~~and Dwelling Liability~~ Policies – Coverage for dwellings and their contents. It may also provide liability coverage and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner's policy, or because of a requirement for the insured to select several different kinds of coverage and limits on this protection.

Include:
- Dwelling Fire and Dwelling Liability policies should be included ONLY IF the policies written under these programs are for personally occupied residential dwellings, not policies written under a commercial program and/or on a commercial lines policy form.

Homeowners Policies – Policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses.

Include:
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
- Renters insurance, policies covering log homes, land homes, and site built homes are included.
- Inland Marine or Personal Articles endorsements.
- Include policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms.

Exclude:
- Farmowners is not included as it is considered to be Commercial Lines for purposes of this project.
- Umbrella policies.
- Lender-placed or creditor-placed policies.

Lawsuit—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.

For purposes of reporting lawsuits for Life & Annuities products:

- 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;
- 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

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lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;

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

Lawsuits Closed During the Period with Consideration for the Consumer—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.

Tenant/Renters/Condo Policies – Policies that provide coverage for the personal property of tenants, renters, condominium and cooperative unit owners. Include policies typically written on the HO-4 and HO-6 policy forms.

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Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Line of Business: Private Passenger Auto

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1—Interrogatories

ID	Description	Comments
1-01	Were there policies in-force during the reporting period that provided Collision coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Comprehensive/Other Than Collision coverage?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Bodily Injury coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Property Damage coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?	Yes/No
1-06	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?	Yes/No
1-07	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-08	Were there policies in-force during the reporting period that provided Combined Single Limits coverage?	Yes/No
1-09	Were there policies in-force during the reporting period that provided Personal Injury Protection coverage?	Yes/No
1-10	Was the Company still actively writing policies in the state at year end?	Yes/No
1-11	Does the Company write in the non-standard market?	Yes/No
1-12	If yes, what percentage of your business is non-standard?	Percentage
1-13	If yes, how is non-standard defined?	Comment

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Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

1-14	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-15	If yes, add additional comments	Comment
1-16	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-17	If yes, add additional comments	Comment
1-18	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment
1-19	Does the company use Managing General Agents (MGAs)?	Yes/No
1-20	If yes, list the names of the MGAs.	Comment
1-21	Does the company use Third Party Administrators (TPAs)?	Yes/No
1-22	If yes, list the names of the TPAs.	Comment
1-23	Does the company use telematics or usage-based data?	Yes/No
1-24	Claims Comments	Comment
1-25	Underwriting Comments	Comment

Coverages

Collision
Comprehensive/Other Than Collision
Bodily Injury
Property Damage
Uninsured Motorists and Underinsured Motorists (UMBI)
Uninsured Motorists and Underinsured Motorists (UMPD)
Medical Payments
Combined Single Limits
Personal Injury Protection

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Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Schedule 2—Private Passenger Auto Claims Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two bodily injury claimants (one property damage claimant, one collision claim for the insured, and one medical payment claim for the insured), it would be reported as follows: Collision – 1, Bodily Injury – 2; Property Damage – 1; and Medical Payments – 1. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

ID	Description
2-26	Number of claims open at the beginning of the period
2-27	Number of claims opened during the period
2-28	Number of claims closed during the period, with payment
2-29	Number of claims closed during the period, without payment.
2-30	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.
2-31	Number of claims remaining open at the end of the period
2-32	Median days to final payment
2-33	Number of claims closed with payment within 0-30 days
2-34	Number of claims closed with payment within 31-60 days
2-35	Number of claims closed with payment within 61-90 days
2-36	Number of claims closed with payment within 91-180 days
2-37	Number of claims closed with payment within 181-365 days
2-38	Number of claims closed with payment beyond 365 days
2-39	Number of claims closed without payment within 0-30 days
2-40	Number of claims closed without payment within 31-60 days
2-41	Number of claims closed without payment within 61-90 days
2-42	Number of claims closed without payment within 91-180 days
2-43	Number of claims closed without payment within 181-365 days
2-44	Number of claims closed without payment beyond 365 days
2-45	Number of lawsuits open at beginning of the period
2-46	Number of lawsuits opened during the period
2-47	Number of lawsuits closed during the period
2-48	Number of lawsuits open at end of period
2-49	Number of lawsuits closed with consideration for the consumer.

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Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

Schedule 3—Private Passenger Auto Underwriting

ID	Description
3-50	Number of autos which have policies in-force at the end of the period
3-51	Number of policies in-force at the end of the period
3-52	Number of new business policies written during the period
3-53	Dollar amount of direct premium written during the period
3-54	Number of Company-Initiated non-renewals during the period
3-55	Number of cancellations for non-pay or non-sufficient funds
3-56	Number of cancellations at the insured's request
3-57	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-58	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-59	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-60	Number of complaints received directly from any person or entity other than the DOI

Definitions:

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also "Date of Final Payment".

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarifications:

- If a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.

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- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:
- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling Additional Payment on Previously Reported Claim/Subsequent Supplemental Payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also "Date of Final Payment".

Include:
- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- ~~Claims that are closed because the amount claimed is below the insured's deductible.~~

Lawsuit—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.

For purposes of reporting lawsuits for Life & Annuities products:

- 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;

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- Do not include arbitrations of any sort;
- 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;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- 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.

Lawsuits Closed During the Period with Consideration for the Consumer—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.

Telematics and Usage-Based Data – Data which is collected through devices installed in a vehicle, through mobile applications, or other method. These devices then transmit the data in real time back to insurers. Examples of usage-based data collected via telematics includes - but is not limited to - miles driven, time of day, where the vehicle is driven (Global Positioning System or GPS), rapid acceleration, hard braking, hard cornering and air bag deployment.

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