NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft date: 3/26/26

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Thursday, April 9, 2026
1:00 – 2:00 p.m. ET / 12:00 – 1:00 p.m. CT / 11:00 a.m. – 12:00 p.m. MT / 10:00 – 11:00 a.m. PT

ROLL CALL

Joshua Guillory, Chair	Louisiana	Elouisa Tyler	New Mexico
Tolanda McNeal, Vice Chair	Arizona	Matt Fischer	North Dakota
Teri Ann Mecca/Lori Plant	Arkansas	Guy Self	Ohio
Sheryl Parker	Florida	Spencer Peacock	Oregon
Paula Shamburger	Georgia	Gary Jones/August Hall/ Karen Veronikis	Pennsylvania
Chris Heisler	Illinois		
Charles Thomas	Kansas	Tara Nixon	South Carolina
Lori Cunningham	Kentucky	Larry D. Deiter	South Dakota
Raymond A. Guzman	Maryland	Rhonda Bowling-Black	Tennessee
Mary Lou Moran	Massachusetts	Shelley Wiseman	Utah
Danielle Torres	Michigan	Melissa Gerachis	Virginia
Jo A. LeDuc/Julie Hesser	Missouri	Sandy Ray	Washington
Martin Swanson	Nebraska	Theresa Miller/Letha Tate	West Virginia
Jonathan Wycoff	Nevada	Jamie Adams	Wisconsin

NAIC Committee Support: Teresa Cooper/Hal Marsh/Kelsey Bollin

AGENDA

1. Consider Adoption of its Dec. 18, 2025 and Feb. 5, 2026 Minutes—*Joshua Guillory (LA)* — Attachment 1, Attachment 2
2. Discuss the Pet Market Conduct Annual Statement (MCAS) Proposal Form Related to Maximum Benefit Limit Reporting—*Joshua Guillory (LA)* — Attachment 3
3. Discuss the "Required to File" Procedures for MCAS Filings —*Joshua Guillory (LA) and Teresa Cooper (NAIC)* — Attachment 4
4. Discuss the Reporting of Accident-Only Coverage on MCAS Blanks —*Joshua Guillory (LA)*
5. Consider Long-Term Care (LTC) MCAS Edits—*Joshua Guillory (LA)* — Attachment 5
6. Discuss Any Other Matters Brought Before the Working Group —*Joshua Guillory (LA)*
7. Adjournment

Draft: 2/20/26

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
February 5, 2026

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 5, 2026. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Christina Huff (FL); Paula Shamburger (GA); Lori Cunningham (KY); Raymond A. Guzman (MD); Danielle Torres (MI); Jo A. LeDuc (MO); Martin Swanson (NE); Jonathan Wycoff (NV); Guy Self (OH); Cassie Soucy (OR); Karen Veronikis (PA); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Melissa Gerachis (VA); Andy Swokowski (WA); Theresa Miller (WV); and Rebecca Rebholz (WI).

1. Discussed its Review of the LTC MCAS Blank

Guillory said he looked forward to finalizing the long-term care (LTC) Market Conduct Annual Statement (MCAS) blank. He reminded the Working Group that during its December meeting, it completed its review of the current blank and reviewed proposed changes. The draft blank presented includes all proposed changes as data elements and was exposed for a 30-day comment period, with one comment received.

Guillory introduced the first proposed data element in the interrogatory section: "Have you had any significant rate changes?" He explained that this element was proposed by Arizona but was withdrawn during the comment period. Arizona indicated the data element would be too complex for companies to answer uniformly, as each state views LTC rates differently. Additionally, the information could be gathered from the forms and rates section. After consideration, it was determined that this would not be a valuable addition to the dataset.

Guillory asked Working Group members, state insurance regulators, and interested parties for questions or comments on the removal of the data element. Hearing none, he stated the item would be removed from the draft. He also noted that formal votes were not planned because positions had not been finalized.

Guillory then moved to the next proposed element: whether there is a reason the reported LTC information may identify the company as an outlier or be substantially different from previously reported data, including an option to add comments.

Dorschner shared his perspective based on general experience working with companies. He questioned whether companies would truly know whether they are outliers and expressed concern that they might not be able to answer the question effectively. Guillory noted that similar questions appear on blanks for other lines of business. Teresa Cooper (NAIC) indicated that similar questions are included on other blanks.

Guillory added that the question is included in the property/casualty (P/C) blanks. Based on his experience, companies have learned when to raise explanations and often use the question to comment on automatic validation questions generated by the system. Torres stated that she supports LeDuc's suggestion to break the question into separate questions for the different product types.

Guillory asked whether there were any comments, either supporting or opposing, to breaking the question into three separate questions. Hearing no objections, he directed that the next draft reflect the question broken into three separate questions to allow responses by product type.

Guillory introduced the next proposed data element: whether the company was still actively writing policies in the state at year's end, noting it should be a simple yes-or-no question. He asked for comments from Working Group members and regulators. Hearing none, he then asked for input from interested parties.

Guillory noted a comment suggesting that the question would also be helpful if broken out by product type. He asked for comments or questions on adding a product type to this item. Hearing no objections, he stated the draft would be updated to include product lines for this question and noted that the revised draft would be available for another comment period.

Guillory then introduced the next proposed element: reporting the number of class action lawsuits. Ray Nelson (AHIP) stated that AHIP reviewed notes from when the original LTC requirements were developed and noted that class action lawsuits had been discussed at that time. He explained that definitional issues were identified, and instead of adding a separate class action lawsuit item, the group chose to capture lawsuit information as reflected in lines 59–63. He recommended retaining the existing approach in lines 59–63 and abandoning the proposed new class-action-lawsuit data element.

Cooper noted that prior discussions included the possibility that, if the item were included, it might be more appropriate to place it in a lower section of the blank since it requests a numerical response. Guillory acknowledged Cooper's point and asked for comments on whether, if retained, the data element should be moved to the lawsuit section rather than remain in its current location. Hearing no immediate feedback, he asked for further comments from any parties and then from Working Group members on whether the item should be included or excluded based on the feedback received.

McNeal asked Nelson to clarify whether AHIP's recommendation was to exclude the class action lawsuit question entirely from both sections. Nelson confirmed that AHIP's recommendation was not to include the question in either section. He explained that lines 59–63 already capture open and closed lawsuits during the reporting period. He reiterated that prior discussions identified definitional challenges, including how to define a class action lawsuit and determine when it is considered open. For those reasons, the existing lawsuit activity section was previously determined to be the appropriate method for capturing this information. Guillory summarized the differing suggestions on the item and asked whether there were any additional comments or questions before moving on.

Guillory transitioned to the General Information section, noting that the items are already broken out by lines of business. He introduced the first two data elements: written premium during the period and earned premium during the period. He then asked for comments from Working Group members and other parties.

Nelson stated that LTC premium information is already provided to the NAIC at the state level through other reporting mechanisms, including the annual statement state pages and Form 5 of the LTC Experience Exhibit. To avoid redundancy, he requested that the premium data elements be removed. He added that policy count data provides a better indicator of a company's LTC block size.

Cooper noted that LTC is the only line of business within MCAS that does not currently include premium data reporting. Guillory made a final call for comments or questions and indicated that the suggestion would be considered.

Guillory moved to the next proposed data element under Line 20, which included edits and additions to application activity: the number of applications approved during the period, the number pending at the beginning and end of the period, the number received, the number denied, and the reasons for denial. He proposed addressing the items incrementally, beginning with the number of applications approved during the period, and invited comments from Working Group members and regulators.

Nelson stated that Working Group members had provided feedback raising concerns about the application-related data elements. He explained that application data is often stored in separate systems and may not move into administrative systems until a policy becomes active, making retrieval burdensome. Some data elements may not exist in a format that supports reporting. He added that "new business issued during the period" would be more reflective of the intended purpose of the data request. He also expressed concern that underwriting practices vary significantly by company and product design, making application and denial data less comparable across carriers. AHIP recommended focusing on policies issued rather than application data.

Guillory asked Nelson to clarify whether those concerns applied to all proposed application-related data elements. Nelson confirmed that the concerns generally applied across the application questions, including approvals. He noted that administrative systems track policy issue dates but may not track the specific application approval date, making reporting difficult.

Guillory referenced a chat comment from LeDuc asking how the proposed item differs from policies issued, noting that this aligned with Nelson's comments. He asked whether the original proponents of the amendments wished to speak.

Guillory summarized the discussion, stating that concerns included: (1) the data may not exist in a reportable format; (2) it may be burdensome to compile even if it exists; and (3) it may duplicate or overlap with other data elements, such as policies issued.

Cooper commented that similar questions may exist in other statements or lines of business, which may have been the source of the proposed additions.

Guillory stated that the comments would be taken under advisement for the next draft and thanked Nelson for gathering member feedback. He clarified that while the discussion began with Line 20, the comments addressed a broader set of application-related questions. He asked if there were any additional comments specific to the other application items that had not already been covered.

Guillory moved to the proposed items between Lines 22 and 23, beginning with the number of lapses during the period and the proposed addition of the number of policies terminated or canceled due to nonpayment.

Ayah Abedali (American Council of Life Insurers—ACLI) shared member company feedback requesting that, if these items are added, firm definitions be provided, including examples of the types of terminations intended for each question. She also suggested that overlapping questions with existing elements should be reconsidered.

Guillory asked for clarification on where confusion might exist, noting that, from a regulatory and company perspective, categories such as canceled due to nonpayment, canceled by the insurer for other reasons, free looks, and terminated at the insured's request seemed straightforward. He acknowledged that definitions would be addressed during the development of rules and definitions but requested more detail on the concerns.

Abedali responded that, specifically regarding "terminated at request of insured," companies indicated they were unaware of reasons other than free looks or full surrenders for terminating cash value policies or annuities with LTC benefits. She noted that free looks are already captured in an existing question, raising concerns about potential overlap.

Guillory referenced LeDuc asking whether the intent was for the sum of the three new elements to equal the

current lapse figure. Guillory asked Cooper if that had been the intent. She stated she was not aware of the original intent.

Guillory responded that the feedback and question would be taken under advisement. He noted that if the elements are retained, definitions and clarification—including whether the totals are intended to reconcile—would be addressed in the data definitions. Hearing no further discussion or comments, he stated the group would take the feedback under advisement for future drafts and moved on to the next item.

Guillory continued with the General Information section under Line 30, introducing proposed additions related to adverse determinations: the number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of review), and the number of adverse determinations upheld upon request for internal review (with the same caveat).

Abedali said, for complaints-related items, member companies indicated the proposed changes would require extensive manual research. While the data may be valuable for follow-up inquiries or market conduct exams, companies expressed concern that it would be burdensome for annual reporting.

Guillory asked whether companies could program system changes within a year if given sufficient lead time. Abedali responded that she was not certain but would take that question back to the ACLI's members. Guillory shared his perspective that comparing companies with high numbers of adverse determinations overturned could be a valuable tool for market conduct regulators in prioritizing investigations or inquiries. Hearing no further comments, he stated the feedback would be taken under consideration for future drafts.

Nelson clarified that under Line 30 there were five additions, not just the two highlighted in blue, and asked whether all were intended as additions. Hal Marsh (NAIC) confirmed that the additional three items were also additions and had not been properly color-coded.

Nelson also asked for clarification on the effective reporting year for any approved changes. Guillory initially stated the reporting would be for 2027, and Cooper clarified that if approved in 2026, the changes would apply to the 2027 data year and be reported in 2028.

Guillory asked for comments on the additional three proposed items: customer-requested appeals, final adverse determinations overturned, and final adverse determinations upheld. Nelson indicated that his prior comments regarding burden would also apply to these items.

Guillory stated that, with no further comments on the six adverse determination items, the group had completed its review of the proposed data elements. He explained that the blank would be updated to reflect the discussions and adjustments made during the meeting. The revised draft would be shared with the Working Group and exposed for a 30-day comment period. He instructed members to submit any additional comments to NAIC committee support.

Cooper asked for clarification that elements without suggested revisions or discussion would remain in the draft for further consideration. Guillory confirmed that items without discussion would remain as drafted. For items that received comments, those would be taken under consideration, and options or revised drafts would be presented at a future meeting. He noted that some items could potentially come to a vote later.

2. Reviewed Items to be Discussed at Working Group Meetings

Guillory noted two items currently brought forward: 1) whether occupational accident coverage should be considered casualty coverage (similar to workers' compensation) rather than health coverage in some states or by some carriers, and 2) a proposal to include the phrase "maximum benefit limit" in the definition of partial payment under the excluded payment claims revision.

Cooper clarified that a proposal form had been received involving prior revisions. She explained that there had been an inconsistency between the blank and the data column definitions, resulting in a prior strikeout. The current proposal seeks to reverse that strike and modify certain data elements. She noted that further discussion is needed to determine the intended outcome.

Guillory stated that these items would be discussed in more detail at the next meeting and invited brief preliminary input.

Caren Alvarado (Crum & Forster) explained that she raised the occupational accident issue because of industry confusion over whether the product should be included in other health MCAS reporting. She noted that other health MCAS typically applies to accident-only products issued through association groups or trusts. Occupational accident coverage, however, is often offered in lieu of workers' compensation and is typically issued to cover independent contractors, such as trucking companies, rather than employees. She requested clarification on whether the product was intended to be included.

Guillory then referenced the second proposal form, stating it would also be discussed in more detail at the next Working Group meeting, as it involves more complex revisions.

Guillory thanked participants for their engagement and stated that the group made significant progress. He expressed the goal of finalizing the updated blank draft and related data definitions in the coming months to complete the long-term care review.

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

Draft: 1/20/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
December 18, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Dec. 18, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Sheryl Parker (FL); Chris Heisler (IL); Paula Shamburger and Elizabeth Nunes (GA); Lori Cunningham (KY); Raymond A. Guzman (MD); Danielle Torres (MI); Jo A. LeDuc (MO); Martin Swanson (NE); Jonathan Wycoff (NV); Guy Self (OH); Spencer Peacock (OR); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); John Kelcher (WA); and Rebecca Rebholz (WI). Also participating was: Timothy N. Schott (ME).

1. Adopted its Nov. 6 Minutes

The Working Group met Nov. 6 and took the following action: 1) adopted its Oct. 2 minutes; 2) discussed the "required to file" procedures for Market Conduct Annual Statement (MCAS) filings; and 3) discussed the review of the long-term care (LTC) MCAS.

Swanson made a motion, seconded by Dorschner, to adopt the Working Group's Nov. 6 minutes (*see NAIC Proceedings – Fall 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*). The motion passed unanimously.

2. Discussed the "Required to File" Procedures for MCAS Filings

Erica Weyhenmeyer (National Association of Mutual Insurance Companies—NAMIC) summarized that member feedback strongly supported continuing with option three, noting that the table was a relatively recent introduction. She explained that carriers are actively working on required actions to ensure completion and compliance. While there have been some variations in communication and issues related to waivers, the overall feedback indicates that carriers are implementing plans, attempting to comply, and addressing identified issues. She emphasized that additional feedback from the Working Group regarding what it is observing would be valuable, as it would help relay information, align expectations, and give a better understanding of what outcomes the Working Group would like to see.

Guillory asked regulators to share feedback on issues they are seeing with the current required-to-file process, noting a key concern that regulators have no effective way to identify improper or incomplete filings without conducting a manual review of all companies required to file MCAS. He invited regulators to comment on this issue or any other problems they are encountering. He noted that both regulators and industry have raised concerns regarding the required-to-file process and that alternatives have been considered, including making no changes at all. Guillory emphasized that any agreed-upon changes would not apply to the 2025 reporting cycle but would instead take effect for the 2026 data year, to be reported in 2027. He stated that no vote would be taken at this meeting, with a potential vote anticipated in January 2026, and encouraged Working Group members to review the options and be prepared to discuss them at the next meeting.

LeDuc explained that regulators are seeing fairly straightforward issues that primarily involve companies incorrectly answering the supplemental exhibit questions—either answering "yes" when they should answer "no," or "no" when they should answer "yes." She noted that when companies answer "no," they are unable to file

because the NAIC system does not open for them. When they answer "yes," regulators expect a filing that never arrives, creating an outstanding item that must be tracked down.

Weyhenmeyer responded that this clarification was helpful in understanding how the systems interact and indicated she could share this feedback with NAMIC's membership.

Guillory then asked if there were any additional comments and, hearing none, moved on to the next item.

3. Continued its Review of the LTC MCAS

Guillory then discussed the Working Group's review of the LTC MCAS reporting blank and related data column definitions, in accordance with the Working Group's charge to review and update MCAS data elements for lines of business in effect for more than three years. He noted that the Working Group completed its review of the blank the prior week and exposed it for a 30-day public comment period ending December 7, 2025, during which no comments were received, as confirmed by Hal Marsh (NAIC). Guillory directed Working Group members to this meeting's attachments for the current blanks and data column definitions and explained that one attachment contains a compiled list of items still under discussion, which would be the focus of the current discussion. He noted that the last two items in one of the attachments would be considered at a later time, as they may apply to all lines of business rather than just LTC. Guillory emphasized that no votes would be taken during this meeting but invited discussion on the outstanding items, beginning with a proposed interrogatory data element regarding whether companies have experienced significant rate changes, noting that a clear definition—such as a threshold percentage increase or decrease—would be needed. He opened the floor for feedback from Working Group members, regulators, and other interested parties. No feedback was received.

Guillory moved the discussion to the second proposed interrogatory data element. He asked Working Group members and other participants to consider, ahead of the next meeting, how "significant rate change" might be defined if that interrogatory is ultimately included.

Guillory then introduced the second proposed interrogatory, which would ask whether a company was still actively writing policies in the state at year-end, with separate breakouts for standalone policies, life hybrids, and annuity hybrids. He opened the floor to all participants for comments or questions on this proposed data element.

LeDuc cautioned that while the proposed question regarding whether a company is actively writing policies may appear simple, it is likely to generate significant confusion and follow-up questions about what "actively marketing" means. She emphasized that if this data element is added, it would be important to include a clear definition, description, or guidance to avoid inconsistent interpretations.

Guillory stated that the comment would be noted. He then invited additional comments from the group.

Schott noted that his comment related to the first proposed data element on significant rate changes, explaining that the Interstate Insurance Product Regulation Commission (Compact) already uses a threshold to determine what constitutes a significant rate change. He indicated that the threshold is approximately 15%, though he was not entirely certain, and suggested that tying the definition to an existing standard could be helpful.

Guillory agreed that reviewing thresholds used elsewhere, such as in the Compact or other standards, would be prudent when considering how to define significant rate changes for the first interrogatory. He then asked if there were any further comments on either item.

Guzman said he supported Schott's suggestion, sharing that in Maryland, the cap for approving a rate increase is 15% in any given year. He explained that while companies can request higher increases, they must be spread over multiple years in 15% increments and require approval. He stated that this approach could be a useful reference and seconded the idea of using a similar threshold for the proposed data element.

Guillory introduced item three, which concerns the reporting of the number of class action lawsuits. He explained that this question currently exists in the disability income MCAS interrogatories and that the Working Group needs to consider whether it should remain in the interrogatory section or be moved to the lawsuit reporting section. He also noted related considerations, including whether the definition of lawsuits should be revised and whether updates should be made across all lines of business for consistency. He invited comments from the Working Group, but none were offered.

Guillory introduced item four, which asks whether a company uses managing general agents and, if so, to list their names. He noted that the Working Group had previously discussed concerns that requiring names may be excessive and suggested that states needing this information could request it directly when a company answers affirmatively. He invited feedback on whether the question should ask generally about managing general agents (MGAs) or also require listing names.

LeDuc stated that Missouri would not support requiring the names of MGAs, explaining that it is too much information for the purpose of the MCAS.

Guillory asked for additional comments, noting that a similar question applies to third-party administrators (TPAs).

Guzman shared that Maryland generally agrees with LeDuc's position, noting that while listings of MGAs and TPAs are requested during the market conduct examination process, requiring that level of detail at the MCAS stage may not be particularly useful. He emphasized that this information is more appropriate once an exam is underway rather than during preliminary MCAS review.

Guillory asked whether other MCAS blanks require listing the names of TPAs or are typically structured as yes/no questions. Teresa Cooper (NAIC) responded that she would need to confirm, but believed that while one or two blanks may require listings, most are limited to yes/no responses.

Kelcher added that in Washington, the reports he reviewed include counts but do not require names.

Guillory noted that Louisiana approaches the issue differently by requiring TPAs to report annually who they work for, though not through MCAS, and stated that the Working Group would take the matter under consideration. He again asked for additional comments.

Guzman added that, based on his recollection, the travel subject matter expert (SME) group may request names in its MCAS blank, though he was uncertain.

Guillory introduced item six, which concerns reporting direct premium written during the period, noting that it appears to be a straightforward data element. He asked whether anyone had comments, but no one did.

Guillory then addressed item seven, which includes several application-related data elements, such as direct written premium during the period, earned premium during the period, the number of applications pending at the beginning and end of the period, the number of applications received during the period, and the number denied during the period. He also noted a related consideration that, if these elements are included, data element number 20, currently defined as the number of new business policies or contracts issued during the period, should

be reviewed and possibly revised to instead reflect the number of applications approved during the period for consistency. He opened the floor to Working Group members and regulators for comments on item number seven.

Guillory introduced item number eight, which addresses cancellations as a replacement for reporting the number of lapses during the period. He outlined the related data elements, including the number of policies terminated due to nonpayment, cancellations initiated by the insurer for reasons other than nonpayment or free-look provisions, and cancellations made at the request of the insured. He asked for comments on this item and, hearing none, moved on.

Guillory then presented item nine, which relates to complaints and internal reviews. He explained that the proposed data elements would track the number of adverse determinations overturned upon request for internal review and the number upheld upon request for internal review, explicitly excluding voluntary levels of review. He invited comments on this item. No feedback was offered.

Guillory began by addressing complaints and complaint request activity, noting that there had been some prior comments on this topic.

Guillory then reviewed questions 32 and 33, explaining that there had been a question about whether the counts in question 33 include the counts in question 32. He clarified that if new claimant requests or terminations were not completed by the end of the period, they would be included in both buckets.

Guillory further discussed question 32, which involves new claimant requests determined not to be actual requests during the period. He explained that if a company adjusts the counts so they no longer match prior numbers, they should include a comment explaining why the counts differ. If the counts do match, companies should add a comment explaining that some requests were determined to be not pertinent.

Guillory concluded by inviting any additional questions or comments on Parts A or B of this section, noting that the language involved was detailed and warranted careful review.

Guillory addressed the scenario in which an insurance benefit eligibility is initially denied but then overturned on appeal in the following year. He explained that the Working Group decided not to request an amendment to the prior year's report; the denial would remain in the first year, and it would be reported as a new claimant request the following year.

Guillory also noted that during the Working Group's November meeting, there were no comments regarding changes or edits to the existing data elements or adding new data elements.

Guillory then indicated that the discussion on claimants and claim request activities appeared to be concluded, as no further comments were offered.

Guillory introduced the discussion on benefit payment request activities, specifically question 49. He explained that the comment period had been opened and highlighted a scenario in which a monthly bill includes an itemized list of expenses, most of which are approved, but one or more items are denied as not covered under the policy. He noted that the main question for discussion is whether companies still need to account for these smaller denials, given that the overall claim was approved.

Guillory stated that this issue is still open for discussion and that comments were requested to be sent to the NAIC. He emphasized the focus on understanding what information would be useful for regulators and what

companies would prefer in reporting these partial denials. He then invited regulators to provide feedback or comment on any related topics.

LeDuc commented that on the health side, claim-related information is typically collected at a line level because some items in a claim may be paid while others are denied. She questioned the level at which the data is actually being collected—whether at the line code level—and suggested that if it is already collected that way, there may not be an issue. If it is not collected at that level, then the Working Group may need to consider adjustments.

Guillory acknowledged LeDuc's point and noted that Marsh was already looking into it. He reviewed the benefit payment requests section himself and agreed that if the data is already collected at the line level, companies would simply report approvals or denials at that level, making the concern moot. He suggested verifying the definitions to be sure.

Guillory directed to the benefit payment requests section, clarifying that this is distinct from general claims. He read the following definition: "Each request or demand for benefit payment is treated as a distinct benefit payment request, and continuing payments for the same service should also be treated as separate requests. The period of time from the company's receipt of documentation to payment should be captured for each approved request."

Guillory concluded that, based on this definition, reporting appears to be at the line-item level, and he asked if anyone had a different interpretation or was aware that it is being done differently.

LeDuc stated that it appears the company or member asking the question may not realize the level of detail—or "grain"—at which they are supposed to report. She agreed with Guillory that the current definitions address the question and that reporting at the line-item level for individual claim requests is already addressed.

Guillory agreed and suggested that if anyone disagreed, the Working Group could consider adding clarifying language to explicitly confirm that reporting is at the line-item level. He invited further comments or thoughts from the Working Group.

Guzman said he interprets the guidance the same way but agreed that including additional clarity in the definition would help alleviate any potential ambiguity.

Guillory checked for other comments or questions. He acknowledged Kelcher's clarification that MCAS questions for private passenger auto (PPA) do ask for the names of MGAs and TPAs, which is relevant to the earlier discussion. He then asked if anyone disagreed that the current guidance can be interpreted to report at the line-item level and suggested that any clarification could be addressed and possibly voted on in a future call.

Guillory closed the discussion on benefit payment requests and transitioned to the next section on lawsuit activity, noting that no comments or questions had been received so far. He invited the Working Group to raise any issues regarding the current lawsuit questions.

Guillory introduced the final section, which covers items to be considered at a later time. He explained that some of these items may require changes beyond the LTC blank. He highlighted data elements four through nine, including a question asking whether the company experienced a significant event or business strategy affecting the reporting period. He noted that the wording is inconsistent across lines of business, with the current version being the most common, and suggested that the Working Group consider whether consistent wording across all lines would be beneficial or problematic. He invited discussion on this topic.

Guillory then addressed a new data element regarding the number of class action lawsuits. He noted that if the group decides to include it, they would also need to decide whether it belongs in the interrogatory section or the lawsuit section and whether the question should be expanded to other lines of business. He asked for any comments or questions on this data element.

Guillory opened the floor for any additional comments or questions on the LTC blank, inviting members to raise any new points they may have reviewed in the intervening period.

4. Discussed Other Matters

Ray Nelson (AHIP) asked a procedural question regarding the LTC blank. He wanted to know whether there would be a step where a draft of new instructions or materials would be available for review and comment, or if the group would move directly toward finalization.

Guillory responded that, generally, because this work did not go before an SME group or subcommittee, the usual process is to take a vote on the wording for each question. He deferred to Cooper to confirm or add to his explanation. Cooper explained that after decisions are made on each individual item, a complete blank and data column definitions would be compiled for the Working Group to review and approve, ensuring that all items are accurately captured. Guillory agreed with Cooper and clarified that a draft would be provided for review, followed by a comment period on the "final draft," and then a vote to approve or adjust that draft.

Guzman raised a concern regarding the health MCAS ratios, noting that while it might be more appropriate for the Market Analysis Procedures (D) Working Group, he wanted to bring it to the attention of this Working Group. He explained that in reviewing health MCAS data for large carriers and completing level one reviews in the market analysis review system, an issue was identified that has likely existed since the inception of these ratios.

Guzman described that some health MCAS ratios are structured such that a lower ratio is preferable to a higher one. For example, ratio four measures the percentage of network claims paid within 30 days. In this case, a lower ratio is concerning for the carrier, whereas a higher ratio indicates better performance.

Guzman pointed out that the issue arises because the ranking system assumes that a higher ratio equals a higher rank, which is inconsistent with the intended interpretation of these ratios. As a result, carriers with the lowest percentages of claims paid within 30 days were incorrectly ranked very low, while carriers with the highest percentages were ranked highest, contrary to what the data should reflect.

Guzman noted that this miscalculation affects multiple ratios, including timeliness ratios four through eight, and other ratios where a higher value is actually worse. He emphasized that the ranking error exists both in the MCAS Market Analysis Prioritization Tool (MAPT) and the level one reviews in the Market Analysis Review System (MARS), impacting all the data they examined. He concluded by bringing this issue to the Working Group's attention for consideration.

Cooper responded to Guzman, acknowledging that she is aware of how the ranks are calculated. She suggested that the situation may simply be a training issue. She explained that the system was designed with the understanding that some ratios are better when higher and some are better when lower. The rankings are meant to distribute companies by size so that analysts can see where a company falls in the range and then determine whether a high or low value is favorable.

Guzman agreed that Cooper's explanation makes sense, but clarified the core issue. He noted that the rank

formula itself does not account for whether a higher or lower ratio is preferable. As a result, the system may signal a potential issue with a company when, in reality, a high ratio represents a positive outcome and a low ratio is the true concern.

Guillory addressed the discussion on the health MCAS ranking issue, noting that it likely falls outside the Working Group's mission and would be better suited for the Market Analysis Procedures (D) Working Group. He emphasized that analysts are expected to interpret ranks in context, understanding that a low rank is not always bad and a high rank is not always good, depending on the specific measure. He suggested that any systemic changes to make ranking consistent across all measures would need to be coordinated with the Market Analysis Procedures (D) Working Group and asked Cooper to confirm his summary.

Guzman agreed that the issue is better addressed by the Market Analysis Procedures (D) Working Group. He appreciated the opportunity to raise it in the current meeting but noted that adjustments would likely be discussed and implemented through the Market Analysis Procedures (D) Working Group to ensure consistency.

Guillory thanked Guzman for raising the topic and acknowledged that tangential issues like this are interesting and valuable, noting that many participants serve across multiple working groups. He then shared a comment from Jared Holshouser (VT), who reported encountering the same ranking issue and conducting their own analysis because the built in ranks were not helpful. Guillory offered to discuss that further offline if needed.

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

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: 2/2/2026	
Proposed Effective Data Year for Reporting: 2026 Data Year	
Proposed ☒ Substantive Change ☐ Non-Substantive Change/Clarification	
Proposal Number	2026.1
Proposal Status	All Submissions ☒ Received – Date 2/2/2026 ☐ 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	Teresa Cooper / Hal Marsh / Kelsey Bollin

Proposal Contact Information

Name of Contact Person	John Fielding
Name of Organization	NAPHIA
Email Address	John@FieldingStrategies.com
Phone Number	202-716-2212
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:

(1) Insert the phrase "maximum benefit limits" to the Partial Payment definition's excluded payment claims provision. With the proposed change, the definition would be restored to the language originally adopted by the NAIC and to its original intent. It would read as follows (restored language bolded/underlined):

> Partial Payment – A claim not paid in full for costs included within the terms of coverage of the insurance policy/certificate.

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- Removal from a claim of charges for costs not covered in the policy – where there is full payment for costs covered in the policy – is not considered a partial payment.
- Do not report as partial payment claims that are reduced by deductibles, copays, **maximum benefit limits,** or other limitations set by the insurance policy/certificate.

(2) Delete interrogatory 3-109 as follows:

~~3-109 Number of claims closed during the period with partial payment – maximum benefit limit~~

(3) Re-number the subsequent interrogatories accordingly.

PROVIDE THE REASON FOR THE CHANGE:

The definition of "Partial Payment" in the Pet MCAS was changed at the NAIC Fall National Meeting in December 2025, when the phrase "maximum benefit limits" was removed from the list of elements that are not considered partial payments under the Partial Payment definition. Prior to the change, claims payments that were affected because a policy's maximum benefit limit had been reached were NOT considered to be Partial Payments. As a result of the recent change, however, a claims payment that is affected because a policy's maximum benefit limit has been reached could be considered a "Partial Payment" and therefore could be subject to MCAS reporting. This was not the intent when the Pet MCAS was adopted.

Background: The purpose of the partial payment interrogatories is to determine the number of claims closed during a given period that **should have been paid but were not paid**. It is **not** intended to include information regarding claims (or portions thereof) that were not paid in accordance with policy terms. That is why the original definition of "Partial Payment" specifically stated that partial payments do not include claims "reduced by deductibles, copays, maximum benefit limits, or other limitations set by the insurance policy/certificate." Maximum benefit limits are an essential element of a pet insurance policy.

Proposal: The phrase "maximum benefit limits" should be included the Partial Payment definition's list of excluded elements because pet insurance policies cover claims up to the policy's maximum benefit limit but do not cover claims in excess of that limit, in accordance with the terms of the policy. Thus, payment of a claim up to the maximum benefit limit is payment in full for the claim even if the insured's losses were greater than the amount paid. Such a payment is not a "Partial Payment."

The proposed addition of the phrase "maximum benefit limits" to the definition of Partial Payment is necessary to ensure that the Partial Payment data reported by insurers accurately reflects claims payments that are not fully paid but otherwise should have been.

In addition to restoring the phrase "maximum benefit limits" to the Partial Payment definition, Pet MCAS interrogatory 3-109 should be deleted. The interrogatory currently states:

3-109 Number of claims closed during the period with partial payment – maximum benefit limit

For the reasons noted above, payment of a claim up to the maximum benefit limit is payment in full for the claim even if the insured's losses were greater than the amount paid. It is not a Partial Payment. Thus, this interrogatory does not make sense and would not provide regulators with accurate information regarding actual Partial Payments. Further, due to the manner in which claims are handled, this is not data that industry has or would be able to provide.

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NAPHIA notes that there are two other interrogatories that address Partial Payments that should remain:

> *3-110 Number of claims closed during the period with partial payment – inadequate documentation*
>
> *3-111 Number of claims closed during the period with partial payment for reasons other than questions 109-110*

These interrogatories provide regulators with accurate information regarding all Partial Payments.

NAPHIA also notes that these interrogatories should be renumbered after the deletion of interrogatory 3-109.

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:

Click or tap here to enter text.

MCAS Required to File (RTF) Reporting Proposal from Oregon

Proposal:

Continue with the current RTF process where companies submit the **MCAS Premium Exhibit For Year** form as part of financials to identify whether they feel they are required to file or not.

In addition, the NAIC will provide each state, possibly as a Tableau report, lists of companies that meet certain criteria.

1. All companies licensed in a state that did not submit the **MCAS Premium Exhibit For Year** form. Include the following indicators by MCAS line…
    a. If the company has submitted past years MCAS data.
    b. If the company submitted an exemption for past years MCAS reporting and if it was approved by the state.
    c. If the company exceeds premium thresholds on their annual financials for the current MCAS reporting period and the reported premium value.
2. Companies that submit the form and report as not required to file for MCAS lines when they meet either of the following criteria.
    a. If the company has submitted past years MCAS data.
    b. If the company exceeds premium thresholds on their annual financials for the current MCAS reporting period and the reported premium value.

This would allow states to review the identified companies and decide if they would like to conduct any outreach or ask the NAIC to include them on the list of companies required to file.

MCAS Market Conduct Annual Statement

Long-Term Care (2025)

Long-Term Care Interrogatories

		Yes/No Response	Explanation
01	Does the company have data to report for Stand-Alone Long-Term Care?		--
02	Does the company have data to report for Life Long-Term Care Hybrid?		--
03	Does the company have data to report for Annuity Long-Term Care Hybrid?		--
04	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
05	If yes, add additional comments.	--	
06	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
07	If yes, add additional comments.	--	
08	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
09	If yes, add additional comments.	--	
10	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
11	If yes, add additional comments.	--	
12	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
13	If yes, add additional comments.	--	
14	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
15	If yes, add additional comments.	--	
	Stand-Alone - Is there a reason that the reported LTC (Stand Alone, Life Hybrid, Annuity Hybrid) 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)?		
	If yes, add additional comments.		
	Life LTC Hybrid - Is there a reason that the reported LTC (Stand Alone, Life Hybrid, Annuity Hybrid) 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)?		
	If yes, add additional comments.		
	Annuity LTC Hybrid - Is there a reason that the reported LTC (Stand Alone, Life Hybrid, Annuity Hybrid) 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)?		
	If yes, add additional comments.		
	Stand-Alone - Was the company still actively writing policies in the state at year end?		
	Life LTC Hybrid - Was the company still actively writing policies in the state at year end?		
	Annuity LTC Hybrid - Was the company still actively writing policies in the state at year end?		
	Number of class action lawsuits?		
	Does the company use Managing General Agents (MGAs)?		
	Does the company use Third Party Administrators (TPAs)?		
16	Additional state specific Stand-Alone Long-Term Care comments (optional).	--	
17	Additional state specific Life Long-Term Care Hybrid comments (optional).	--	
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional).	--	

Long-Term Care General Information

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
	Direct written premium during the period.			
	Direct earned premium during the period.			
19	Number of policies/contracts in-force as of the beginning of the reporting period.			
20	Number of new business policies/contracts issued during the period.			
	Possible edit to #20 - Number of applications approved during the period			
	Number of applications pending at the beginning of the period.			
	Number of applications pending at the end of the period.			
	Number of applications received.			
	Number of applications denied during the period.			
	Reasons for denied applications.			
21	Number of free look cancellations during the period.			
22	Number of lapses during the period.			

	Number of policies terminated or cancelled due to non-payment.	
	Number of policies terminated or cancelled by the insurer for reasons other than non-payment or free looks.	
	Number of policies terminated or cancelled at the request of the insured.	
23	Number of rescissions during the period.	
24	Number of policies/contracts in-force as of the end of the reporting period.	
25	Number of internal replacements during the period.	
26	Number of external replacements during the period.	--
27	Number of policies/contracts replaced where age of insured at replacement was < 65.	--
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.	--
29	Number of policies/contracts replaced where age of insured at replacement was > 80.	

Long-Term Care (2025)

Long-Term Care General Information Continued

30	Number of complaints received directly from consumers.	
	Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews).	
	Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels or reviews).	
	Number of customer requested appeals on final adverse determinations to an external review organization.	
	Number of final adverse determinations overturned upon request for external review.	
	Number of final adverse determinations upheld upon request for external review.	

Long-Term Care Claimants and Claimant Requests Activity

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

Long-Term Care Benefit Payment Requests Activity

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

Long-Term Care Lawsuit Activity

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

Long-Term Care Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
64	First Attestor Information.						--
65	Second Attestor Information.						--
66	Overall comments for the filing period.	--	--	--	--	--	