NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft date: 3/31/25

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Thursday, April 3, 2025
3:00 – 4:00 p.m. ET / 2:00 – 3:00 p.m. CT / 1:00 – 2:00 p.m. MT / 12:00 – 1:00 p.m. PT

ROLL CALL

Joshua Guillory, Chair	Louisiana	Hermoliva Abejar	Nevada
Tolanda Coker, Vice Chair	Arizona	Alma Tapia	New Mexico
Teri Ann Mecca/Lori Plant	Arkansas	Guy Self	Ohio
Sheryl Parker	Florida	Gary Jones/August Hall/ Karen Veronikis	Pennsylvania
Elizabeth Nunes/ Paula Shamburger	Georgia	Gwendolyn Fuller-McGriff/ Rachel Moore	South Carolina
Chris Heisler	Illinois		
Charles Thomas	Kansas	Larry D. Deiter	South Dakota
Lori Cunningham	Kentucky	Rhonda Bowling-Black	Tennessee
Raymond A. Guzman	Maryland	Shelley Wiseman	Utah
Mary Lou Moran	Massachusetts	Melissa Gerachis	Virginia
Jeff Hayden	Michigan	John Kelcher	Washington
Jo A. LeDuc/Julie Hesser	Missouri	Letha Tate	West Virginia
Martin Swanson	Nebraska	Rebecca Rebholz	Wisconsin

NAIC Support Staff: Teresa Cooper/Hal Marsh

AGENDA

1. Consider Adoption of its March 6 Minutes—*Joshua Guillory (LA)* — Attachment 1

2. Receive an Update from the Subject Matter Expert (SME) Group Reviewing the Other Health Market Conduct Annual Statement (MCAS) Blank —*Mary Kay Rodriguez (WI)* — Attachments 2 & 3

3. Consider Adoption of the MCAS Private Passenger Auto (PPA) Proposal Received from the SME Group—*Joshua Guillory (LA)* — Attachment 4

4. Discuss Comments and Questions Regarding the Travel MCAS Blank —*Joshua Guillory (LA)* — Attachment 5

5. Discuss Comments Received on the MCAS Blanks Proposal Form for the Definition of Cancellations on the MCAS Lender-Placed Insurance (LPI) Blank —*Joshua Guillory (LA)* — Attachments 6 & 7

6. Discuss Any Other Matters Brought Before the Working Group
   —*Joshua Guillory (LA)*

7. Adjournment

Draft: 3/21/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
March 6, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 6, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Sheryl Parker and Rachael Lozano (FL); Elizabeth Nunes and Paula Shamburger (GA); Chris Heisler (IL); Lori Cunningham (KY); Raymond A. Guzman (MD); Jeff Hayden (MI); Jo A. LeDuc (MO); Guy Self (OH); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); John Kelcher (WA); Rebecca Rebholz and Mary Kay Rodriguez (WI); and Letha Tate (WV). Also participating were Susan Jennette (DE) and Brian Werbeloff (RI).

1. Discussed its 2025 Charges

Guillory said the Working Group has two charges for 2025. The first is to review the data elements, data calls, and definitions for lines of business that have been in effect for more than three years and to update them as needed. The second charge is to develop a Market Conduct Annual Statement (MCAS) blank to collect data for additional lines of business where appropriate.

2. Adopted its Dec. 5, 2024, Minutes

The Working Group met Dec. 5, 2024, and took the following action: 1) adopted its Sept. 5 minutes; 2) received an update from the subject matter expert (SME) group that is reviewing the other health MCAS blank, discussed topics where Working Group feedback is needed, and the removal of duplicate data element No. 51 from the other health MCAS; 3) received an update on the formation of an SME group to review the private passenger auto (PPA) MCAS blank and the draft FAQ and definitions of artificial intelligence (AI) and machine learning (ML); 4) discussed comments regarding the travel MCAS blank; and 5) discussed the definition of cancellations on the MCAS lender-placed insurance (LPI) blank.

Gerachis made a motion, seconded by Wiseman, to adopt the Working Group's Dec. 5 minutes. The motion passed unanimously.

3. Received an Update from the SME Group Reviewing the Other Health MCAS Blank

Rodriguez said the other health MCAS SME group met Feb. 20. During this meeting, the group completed its review of the other health MCAS blank. The SME group is currently reviewing its final recommendations and intends to submit the updated blank, along with its proposed edits and additions to the definitions, to the Working Group by the April 2025 meeting. The SME group plans to conclude its discussions about collecting employer group data on the blank at next week's SME group meeting.

4. Received Recommendations from the SME Group Reviewing the PPA MCAS Blank

Guillory said the group completed its review of the PPA MCAS blank and recommended several updates. He requested the Working Group, interested regulators, and interested parties review the redlined version of the proposed changes to the blank and send their comments to Hal Marsh (NAIC) by March 20.

5. Discussed Comments and Questions Regarding the Travel MCAS Blank

Rebholz said that during its Dec. 5, 2024, meeting, the Working Group was presented with comments and questions regarding the travel MCAS blank from Caren Alvarado (Crum & Forster). It was suggested that an SME group be formed to address those questions and comments; however, because the minimum number of Working Group jurisdictions did not volunteer to participate, the SME group was not formed. Rebholz said Crum & Forster's comments and questions will be brought to the Working Group to determine the next steps.

In an email on Nov. 11, 2024, Alvarado provided the following issues that needed clarification:

- There are several items in the claims section that rely on when a claim is reported or the date a claim is opened. Not all claims administrators record this information in the same way.
- Interrogatories ask about a third-party administrator (TPA) and, separately, ask about an administrator.
- Interrogatories ask about managing general agents (MGAs) but not producers. They are defined differently. (As an example, we work with many producers but only one MGA.)
- Not all partners capture losses separately for each person.
- Other items, such as the number of days to closure, is impacted when the date the claim is reported or open is captured in different ways by different partners.
- Claims closed does not take into account when the claim became clean, so numbers are often skewed. 7. Lawsuits are asked to be reported based on the number of policies or the number of people party to the suit. That is not how it is captured currently.

Alverado explained that these questions arose after issues were raised following some MCAS reporting. It became clear through discussion with certain states that not everyone interpreted the information the same way, which led to the decision to send this list of questions. Alverado explained that this issue stems from the *Travel Insurance Model Act* (#632), which is currently in effect in 37 states and pending in several others. Since travel insurance operates differently, the law includes specific definitions for terms such as travel administrator, producer, and MGA. Many questions reference a TPA separately from a travel administrator. However, because travel insurance is an inland marine product, TPAs are not typically involved. Without clear definitions, the question becomes complex and may lead to redundant or inconsistent responses from different industry professionals interpreting it differently.

Alvarado added that there is no question addressing clean claims. Without this clarification, the data could be misleading, making it appear that a claim sat unresolved for an extended period when, in reality, it was awaiting the necessary information to be classified as a clean claim.

Guillory reminded the group that at least five working group jurisdictions typically need to volunteer and participate in SME groups, and one is needed for this topic.

6. Discussed the Definition of a Lawsuit in the Pet MCAS Data Call and Definitions

Teresa Cooper (NAIC) explained that when the Working Group was working on the pet data column definitions, it coincided with discussions about changes to the definition of "lawsuit." As part of those discussions, a specific bullet point was removed from all other lines of business but was not removed from the pet definition. It states, "for non-claim related lawsuits include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plain as a plaintiff against the reporting insurer as a defendant." Since this language was removed from all other lines of business, Cooper asked the Working Group to consider removing it from the pet definition for consistency.

Cooper said if the Working Group was comfortable with the change, then it should proceed with a motion. Guillory asked for any comments or questions.
Self made a motion, seconded by Dorschner, to delete the bullet and give the guidance as Cooper specified. The motion passed unanimously.

7. Discussed the MCAS Blanks Proposal Form for the Definition of Cancellations on the MCAS LPI Blank

Guillory stated that in December, the Working Group was informed of an issue with the definitions of cancellations on the LPI blank, which was skewing certain ratios involving certificates. A proposal was introduced outlining changes to the existing definitions, new definitions for consideration, and additional data elements to be included in the LPI blank.

Guillory requested the Working Group review the proposal and submit any comments to Marsh by March 20.

Guillory further explained that the issue stemmed from certificates being categorized as cancellations, even when the data was only meant to capture overall cancellations. Guillory then invited comments or questions from Working Group members or other regulators regarding the definitions or the issue as a whole.

Guzman clarified that the primary concern was that some carriers reported all certificates as canceled at the end of the year and then reissued them at the beginning of the year as part of a standard process. This practice led to an overinflated number of reported cancellations.

Guillory reiterated the request for the Working Group to review the proposal and submit any comments or questions to Marsh by March 20.
Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

MCAS Market Conduct Annual Statement

Other Health Insurance (2026)

Other Health Insurance Interrogatories

	Interrogatories - Individual Products	Yes/No Response	Explanation
01	Accident Only: Were there policies in force during the reporting period?		--
02	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
03	Accident Only: Do the reported products include closed or frozen blocks of business?		--
04	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
05	Accidental Death and Dismemberment: Were there policies in force during the reporting period?		--
06	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
07	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
08	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
09	Specified Disease – Limited Benefit/Critical Illness: Were there policies in force during the reporting period?		--
10	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
11	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
12	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
13	Hospital/Other Indemnity: Were there policies in force during the reporting period?		--
14	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
15	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
16	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
17	Hospital/Surgical/Medical Expense: Were there policies in force during the reporting period?		--
18	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
19	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
20	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
21	Has the company had a significant event/business strategy change that would affect the Individual product data reported this period?		--
22	If yes, explain the situation and how it may affect the data	--	
23	Additional jurisdiction-specific Individual product comments (optional):	--	

	Interrogatories - Associations/Trusts Products	Yes/No Response	Explanation
24	Accident Only: Were there policies/certificates in force during the reporting period?		--
25	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
26	Accident Only: Do the reported products include closed or frozen blocks of business?		--
27	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
28	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?		--
29	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
30	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
31	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
32	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?		--
33	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
34	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
35	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
36	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?		--
37	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
38	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
39	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
40	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?		--
41	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
42	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
43	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
44	Does the company have a contractual relationship (outside or in addition to the group policies issued to the Association/Trust) with each Association/Trust?		--
45	Does the company delegate authority to any of the associations/trusts to market products?		--
46	If yes, does the company conduct compliance audits of all associations/trusts allowed to market products?		--
47	Does the company delegate authority to any of the associations/trusts to collect policy or contract premiums?		--
48	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect policy or contract premiums?		--
49	Does the company delegate authority to any of the associations/trusts to collect and pay commissions?		--
50	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect and pay commissions?		--

Other Health Insurance (2026)		
51 Does the company delegate authority to any of the associations/trusts to adjudicate claims?		--
52 If yes, does the company conduct compliance audits of all associations/trusts allowed to adjudicate claims?		--
53 Has the company had a significant event/business strategy change that would affect the Associations/Trusts product data reported this period?		--
54 If yes, explain the situation and how it may affect the data	--	
55 Additional jurisdiction-specific Associations/Trusts product comments (optional):	--	
Interrogatories - Employer Group Products	Yes/No Response	Explanation
56 Accident Only: Were there policies/certificates in force during the reporting period?		--
57 Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
58 Accident Only: Do the reported products include closed or frozen blocks of business?		--
59 Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
60 Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?		--
61 Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
62 Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
63 Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
64 Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?		--
65 Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
66 Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
67 Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
68 Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?		--
69 Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
70 Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
71 Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
72 Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?		--
73 Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
74 Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
75 Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
76 Does the company allow any of the Employer Groups to adjudicate claims?		--
77 If yes, does the company have a contractual relationship (outside or in addition to the group policy issued to the Employer Group) with each Employer Group with this delegated authority?		--
78 If yes, does the company conduct compliance audits of all Employer Groups allowed to adjudicate claims?		--
79 Has the company had a significant event/business strategy change that would affect the Employer Group product data reported this period?		--
80 If yes, explain the situation and how it may affect the data	--	
81 Additional jurisdiction-specific Employer Group product comments (optional):	--	
Interrogatories - Third-Party Administrators/Vendors	Yes/No Response	Explanation
82 Does the company contract with third-parties, either third-party administrators or other vendors (other than Associations/Trusts and Employer Groups) for any administrative services related to Other Health products?		--
83 If yes, does the company issue any Other Health products through administrators/TPAs?		--
84 If yes, does the company contract any claims services related to Other Health products?		--
85 If yes, does the company contract any complaints handling related services related to Other Health products?		--
86 If yes, does the company contract any medical underwriting services related to Other Health products?		--
87 If yes, does the company contract any pricing services related to Other Health products?		--
88 If yes, does the company contract any producer appointment services related to Other Health products?		--
89 If yes, does the company contract any marketing, advertisement, or lead generation, services related to Other Health products?		--
90 If yes, does the company contract any policyholder services related to Other Health products?		--
91 If yes, does the company contract any premium collection services related to Other Health products?		--
92 If yes, does the company conduct compliance audits of all third parties to whom responsibilities have been delegated?		--
93 Additional jurisdiction-specific Third-Party Administrators/Vendors comments (optional):	--	
Interrogatories - General	Yes/No Response	Explanation
94 Does your company distribute its product through independent agents?		--
95 Does your company distribute its products through captive agents?		--
96 Does your company distribute its products through its employees?		--
97 Does the company contract with producers to collect premium or bind coverage on behalf of the company?		--
98 Does the company charge fees (other than commissions) to applicants or policyholders/certificate holders that are included in reported premium?		--
99 Additional jurisdiction-specific General comments (optional):	--	

Other Health Insurance (2026)

Policy/Certificate Administration

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
100	Direct Written Premium.															
101	Earned premiums for reporting year.															
102	Number of policies/certificates in force at the beginning of the period.															
103	Number of covered lives on policies/certificates in force at the beginning of the period.											--	--	--	--	--
104	Number of new policy/certificate applications/enrollments received during the period.															
105	Number of new policy/certificates issued during the period.															
106	Number of covered lives on new policies/certificates issued during the period.											--	--	--	--	--
107	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period.															
108	Number of policies/certificates cancelled during the free look period.															
109	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period.											--	--	--	--	--
110	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period.															
111	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period.															
112	Number of rescissions during the period.						--	--	--	--	--	--	--	--	--	--
113	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder.											--	--	--	--	--
114	Number of covered lives impacted on terminations and cancellations due to non-payment.											--	--	--	--	--
115	Number of covered lives impacted by rescissions.						--	--	--	--	--	--	--	--	--	--
116	Number of policies/certificates in force at the end of the period.															
117	Number of covered lives on policies/certificates in force at the end of the period.											--	--	--	--	--

Claims Administration (Including Pharmacy)

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
118	Number of claims pending at the beginning of the period.															
119	Total ~~N~~number of claims received (include non-clean claims).															
120	Total number of claims denied, rejected or returned.															
121	Number denied, rejected, or returned as non-covered or maximum benefit exceeded.															
122	Number denied, rejected, or returned as subject to pre-existing condition exclusion.															
123	Number denied, rejected, or returned due to failure to provide adequate documentation.															
124	Number denied, rejected, or returned due to being within the waiting period.		--					--					--			
125	Number of claims pending at the end of the period.															
126	Median number of days from receipt of claim to decision for denied claims.															
127	Average number of days from receipt of claim to decision for denied claims.															
128	Median number of days from receipt of claim to decision for approved claims.															
129	Average number of days from receipt of claim to decision for approved claims.															
130	Number of claims paid (include partially paid claims).															
131	Aggregate dollar amount of paid claims during the period.															
132	Number of claims where the claims payment was reduced by premium owed.															
133	Dollar amount of claims payments applied to unpaid premiums.															

Other Health Insurance (2026)

Consumer Complaints and Lawsuits

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
134	Number of complaints received by Company (other than through the DOI).															
	~~Number of complaints received through DOI.~~															
135	Number of complaints resulting in claims reprocessing.															
136	Number of lawsuits open at the beginning of the period.															
137	Number of lawsuits opened during the period.															
138	Number of lawsuits closed during the period.															
139	Number of lawsuits closed during the period with consideration for the consumer.															
140	Number of lawsuits open at the end of the period.															

Marketing and Sales

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
141	Number of individual applications/enrollments pending at the beginning of the period.															
142	Number of individual applications/enrollments denied during the period for any reason.															
143	Number of individual applications/enrollments denied during the period - health status or condition.															
144	Number of individual applications/enrollments approved during the period.															
145	Number of individual applications/enrollments pending at the end of the period.															
146	Number of applications/enrollments received via phone (audio only) during the period.						--	--	--	--	--	--	--	--	--	--
147	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) during the period.						--	--	--	--	--	--	--	--	--	--
148	Number of applications/enrollments received online (electronically) during the period.						--	--	--	--	--	--	--	--	--	--
149	Number of applications/enrollments received by mail during the period.						--	--	--	--	--	--	--	--	--	--
150	Number of applications/enrollments received by any other method during the period.						--	--	--	--	--	--	--	--	--	--
151	Commissions paid during reporting period (dollar amount of commissions incurred during the period).															
152	Unearned commissions returned to company on policies/certificates sold during the period.															

Other Health Insurance Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
153	First Attestor Information.						--
154	Second Attestor Information.						--
155	Overall Comments for the Filing Period.	--	--	--	--	--	

MCAS Market Conduct Annual Statement

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Line of Business: Other Health Insurance
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: May 31, 2027

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 – Individual Products

ID	Description	Response
1-01	~~Are you currently marketing these products in this jurisdiction?~~ Accident Only: Were there policies in force during the reporting period?	Yes/No
1-02	~~Do the products you are reporting on in response to this blank include closed or frozen blocks of business?~~ Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-03	~~If yes, list the closed or frozen blocks of business?~~ Accident Only: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-04	~~Number of Other Health products offered to residents in this state~~ Accident Only: Do any of the reported products contain pre-existing condition exclusions?	~~Number~~ Yes/No
1-05	~~For products reported to this MCAS jurisdiction, list the states where your Other Health products are filed (provide SERFF tracking number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing.~~ Accidental Death and Dismemberment: Were there policies in force during the reporting period?	~~Comment~~ Yes/No
1-06	~~For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?~~ Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-07	~~If yes, list the associations/trusts.~~ Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-08	~~If yes, do you have a contractual relationship with any association/trust?~~ Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-09	~~If yes, please identify which associations/trusts.~~ Specified Disease – Limited Benefit/Critical Illness: Were there policies in force during the reporting period?	~~Comment~~ Yes/No
1-10	~~If yes, does the contract allow any association/trust to market the product?~~ Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-11	~~If yes, please identify which associations/trusts.~~ Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-12	~~If yes, does the contract allow any association/trust to collect policy or contract premiums?~~ Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-13	~~If yes, does the contract allow any association/trust to collect and pay commissions?~~ Hospital/Other Indemnity: Were there policies in force during the reporting period?	Yes/No
1-14	~~If yes, please identify which associations/trusts.~~ Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	~~Comment~~ Yes/No
1-15	~~If yes, does the contract allow any association/trust to adjudicate claims?~~ Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No
1-16	~~If yes, please identify which associations/trusts.~~ Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-17	~~Has the company filed the associations by-laws and articles of incorporation in their state of domicile?~~ Hospital/Surgical/Medical Expense: Were there policies in force during the reporting period?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-18	~~Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?~~ Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-19	~~If yes please provide the state, and the SERFF tracking number, if applicable~~ Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-20	~~Has the company filed the association by-laws and articles of incorporation in the filing state?~~ Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-21	~~Has the company filed the certificate of insurance in the filing state, if applicable?~~ Has the company had a significant event/business strategy change that would affect the Individual product data reported this period?	Yes/No
1-22	~~Does the company contract with third-party administrators for administrative services related to Other Health products?~~ If yes, explain the situation and how it may affect the data.	~~Yes/No~~ Comment
1-23	~~If yes, does the company issue Other Health products through administrators/TPAs?~~ Additional jurisdiction-specific Individual product comments (optional):	~~Yes/No~~ Comment

Schedule 1 – Interrogatories – Associations/Trusts Products

1-24	~~If yes, how many administrators/TPAs?~~ Accident Only: Were there policies/certificates in force during the reporting period?	~~Number~~ Yes/No
1-25	~~If yes, list the TPAs and provide their respective National Producer Number (NPN), if required by the state.~~ Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	~~Comment~~ Yes/No
1-26	~~If yes, does your company contract claims services related to Other Health products?~~ Accident Only: Do the reported products include closed or frozen blocks of business?	Yes/No
1-27	~~If yes, does your company contract complaints-related services related to Other Health products?~~ Accident Only: Do any of the reported products contain pre-existing condition exclusions?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-28	~~If yes, does your company contract medical underwriting services related to Other Health products?~~ Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?	Yes/No
1-29	~~If yes, does your company contract pricing services related to Other Health products?~~ Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-30	~~If yes, does your company contract producer appointment services related to Other Health products?~~ Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	Yes/No
1-31	~~If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?~~ Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-32	~~If yes, does your company contract policyholder services related to Other Health products?~~ Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?	Yes/No
1-33	~~If yes, does your company contract premium collection services related to Other Health products?~~ Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-34	~~Does your company audit third parties to whom you have delegated responsibilities?~~ Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	Yes/No
1-35	~~If yes, please provide frequency of audits.~~ Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-36	~~Does your company distribute its product through independent agents?~~ Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?	Yes/No
1-37	~~Does your company distribute its products through captive agents?~~ Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-38	~~Does your company distribute its products through its employees?~~ Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-39	~~Does the company use pre-existing condition exclusions?~~ Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-40	~~If yes, identify which products.~~ Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?	~~Comment~~ Yes/No
1-41	~~Does the company contract with producers to collect premium or bind coverage on behalf of the company?~~ Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-42	~~For fees that are included in reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.~~ Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-43	~~For fees not included in the reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.~~ Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-44	~~Additional state specific comments (optional)~~ Does the company have a contractual relationship (outside or in addition to the group policies issued to the Association/Trust) with each Association/Trust?	~~Comment~~ Yes/No
1-45	Does the company delegate authority to any of the associations/trusts to market products?	Yes/No
1-46	If yes, does the company conduct compliance audits of all associations/trusts allowed to market products?	Yes/No
1-47	Does the company delegate authority to any of the associations/trusts to collect policy or contract premiums?	Yes/No
1-48	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect policy or contract premiums?	Yes/No
1-49	Does the company delegate authority to any of the associations/trusts to collect and pay commissions?	Yes/No
1-50	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect and pay commissions?	Yes/No
1-51	Does the company delegate authority to any of the associations/trusts to adjudicate claims?	Yes/No
1-52	If yes, does the company conduct compliance audits of all associations/trusts allowed to adjudicate claims?	Yes/No

1-53	Has the company had a significant event/business strategy change that would affect the Associations/Trusts product data reported this period?	Yes/No
1-54	If yes, explain the situation and how it may affect the data	Comment
1-55	Additional jurisdiction-specific Associations/Trusts product comments (optional):	Comment

Schedule 1 – Interrogatories – Employer Group Products

1-56	Accident Only: Were there policies/certificates in force during the reporting period?	Yes/No
1-57	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-58	Accident Only: Do the reported products include closed or frozen blocks of business?	Yes/No
1-59	Accident Only: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-60	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?	Yes/No
1-61	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-62	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	Yes/No
1-63	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-64	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?	Yes/No
1-65	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-66	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	Yes/No
1-67	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-68	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?	Yes/No
1-69	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-70	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No
1-71	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-72	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-73	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-74	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	Yes/No
1-75	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-76	Does the company allow any of the Employer Groups to adjudicate claims?	Yes/No
1-77	If yes, does the company have a contractual relationship (outside or in addition to the group policy issued to the Employer Group) with each Employer Group with this delegated authority?	Yes/No
1-78	If yes, does the company conduct compliance audits of all Employer Groups allowed to adjudicate claims?	Yes/No
1-79	Has the company had a significant event/business strategy change that would affect the Employer Group product data reported this period?	Yes/No
1-80	If yes, explain the situation and how it may affect the data	Comment
1-81	Additional jurisdiction-specific Employer Group product comments (optional):	Comment

Schedule 1 – Interrogatories – Third Party Administrators/Vendors

1-82	Does the company contract with third-parties, either third-party administrators or other vendors (other than Associations/Trusts and Employer Groups) for any administrative services related to Other Health products?	Yes/No
1-83	If yes, does the company issue any Other Health products through administrators/TPAs?	Yes/No
1-84	If yes, does the company contract any claims services related to Other Health products?	Yes/No
1-85	If yes, does the company contract any complaints handling related services related to Other Health products?	Yes/No
1-86	If yes, does the company contract any medical underwriting services related to Other Health products?	Yes/No
1-87	If yes, does the company contract any pricing services related to Other Health products?	Yes/No
1-88	If yes, does the company contract any producer appointment services related to Other Health products?	Yes/No
1-89	If yes, does the company contract any marketing, advertisement, or lead generation, services related to Other Health products?	Yes/No
1-90	If yes, does the company contract any policyholder services related to Other Health products?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-91	If yes, does the company contract any premium collection services related to Other Health products?	Yes/No
1-92	If yes, does the company conduct compliance audits of all third parties to whom responsibilities have been delegated?	Yes/No
1-93	Additional jurisdiction-specific Third-Party Administrators/Vendors comments (optional):	Comment

Schedule 1 – Interrogatories – General

1-94	Does your company distribute its product through independent agents?	Yes/No
1-95	Does your company distribute its products through captive agents?	Yes/No
1-96	Does your company distribute its products through its employees?	Yes/No
1-97	Does the company contract with producers to collect premium or bind coverage on behalf of the company?	Yes/No
1-98	Does the company charge fees (other than commissions) to applicants or policyholders/certificate holders that are included in reported premium?	Yes/No
1-99	Additional jurisdiction-specific General comments (optional):	Comment

Products

Product Identifiers	Explanation of Product Identifiers
Individual H-AO	Accident Only. Purchased by an individual
Individual ADD	Accidental Death and Dismemberment. Purchased by an individual
Individual SD	Specified Disease-Limited Benefit/Critical Illness. Purchased by an individual
Individual H-H/OI	Hospital/Other Indemnity. Purchased by an individual
Individual H-HSME	Hospital/Surgical/Medical Expense. Purchased by an individual
Association H-AO	Accident Only. Purchased through an association/trust
Association ADD	Accidental Death and Dismemberment. Purchased through an association/trust
Association SD	Specified Disease-Limited Benefit/Critical Illness. Purchased through an association/trust
Association H-H/OI	Hospital/Other Indemnity. Purchased through an association/trust
Association H-HSME	Hospital/Surgical/Medical Expense. Purchased through an association/trust
Employer Group H-AO	Accident Only. Purchased through an employer group
Employer Group ADD	Accidental Death and Dismemberment. Purchased through an employer group

Employer Group SD	Specified Disease-Limited Benefit/Critical Illness. Purchased through an employer group
Employer Group H-H/OI	Hospital/Other Indemnity. Purchased through an employer group
Employer Group H-HSME	Hospital/Surgical/Medical Expense. Purchased through an employer group

Schedule 2 – Policy/Certificate Administration

ID	Description
~~2-45~~ 2-100	Direct written premium
~~2-46~~ 2-101	Earned premiums for reporting year
~~2-47~~ 2-102	Number of policies/certificates in force at the beginning of the period
~~2-48~~ 2-103	Number of covered lives on policies/certificates in force at the beginning of the period (only answer for individual and association products)
~~2-49~~ 2-104	Number of new policy/certificate applications/enrollments received during the period
~~2-50~~ 2-105	Number of new policy/certificates issued during the period
~~2-51~~ 2-106	Number of Covered Lives on New Policies/Certificates Issued During the Period (only answer for individual and association products)
~~2-52~~ 2-107	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
2-53 2-108	Number of policies/certificates cancelled during the free look period
~~2-54~~ 2-109	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period (only answer for individual and association products)
~~2-55~~ 2-110	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period
~~2-56~~ 2-111	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
~~2-57~~ 2-112	Number of rescissions during the period (only answer for individual products)
~~2-58~~ 2-113	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder (only answer for individual and association products)
~~2-59~~ 2-114	Number of covered lives impacted on terminations and cancellations due to non-payment (only answer for individual and association products)
~~2-60~~ 2-115	Number of covered lives impacted by rescissions (only answer for individual products)

~~2-61~~ 2-116	Number of policies/certificates in force at the end of the period
~~2-62~~ 2-117	Number of covered lives on policies/certificates in force at the end of the period (only answer for individual and association products)

Schedule 3 – Claims Administration (Including Pharmacy)

ID	Description
~~3-63~~ 3-118	Number of claims pending at the beginning of the period
~~3-64~~ 3-119	Total ~~N~~number of claims received (include non-clean claims)
~~3-65~~ 3-120	Total number of claims denied, rejected or returned
~~3-66~~ 3-121	Number denied, rejected, or returned as non-covered or maximum benefit exceeded
~~3-67~~ 3-122	Number denied, rejected, or returned as subject to pre-existing condition exclusion
~~3-68~~ 3-123	Number denied, rejected, or returned due to failure to provide adequate documentation
~~3-69~~ 3-124	Number denied, rejected, or returned due to being within the waiting period (do not answer for ADD products)
~~3-70~~ 3-125	Number of claims pending at the end of the period
~~3-71~~ 3-126	Median number of days from receipt of claim to decision for denied claims
~~3-72~~ 3-127	Average number of days from receipt of claim to decision for denied claims
~~3-73~~ 3-128	Median number of days from receipt of claim to decision for approved claims
~~3-74~~ 3-129	Average number of days from receipt of claim to decision for approved claims
~~3-75~~ 3-130	Number of claims paid (include partially paid claims)
~~3-76~~ 3-131	Aggregate dollar amount of paid claims during the period
~~3-77~~ 3-132	Number of claims where the claims payment was reduced by premium owed
~~3-78~~ 3-133	Dollar amount of claims payments applied to unpaid premiums.

Schedule 4 – Consumer Complaints and Lawsuits

ID	Description

~~4-80~~ 4-134	Number of complaints received by Company (other than through the DOI)
~~4-81~~	~~Number of complaints received through DOI~~
~~4-82~~ 4-135	Number of complaints resulting in claims reprocessing
~~4-83~~ 4-136	Number of lawsuits open at the beginning of the period
~~4-84~~ 4-137	Number of lawsuits opened during the period
~~4-85~~ 4-138	Number of lawsuits closed during the period
~~4-86~~ 4-139	Number of lawsuits closed during the period with consideration for the consumer
~~4-87~~ 4-140	Number of lawsuits open at the end of the period

Schedule 5 – Marketing and Sales

ID	Description
~~5-88~~ 5-141	Number of individual applications/enrollments pending at the beginning of the period
~~5-89~~ 5-142	Number of individual applications/enrollments denied during the period for any reason
~~5-90~~ 5-143	Number of individual applications/enrollments denied during the period - health status or condition
~~5-91~~ 5-144	Number of individual applications/enrollments approved during the period
~~5-92~~ 5-145	Number of individual applications/enrollments pending at the end of the period
~~5-93~~ 5-146	Number of applications/enrollments received via phone (audio only) during the period (only answer for individual products)
~~5-94~~ 5-147	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) during the period (only answer for individual products)
~~5-95~~ 5-148	Number of applications/enrollments received online (electronically) during the period (only answer for individual products)
~~5-96~~ 5-149	Number of applications/enrollments received by mail during the period (only answer for individual products)
~~5-97~~ 5-150	Number of applications/enrollments received by any other method during the period (only answer for individual products)
~~5-98~~ 5-151	Commissions paid during reporting period (dollar amount of commissions incurred during the period)
~~5-99~~ 5-152	Unearned commissions returned to company on policies/certificates sold during the period

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Schedule 6– Other Health Insurance Attestation

ID	Description
~~6-100~~ 6-153	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~6-101~~ 6-154	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~6-102~~ 6-155	Overall Comments for the Period

Participation Requirements: All companies licensed and reporting at least $50,000 of other health insurance premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Report by Residency: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situsued.

General Definitions:

Other Health - Health insurance forms that are not subject to the Affordable Care Act (ACA). For this MCAS blank, they are Health-Accident Only; Health - Accidental Death and Dismemberment; Health-Specified Disease-Limited Benefit/Critical Illness; Health - Hospital/Other Indemnity; and Health - Hospital/Surgical/Medical Expense

Exclude the following from Other Health MCAS reporting:

- Discretionary policies (i.e. Labor Unions, Financial Institutions, Debtors, other Discretionary groups)
- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

Health-Accident Only - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability (not disability income), or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident

Health-Accidental Death and Dismemberment - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Health-Specified Disease-Limited Benefit/Critical Illness - An insurance contract that pays benefits for the diagnosis and/or treatment of a specifically named disease, diseases, or critical illness. Benefits can be paid as expense incurred, per diem, or a principle sum.

Health-Hospital/Other Indemnity - An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred.

Health-Hospital/Surgical/Medical Expense - An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.

Association/Trust – For purposes of this MCAS blank, a non-employer group that offers benefits to its members (does not include banks or credit unions).

Exclude the following from Other Health MCAS reporting:

- Discretionary policies (i.e. Labor Unions, Financial Institutions, Debtors, other Discretionary groups)
- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

Individual Product - Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance.

Group Product / Coverage - Policies issued to a trust, association, employer, or administrator for the purpose of marketing, selling, and issuing certificates to eligible members or employees, regardless of whether or not the policy forms have been filed with any State's department of insurance and regardless of where the association, trust, employer, or administrator is situsued.

~~**National Producer Number (NPN) –** This is a specific number provided by National Insurance Producers Registry (NIPR) to individuals and most business entities that are listed in the NIPR's Producer Database (PDB).~~

Policies/Certificates - Refers to the coverage documents provided to individuals, families, or eligible members (i.e., state residents) who are enrolled in coverage (not the association/trust)

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Policyholder/Certificate holder – Refers to the individual or member who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association/trust)

Policyholder Service - A company's activities relating to servicing its policyholders which incudes, but is not limited to, notice/billing, disclosures, premium refunds and coverage questions.

Actively Writing Policies – Refers to premium written during the reporting period.

Pre-existing Condition - A medical condition of the policyholder/certificate holder that existed prior to eligibility for coverage under the Other Health policy.

Third party Entity – Licensed Administrators, licensed producers, vendors

Compliance Audits - A compliance audit is a formal review of an organization's procedures and operations mainly focusing on whether an entity is complying with internal rules, regulations, policies, decisions, and procedures. The audit ensures that the organization is fulfilling outside obligations such as agreements, rules and regulations, or standards.

Marketing - The process of actively promoting, selling, and distributing a product.

Schedule 2 Definitions (Policy/Certificate Administration):

Rescission – A rescission is a cancellation or discontinuance of coverage based on a misrepresentation that is retroactive to the issue date. (Does not include cancellations for non-payment.)

Free Look – A set number of days provided in an insurance policy/certificate that allows time for the purchaser to review the contract provisions with the right to return the policy/certificate for a full refund of all premium paid. Report the number of policies/certificates that were returned by the insured under the free look provision during the period, regardless of the original issuance date.

Schedule 3 Definitions (Claims Administration):

Claim – Provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Duplicate claims should not be reported.

For the purposes of this Market Conduct Annual Statement, a "Claim" includes any such request or demand, even those with incomplete or inadequate documentation and those made by an individual not eligible or covered under the policy against which the claim is made.

Communications with an insurer that are not explicit claims as per the definition above should not be reported on this MCAS. Such communications could include general queries regarding policy provisions, potential coverage, events reported for "information only", or other communications for which a clear request or demand for payment has not been made.

If a claim is reopened, treat the reopened claim as a new and distinct claim apart from the original claim. For reopened claims, the claim determination time period is measured from the date the claim was re-opened to the date a benefit determination is made.

Claims Received - provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

Claims Denied - provide the total number of claims denied during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed; includes rejected and returned claims, whether in whole or in part

Claims Paid - provide the total number of claims paid during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

Waiting Period: Period of time a covered person who is entitled to receive benefits must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

Schedule 4 Definitions (Consumer Complaints and Lawsuits):

Clean Claim - A "clean claim" refers to a claim submitted without any errors or missing information, meaning it can be processed and paid promptly without requiring additional investigation or development by the claims processor; essentially, a complete and accurate claim with all necessary details filled in correctly.

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Complaint - any written communication that expresses dissatisfaction with a specific person or entity. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose. A complaint should be reported to the state where the policyholder resides.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.).
- Complaints received from third parties.

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 Other Health Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/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 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 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.

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Schedule 5 Definitions (Marketing and Sales)

Commissions - The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. NOTE: For products ***not*** related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting. Do not include any fees or other compensation paid for outsourced services.

Schedule 6– Other Health Insurance Attestation

By completing the attestation information, those named understand, agree, and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

MCAS Market Conduct Annual Statement

Private Passenger Auto (2025)

Private Passenger Auto Interrogatories

		Yes/No Response	Explanation
01	Were there policies in force during the reporting period that provided Collision coverage?		———
02	Were there policies in force during the reporting period that provided Comprehensive coverage?		———
03	Were there policies in force during the reporting period that provided Bodily Injury coverage?		———
04	Were there policies in force during the reporting period that provided Property Damage coverage?		———
05	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?		———
06	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?		———
07	Were there policies in force during the reporting period that provided Medical Payments coverage?		———
08	Were there policies in force during the reporting period that provided Combined Single Limits coverage?		———
09	Were there policies in force during the reporting period that provided Personal Injury Protection coverage?		———
10	Was the company actively writing policies in the state at year end?		———
11	Does the company write in the non-standard market?		———
~~12~~	~~If Yes, what percentage of your business is non-standard?~~	———	
~~13~~12	If Yes, how is non-standard defined?	———	
~~14~~13	Has the company had a significant event/business strategy that would affect data for this reporting period?		———
~~15~~14	If yes, add additional comments.	———	
~~16~~15	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?		———
~~17~~16	If yes, add additional comments.	———	
~~18~~17	How does the company treat subsequent supplemental or additional payments on previously closed claims?	———	
~~19~~18	Does the company use Managing General Agents (MGAs)?		———
~~20~~19	If yes, list the names of the MGAs	———	
~~21~~20	Does the company use Third Party Administrators (TPAs)?		———
~~22~~21	If yes, list the names of the TPAs	———	
~~23~~22	Does the company use telematics or usage-based data:?		———
~~24~~23	Does the company use digital claim settlement?		———
~~25~~24	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process	———	
~~26~~25	Additional state specific Claims comments (optional):	———	
~~27~~26	Additional state specific Underwriting comments (optional):	———	

Private Passenger Auto (2025)

Private Passenger Auto Claims Activity

		Collision				Comprehensive				Bodily Injury	Property Damage			
		Digital	Hybrid	Non-Digital	All	Digital	Hybrid	Non-Digital	All		Digital	Hybrid	Non-Digital	All
~~28~~27	Number of claims open at the beginning of the period.													
~~29~~28	Number of claims opened during the period.													
~~30~~29	Number of claims closed with payment during the period.													
~~31~~30	Number of claims closed without payment during the period.													
~~32~~31	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.													
~~33~~32	Number of claims remaining open at the end of the period.													
~~34~~33	Median days to final payment.													
~~35~~34	Number of claims closed with payment within 0-30 days.													
~~36~~35	Number of claims closed with payment within 31-60 days.													
~~37~~36	Number of claims closed with payment within 61-90 days.													
~~38~~37	Number of claims closed with payment within 91-180 days.													
~~39~~38	Number of claims closed with payment within 181-365 days.													
~~40~~39	Number of claims closed with payment beyond 365 days.													
~~41~~40	Number of claims closed without payment within 0-30 days.													
~~42~~41	Number of claims closed without payment within 31-60 days.													
~~43~~42	Number of claims closed without payment within 61-90 days.													
~~44~~43	Number of claims closed without payment within 91-180 days.													
~~45~~44	Number of claims closed without payment within 181-365 days.													
~~46~~45	Number of claims closed without payment beyond 365 days.													

Private Passenger Auto (2025)

Private Passenger Auto Claims Activity (Continued)

		UMBI and UIMBI	UMPD and UIMPD				Medical Payments	Combined Single Limits	Personal Injury Protection
			Digital	Hybrid	Non-Digital	All			
~~28~~27	Number of claims open at the beginning of the period.					———			
~~29~~28	Number of claims opened during the period.					———			
~~30~~29	Number of claims closed with payment during the period.					———			
~~31~~30	Number of claims closed without payment during the period.					———			
~~32~~31	Number of claims closed during the					———			
~~33~~32	Number of claims remaining open at the end of the period.					———			
~~34~~33	Median days to final payment.		———	———	———				
~~35~~34	Number of claims closed with payment within 0-30 days.					———			
~~36~~35	Number of claims closed with payment within 31-60 days.					———			
~~37~~36	Number of claims closed with payment within 61-90 days.					———			
~~38~~37	Number of claims closed with payment within 91-180 days.					———			
~~39~~38	Number of claims closed with payment within 181-365 days.					———			
~~40~~39	Number of claims closed with payment beyond 365 days.					———			
~~41~~40	Number of claims closed without payment within 0-30 days.					———			
~~42~~41	Number of claims closed without payment within 31-60 days.					———			
~~43~~42	Number of claims closed without payment within 61-90 days.					———			
~~44~~43	Number of claims closed without payment within 91-180 days.					———			
~~45~~44	Number of claims closed without payment within 181-365 days.					———			
~~46~~45	Number of claims closed without payment beyond 365 days.					———			

Private Passenger Auto (2025)

Private Passenger Auto Underwriting Activity

		Value
~~47~~46	Number of autos which have policies in force at the end of the period.	
~~48~~47	Number of policies in force at the end of the period.	
~~49~~48	Number of new policies written during the period.	
49	Number of non-standard policies issued during the period.	
50	Total number of policies in force at the end of the period that have Collision coverage.	
51	Total number of policies in force at the end of the period that have Comprehensive coverage.	
52	Total number of policies in force at the end of the period that have Bodily Injury coverage.	
53	Total number of policies in force at the end of the period that have Property Damage coverage.	
54	Total number of policies in force at the end of the period that have UMBI and UIMBI coverage.	
55	Total number of policies in force at the end of the period that have UMPD and UIMPD coverage.	
56	Total number of policies in force at the end of the period that have Medical Payments coverage.	
57	Total number of policies in force at the end of the period that have Combined Single Limits coverage.	
58	Total number of policies in force at the end of the period that have Personal Injury Protection coverage.	
59	Number of policies in force at the end of the period that are enrolled through a Telematics product(s).	
~~50~~60	Dollar amount of direct written premium during the period.	
~~51~~61	Number of company-initiated non-renewals during the period.	
~~52~~62	Number of cancellations for non-pay or non-sufficient funds.	
~~53~~63	Number of cancellations at the insured's request	
~~54~~64	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.	
~~55~~65	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.	
~~56~~66	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.	
~~57~~67	Number of complaints received directly from any person or entity other than the DOI.	

Lawsuit Activity

		Collision	Comprehensive	Bodily Injury	Property Damage	UMBI and UIMBI	UMPD and UIMPD	Medical Payments	Combined Single Limits	Personal Injury Protection	Non-Claim Related Lawsuits
~~58~~68	Number of lawsuits open at beginning of the period.										
~~59~~69	Number of lawsuits opened during the period.										
~~60~~70	Number of lawsuits closed during the period.										
~~61~~71	Number of lawsuits open at end of period.										
~~62~~72	Number of lawsuits closed with consideration for the consumer.										

Private Passenger Auto Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
~~63~~73	First Attestor Information						———
~~64~~74	Second Attestor Information						———
~~65~~75	Overall Comments for the Filing Period	———	———	———	———	———	

November 11, 2024

Sent via email to Rebecca.Rebholz@wisconsin.gov

Regarding some of the specifics we were looking to discuss and get clarification on is:

1. There are several items in the claims section that rely on when a claim is reported or date a claim is opened - not all claims administrators record this information in the same way;
2. Interrogatories ask about a TPA and separately ask about an administrator
3. Interrogatories asks about MGAS but not producers - they are defined differently (as an example we work with many producers but only one MGA)
4. Not all partners capture losses separately for each person
5. Other items such as number of days to closure is impacted when the date claim is reported or open is captured in different ways by different partners
6. Claims closed does not take into account when the claim became clean so numbers are often skewed
7. Lawsuits are asked to be reported based on number of policies or number of people party to the suit – that is not how it is captured currently

Thanks again for reviewing!

Caren Alvarado l Vice President Regulatory Affairs & Industry Relations, A&H Division
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NAIC MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Changes/Additions to Approved Blanks and Data Call and Definitions
Proposal Submission Form

NAIC USE ONLY

Proposal Submission Date: 2/28/2025	
Proposed Effective Data Year for Reporting: 2025 Data Year	
Proposed ☒ Substantive Change ☐ Non-Substantive Change/Clarification	
Proposal Number	2025.1
Proposal Status	All Submissions ☐ Received – Date Click or tap to enter a date. ☐ Accepted ☐ Rejected by MCAS Blanks WG Chair ☐ Posted to Web Page for Public Exposure/Comment – Date Click or tap to enter a date. ☐ Referred to Another NAIC Group – Date Click or tap to enter a date. – Name of Group Click or tap here to enter text. ☐ Adopted ☐ Modified ☐ Rejected ☐ Deferred by WG – Date Click or tap to enter a date. Substantive Revisions ☐ Adopted ☐ Rejected by D Committee – Date Click or tap to enter a date. ☐ Adopted ☐ Rejected by EX/Plenary – Date Click or tap to enter a date. ☐ Other – Date Click or tap to enter a date. Specify Click or tap here to enter text.
NAIC Staff Input	Click or tap here to enter text.

Proposal Contact Information

Name of Contact Person	Birny Birnbaum
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Email Address	birny@cej-online.org
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Affiliation Type	☐ State Regulator ☐ NAIC Staff ☐ Other Regulator ☐ Reporting Company ☐ Industry Trade Association ☒ Consumer Representative ☐ Other

PROPOSAL IS FOR: ☒ Data Element ☒ Data Definitions ☐ Data Validation

APPLICABLE LINE(S) OF BUSINESS:

☐ Annuity	☒ Lender Placed Auto and Home	☐ Private Flood
☐ Disability Income	☐ Life	☐ Private Passenger Auto
☐ Health	☐ Long-Term Care	☐ Travel
☐ Homeowners	☐ Other Health	☐ STLD
☐ Pet		

PROVIDE A CONCISE STATEMENT OF THE PROPOSED CHANGE:

There has been confusion about how an insurer should report the issuance of a subsequent LPI individual policy or certificate on the same property following the expiration of the term of the previous individual policy or certificate. The proposal clarifies that such policies do not involve cancellations and adds data elements to further clarify reporting. See attached memo for details.

PROVIDE THE REASON FOR THE CHANGE:

NAIC MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Changes/Additions to Approved Blanks and Data Call and Definitions
Proposal Submission Form

See concise statement

IF ADDITIONAL DOCUMENTS CONTAIN DEFINITIONS, BLANK MOCK-UPS, ETC, PROVIDE A LISTING OF THESE DOCUMENTS BELOW. SEND THE LISTED DOCUMENTS TO NAIC STAFF ALONG WITH THE COMPLETED FORM:

See attached explanation.

Proposal from the Center for Economic Justice to

Address End of Coverage Issues on the Lender-Placed MCAS

February 28, 2025

Background

LPI coverage typically comes in two forms. One form of LPI is a blanket group policy issued to a lender or loan servicer providing coverage for all vehicles or properties in the loan portfolio. Under a blanket policy, the premium charged to the lender / loan servicer is based on the total number of vehicles or properties insured or the total amount of outstanding debt on the loans in the covered loan portfolio. If there are LPI charges by the lender or loan servicer to individual borrowers, it would typically be the same amount across borrowers at the loan issuance.

The second form is the more common method used for LPI home insurance in which coverage is issued under the group policy if the lender / loan servicer identifies a lapse in coverage. (Note: the lender / loan servicer often hires the LPI insurer or affiliate of the LPI insurer for insurance tracking services. While the LPI insurer or its affiliate may perform the loan tracking, including sending letters to borrowers regarding missing evidence of insurance and issuance of LPI coverage, the responsibility remains with the lender / loan servicer and the insurance tracking correspondence contains the name of the lender / loan servicer and not the LPI insurer or affiliate performing the tracking services.)

With the second form of LPI, if the borrower fails to provide evidence of required insurance, the lender / loan servicer directs the LPI insurer to issue coverage (e.g. a certificate) under the group policy. The LPI insurer than charges the lender / loan servicer a premium based on the rating factors filed in a rate filing by the LPI insurer. Such rating factors are typically limited to amount of coverage and any additional coverages offered to and selected by the lender / loan servicer or the borrower. The lender / loan servicer then makes a charge to the affected borrower styled as insurance typically in the same amount charged by the LPI insurer to the lender / loan servicer.

Coverage Cancellation and New Coverage Issuance

The typical home certificate under this individualized premium charge form of LPI has a coverage term of 12 months. The majority of such certificates are cancelled by the lender / loan servicer and LPI insurer before the end of the term of coverage due to insurance being falsely force-placed due to tracking records (a “flat cancel”) or because the borrower obtains voluntary market insurance before the end of the 12-month term of the LPI.

In some markets and some situations, individualized premium LPI coverage extends beyond the initial 12-month term of coverage because the borrower either cannot obtain voluntary coverage or simply fails to take action to obtain voluntary market coverage. In these types of situations, the initial LPI coverage ends at the end of coverage term and another LPI coverage (certificate) is issued by the LPI insurer.

The MCAS blank includes data elements and interrogatories in three categories of policy types – group policy, certificates under group policies and individual policies. In a few states, individualized premium LPI is provided through an individual policy and not as a certificate under a group policy. For purposes of MCAS analysis, individual policies and certificates under group policies are comparable.

Based on the above, we offer the following definitions and additional data elements for the LPI MCAS:

Proposed New or Revised Definitions

Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage. Coverage under an individual policy or a certificate under a group policy ending at the end of the term of coverage is not a cancellation, even if the coverage is renewed through a subsequent individual policy or certificate. See also Flat Cancellation

Coverage Renewed – Includes only those new coverage individual policies and certificates issued for the same property at the end of the term of coverage for the prior individual policy or certificate on that property. Include Coverage Renewed individual policies and certificates in individual policies written and certificates written during the period, respectively.

Term of Coverage Completed – Include individual policies and certificates for which the term of coverage was completed and ended during the period.

Individual Policies Written During the Period – Include all individual policies issued during the period before any flat or other cancellations, even if issued in error. Include all individual policies with Coverage Renewed.

Certificates Written During the Period – Include all certificates issued during the period before any flat or other cancellations, even if issued in error. Include all certificates with Coverage Renewed.

Proposed New Data Elements

3-59A Number of certificates for which Term of Coverage Completed during the period

3-59B Number of certificates issued for Coverage Renewed during the period

3-67A Number of individual policies for which Term of Coverage Completed during the period

3-67B Number of individual policies issued for Coverage Renewed during the period

March 19, 2025

Mr. Joshua Guillory, Chair
NAIC Market Conduct Annual Statement Blanks (D) Working Group
National Association of Insurance Commissioner
110 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Attn: Teresa Cooper, Sr. Market Analysis Manager
By email: tcooper@naic.org

RE: Comments to Market Conduct Annual Statement Blanks (D) Working Group (MCAS WG) Lender Placed Insurance (LPI) Definitions and Additional Data Elements Changes

Dear Chair Guillory,

Consumer Credit Industry Association (CCIA) and American Property and Casualty Insurance Association (APCIA) thank you for opportunity to comment to the proposed MCAS Working Group LPI MCAS definition and additional data elements changes exposed during the MCA Working Group's March 6, 2025, meeting.

We would welcome further dialogue with the Working Group to understand the necessity for these changes related to reporting "renewals" for LPI placements where none has existed before. We support data changes helpful for regulation, but their need should be compelling considering anticipated additional costs for time and efforts to generate the changes for reporting insurers as well as other parties providing data elements to the insurer.

The LPI blanks report currently includes 20 data elements identifying numbers of in-force, written and cancelled policies or certificates. Additionally, segmenting "renewals" of placed coverage does not seem particularly helpful to measure compliance by insurers or to protect insureds and claimants. Whether a LPI certificate or policy was cancelled or expired during a reporting year, which the proposed "renewal" data elements allegedly intend to identify, may be understood differently by reporting parties and a distinction without a difference for MCAS purposes.

We look forward to further discussions with the Working Group regarding the utility of and necessity for the proposed LPI definition and data element changes.

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