

Draft date: 05/01/26

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP

Thursday, May 7, 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	Matt Fischer	North Dakota
Tolanda McNeal, Vice Chair	Arizona	Guy Self	Ohio
Teri Ann Mecca/Lori Plant	Arkansas	Spencer Peacock	Oregon
Sheryl Parker	Florida	Gary Jones/August Hall/ Karen Veronikis	Pennsylvania
Paula Shamburger	Georgia	Gwendolyn Fuller McGriff/ Rachel Moore	South Carolina
Chris Heisler	Illinois	Larry D. Deiter	South Dakota
Charles Thomas	Kansas	Rhonda Bowling-Black	Tennessee
Lori Cunningham	Kentucky	Shelley Wiseman	Utah
Raymond A. Guzman	Maryland	Melissa Gerachis	Virginia
Mary Lou Moran	Massachusetts	Sandy Ray	Washington
Danielle Torres	Michigan	Theresa Miller/Letha Tate	West Virginia
Julie Hesser	Missouri	Jamie Adams	Wisconsin
Martin Swanson	Nebraska		
Elouisa Tyler	New Mexico		

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

AGENDA

1. Consider Adoption of its April 4 Minutes—*Joshua Guillory (LA)* Attachment 1
2. Consider Long-Term Care (LTC) Market Conduct Annual Statement (MCAS) Edits—*Joshua Guillory (LA)* Attachment 2
3. Consider the Pet MCAS Proposal Form Related to Maximum Benefit Limit Reporting—*Joshua Guillory (LA)* Attachment 3
4. Review LTC MCAS Data Call and Definitions Edits—*Joshua Guillory (LA)* Attachment 4
5. Review the Frequently Asked Questions (FAQ) for Other Health (OH) Accident-Only Coverage—*Joshua Guillory (LA)* Attachment 5
6. Discuss Any Other Matters Brought Before the Working Group—*Joshua Guillory (LA)*
7. Adjournment

Draft: 4/23/26

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 9, 2026

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 9, 2026. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Karen McGlynn (FL); Paula Shamburger (GA); Chris Heisler (IL); Desirée Neyens (KS); Lori Cunningham (KY); Raymond A. Guzman (MD); Danielle Torres (MI); Julie Hesser (MO); Robert McCullough (NE); Ryan McConnell and Ben Hauck (OH); Spencer Peacock (OR); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Melissa Gerachis (VA); and Darcy Paskey (WI).

1. Adopted its Dec. 18, 2025, and Feb. 5, 2026, Minutes

Veronikis made a motion, seconded by McNeal, to adopt its Dec. 18, 2025, (*see NAIC Proceedings – Spring 2026, Market Regulation and Consumer Affairs (D) Committee, Attachment Four*) minutes. The motion passed unanimously.

Hesser made a motion, seconded by Torres, to adopt its Feb. 5, 2026, (*see NAIC Proceedings – Spring 2026, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*) minutes. The motion passed unanimously.

2. Discussed the Pet MCAS Proposal Form on Maximum Benefit Limit Reporting

Guillory said the Working Group will consider a submitted pet Market Conduct Annual Statement (MCAS) proposal regarding the reporting of maximum benefit limits regarding partial payments. He noted the proposal was included in the meeting materials and had been submitted by John Fielding (Fielding Strategies).

Fielding stated that he represents the North American Pet Health Insurance Association (NAPHIA) and noted the association's prior involvement in the development of the pet MCAS. He explained that although a prior revision clarified the definition of partial payments, reporting issues and confusion remain. He summarized his proposal, which would revise the definition of "partial payment" to expressly exclude claims reduced by maximum benefit limits and would delete Interrogatory 3.109 regarding claims closed with partial payments involving maximum benefit limits. Fielding stated that claims that reach the maximum benefit limit constitute full payments under the policy terms and should not be reported as partial payments. He indicated that the proposed changes would improve consistency and clarity for both regulators and reporting entities.

Lisa Brown (American Property Casualty Insurance Association—APCIA) expressed support for the proposed changes.

Guillory noted that the proposal had been submitted in early February and had been discussed at multiple meetings. He asked whether any Working Group member wished to make a motion to adopt the proposed revisions. No motion was made.

Guillory indicated that the Working Group would allow an additional comment and review period and would consider the proposal again at the next meeting. He stated that if no motion is made at the next meeting, the Working Group may decide not to take any further action on the proposal. Guillory requested that the item be included on the next meeting agenda, and NAIC committee support confirmed the request.

3. Discussed the Required-to-File Procedures for MCAS Filings

Guillory noted that this topic had been discussed previously and that concerns regarding the current required-to-file process had originally been raised by Peacock. Guillory referenced a prior discussion in which NAIC committee support outlined the existing process and potential options for improvement. He noted that Peacock had recently submitted a proposal to enhance the required-to-file process, which was included in the meeting materials, and asked Peacock to present his proposal.

Peacock explained that the proposal reflects work conducted in Oregon to identify companies that may not have properly complied with MCAS required-to-file obligations. He stated that the analysis focused on identifying companies that either did not submit the required form despite meeting premium thresholds, submitted blank forms, responded “no” where reporting was expected, or may have relied on prior exemptions. He explained that the review was limited to life, annuity, homeowners, and private passenger auto lines and to companies with more than \$1 million in written premium. Through this analysis, Oregon identified a number of companies across these lines that appeared to be out of compliance and conducted outreach to request clarification or correction.

Peacock stated that the majority of responses indicated inadvertent errors and that companies intended to correct their reporting. He indicated that the purpose of the proposal was to determine whether similar analytical reports could be made available by the NAIC for use by all interested states, thereby reducing duplicative state efforts and helping identify companies that may have unintentionally failed to comply with required-to-file reporting. He stated that the proposal was shared as an example of Oregon’s approach and as a potential framework for broader use.

Guillory thanked Peacock and opened the discussion to Working Group members, state regulators, and interested parties. No questions were raised. He then noted that NAIC committee support had been asked to review the proposal and invited them to provide feedback.

Teresa Cooper (NAIC) stated that she supported the proposal and agreed with the logic presented. She indicated that the NAIC has the capability to develop reports of this nature, though some data preparation would be required to make the information easier to report. She noted that such work could be placed in the NAIC backlog, though timing for completion could not be determined. Cooper expressed support for moving forward with the concept.

Guillory noted a comment from a West Virginia regulator indicating that West Virginia already tracks lines of business annually against premium thresholds and compares that information to the NAIC required-to-file list for outreach purposes. He then asked whether Working Group members or state regulators had additional questions or comments regarding the creation of similar reports to support required-to-file indicators.

Guillory specifically asked state regulators whether such reports would be used if developed, noting the importance of ensuring the value of the effort. Multiple state regulators responded affirmatively. Guillory stated his support for the proposal. NAIC committee support indicated that a vote was not necessary and that work could begin without formal action. Guillory requested that NAIC committee support proceed with exploring the development of the proposed reporting enhancements and thanked staff and participants for their input.

4. Discussed the Reporting of Accident-Only Coverage on MCAS Blanks

Guillory stated that this issue had been brought to the Working Group by Caren Alvarado (Crum & Forster) and asked Alvarado to present the issue.

Alvarado explained that she had previously raised this topic during earlier other health MCAS discussions and was requesting additional clarification due to continued confusion regarding the reporting of accident-only coverage. She noted that the MCAS provides clear guidance on certain exemptions, such as blanket coverage; however, ambiguity remains regarding group types that do not qualify as employer groups but do not clearly meet the definition of an association under various state eligibility rules. She stated that this lack of clarity has led to inconsistent reporting.

Alvarado highlighted occupational accident coverage as a primary source of confusion. She explained that occupational accident coverage is typically issued to independent contractors and offered in lieu of workers' compensation, although it is filed as accident and health insurance. She stated that she does not believe this coverage was intended to be captured as accident-only coverage in the other health MCAS. She further noted that some carriers are being instructed to report occupational accident coverage as accident-only, while others are instructed to exclude it because it functions as a workers' compensation substitute. Alvarado stated that this inconsistency has resulted in uneven reporting and requested either clarification or exclusion of occupational accident coverage from accident-only reporting to ensure consistent treatment across carriers.

Alvarado suggested that the issue could be addressed by clarifying the MCAS FAQs. Alvarado agreed that updated FAQ guidance would be helpful, noting that the current instructions are silent on this issue.

JP Wieske (Health Benefit Institute) expressed support for Alvarado's comments and stated that clarification would be very helpful. No further questions or comments were raised.

Guillory proposed providing a 30-day public comment period on the issue and requested that NAIC committee support prepare a draft FAQ or definitional language for consideration at the next Working Group meeting, with the intent of voting on a resolution thereafter. No objections were raised.

NAIC committee support indicated that assistance could be provided, but requested subject-matter input to ensure appropriate language. Alvarado offered to draft proposed language for staff review and to be available for follow-up discussion as needed.

5. Considered LTC MCAS Edits

Guillory said the Working Group will review the draft long-term care (LTC) MCAS blank, which was provided in the meeting materials. He stated that the objective of the discussion was to review each proposed edit to determine whether it should remain in the draft. He noted that, time permitting, the Working Group would also discuss updates to the related data call and definitions. Guillory indicated that NAIC committee support would clean up and repost drafts following the meeting for comment, with the intent of taking final action at the next Working Group meeting.

Guillory noted that written comments had been received from the American Council of Life Insurers (ACLI) and AHIP.

Ray Nelson (AHIP) and Ayah Abedali (ACLI) provided a summary of their joint comments on the draft blank. They expressed concern about a proposed interrogatory regarding the number of class action lawsuits, noting that this issue had been previously considered during the original development of the LTC MCAS and that existing lawsuit activity questions already capture this information. They recommended removing the proposed addition to avoid

duplication. They further requested clarification on whether the newly proposed items shown in the draft were intended to be added in addition to or in lieu of existing questions.

Industry representatives also commented on proposed additions, requesting direct written and earned premium information. They noted that LTC premiums are already reported to the NAIC through annual statements and experience exhibits and that hybrid products present challenges because financial statements capture total product premiums rather than LTC-specific amounts. They requested the removal of the proposed premium items due to redundancy and limited added value.

Additional concerns were raised regarding proposed edits related to application activity, including applications approved, pending, or denied. Industry representatives stated that underwriting practices and systems vary significantly across companies and that such data may not be readily available or comparable. They also raised concerns about policy terminations and adverse determinations, noting the need for clarification, definitional consistency, and the potential burden of collecting such data. Industry representatives requested confirmation of the implementation timeline, which Guillory confirmed would apply to calendar year 2027 data, reported in 2028, provided the blank is adopted by mid-2026.

Guillory confirmed the target timeline and emphasized the goal of adopting the blank by June 1, 2026, to avoid delaying implementation. He then opened the floor for Working Group members and regulator questions and comments.

During the discussion, Guillory conducted an informal line-by-line review of proposed changes to the draft blank. For each item, Working Group members were asked to provide feedback and informal indications of support or opposition. No formal motions were taken during the meeting, though general support was expressed for several proposed interrogatories, including free-form explanatory questions, questions regarding whether companies remain actively writing business in a state, use of managing general agents (MGAs) or third-party administrators (TPAs), and several general information items.

With respect to the proposed class action lawsuit item, the Working Group expressed interest in retaining the concept but agreed that it would be more appropriately placed in the lawsuit activity section rather than as a separate interrogatory. NAIC committee support agreed to revise the draft accordingly.

Discussion continued on proposed items regarding application tracking, policy terminations, and adverse determinations. Regulators requested additional industry input on the feasibility, given the implementation timeline. NAIC committee support noted that reporting reasons for denied applications would require predefined categories, as free-text entries are not supported. Guillory indicated that the Working Group would further consider whether to include reasons for denial or to limit reporting to summary counts, and whether such information may already be available through other regulatory reporting sources.

Following completion of the informal review, Guillory summarized the next steps. He stated that all proposed items would remain in the draft pending formal motions and votes at the next Working Group meeting. NAIC committee support will revise the draft to reflect the discussion, including relocation of the class action lawsuit item, and repost the updated blank for review. Guillory noted that votes will be required on the LTC MCAS blank at the next meeting and that the data call and definitions would also need to be reviewed and acted upon prior to June.

Guillory confirmed that data call changes require higher-level Working Group approval, while FAQs do not. He reiterated that additional meetings may be scheduled in April or May to complete remaining work prior to the June deadline.

Guillory thanked industry representatives for their comments and invited continued participation during the upcoming line-by-line review and voting process.

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

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.	--	
16 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)?		
17 If yes, add additional comments.		
18 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)?		
19 If yes, add additional comments.		
20 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)?		
21 If yes, add additional comments.		
22 Stand-Alone - Was the company still actively writing policies in the state at year end?		
23 Life LTC Hybrid - Was the company still actively writing policies in the state at year end?		
24 Annuity LTC Hybrid - Was the company still actively writing policies in the state at year end?		
25 Does the company use Managing General Agents (MGAs)?		
26 Does the company use Third Party Administrators (TPAs)?		
16 27 Additional state specific Stand-Alone Long-Term Care comments (optional).	--	
17 28 Additional state specific Life Long-Term Care Hybrid comments (optional).	--	
18 29 Additional state specific Annuity Long-Term Care Hybrid comments (optional).	--	

Long-Term Care General Information

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
30 Direct written premium during the period.			
31 Direct earned premium during the period.			
19 32 Number of policies/contracts in-force as of the beginning of the reporting period.			
20 33 Number of new business policies/contracts issued during the period.			
34 Possible edit to #20 - Number of applications approved during the period			
35 Number of applications pending at the beginning of the period.			
36 Number of applications pending at the end of the period.			
37 Number of applications received.			
38 Number of applications denied during the period.			
Reasons for denied applications: (Text entry not allowed in this reporting section. No specific reasons to report were identified.)			
21 39 Number of free look cancellations during the period.			
22 40 Number of lapses during the period.			

Long-Term Care (2025)

Long-Term Care General Information Continued

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
41	Number of policies terminated or cancelled due to non-payment.			
42	Number of policies terminated or cancelled by the insurer for reasons other than non-payment or free looks.			
43	Number of policies terminated or cancelled at the request of the insured.			
23 44	Number of rescissions during the period.			
24 45	Number of policies/contracts in-force as of the end of the reporting period.			
25 46	Number of internal replacements during the period.			
26 47	Number of external replacements during the period.	--		
27 48	Number of policies/contracts replaced where age of insured at replacement was < 65.	--		
28 49	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.	--		
29 50	Number of policies/contracts replaced where age of insured at replacement was > 80.			
30 51	Number of complaints received directly from consumers.			
52	Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews).			
53	Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels or reviews).			
54	Number of customer requested appeals on final adverse determinations to an external review organization.			
55	Number of final adverse determinations overturned upon request for external review.			
56	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 57	Number of claimants approved for benefits as of the beginning of the period.			
32 58	Number of claimants with pending claimant request determinations as of the beginning of the period.			
33 59	Number of new claimants during the period.			
34 60	Number of claimants with pending claimant request determinations as of the end of the period.			
35 61	Number of claimants approved for benefits as of the end of the period.			
36 62	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).			
37 63	Number of claimant requests denied or not paid because of preexisting condition exclusion.			
38 64	Number of claimant requests denied or not paid because of elimination or waiting period not met.			
39 65	Number of claimant requests denied or not paid because services provided not covered under the policy.			
40 66	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.			
41 67	Number of claimant requests denied or not paid because benefits eligibility criteria not met.			
42 68	All other claimant requests denied or closed without payment.			
43 69	Number of claim request determinations made within 0-30 days.			
44 70	Number of claim request determinations made within 31-60 days.			
45 71	Number of claim request determinations made within 61-90 days.			
46 72	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 73	Number of benefit payment requests pending as of the beginning of the period.			
48 74	Number of benefit payment requests received during the period.			
49 75	Number of benefit payment requests denied or not paid during the period.			
50 76	Number of benefit payment requests pending as of the end of the period.			
51 77	Number of benefit payment requests paid within 0-30 days.			
52 78	Number of benefit payment requests paid within 31-60 days.			
53 79	Number of benefit payment requests paid within 61-90 days.			
54 80	Number of benefit payment requests paid beyond 90 days.			
55 81	Number of benefit payment requests denied or not paid within 0-30 days.			
56 82	Number of benefit payment requests denied or not paid within 31-60 days.			
57 83	Number of benefit payment requests denied or not paid within 61-90 days.			
58 84	Number of benefit payment requests denied or not paid beyond 90 days.			

Long-Term Care (2025)

Long-Term Care Lawsuit Activity

	Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59 85	Number of lawsuits open as of the beginning of the period.		
60 86	Number of lawsuits opened during the period.		
61 87	Number of lawsuits closed during the period - total.		
62 88	Number of lawsuits closed during the reporting period with consideration for the consumer.		
63 89	Number of lawsuits open as of the end of the period.		
90	Number of class action lawsuits?		

Long-Term Care Attestation

	First Name	Middle Name	Last Name	Suffix	Title	Comments
64 91	First Attestor Information.					
65 92	Second Attestor Information.					
66 93	--	--	--	--	--	--

**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 <input checked="" type="checkbox"/> Substantive Change <input type="checkbox"/> Non-Substantive Change/Clarification	
Proposal Number	2026.1
Proposal Status	<u>All Submissions</u> <input checked="" type="checkbox"/> Received – Date 2/2/2026 <input type="checkbox"/> Accepted <input type="checkbox"/> Rejected by MCAS Blanks WG Chair <input type="checkbox"/> Posted to Web Page for Public Exposure/Comment – Date Click or tap to enter a date. <input type="checkbox"/> Referred to Another NAIC Group – Date Click or tap to enter a date. – Name of Group Click or tap here to enter text. <input type="checkbox"/> Adopted <input type="checkbox"/> Modified <input type="checkbox"/> Rejected <input type="checkbox"/> Deferred by WG – Date Click or tap to enter a date. <u>Substantive Revisions</u> <input type="checkbox"/> Adopted <input type="checkbox"/> Rejected by D Committee – Date Click or tap to enter a date. <input type="checkbox"/> Adopted <input type="checkbox"/> Rejected by EX/Plenary – Date Click or tap to enter a date. <input type="checkbox"/> 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	<input type="checkbox"/> State Regulator <input type="checkbox"/> NAIC Staff <input type="checkbox"/> Other Regulator <input type="checkbox"/> Reporting Company <input checked="" type="checkbox"/> Industry Trade Association <input type="checkbox"/> Consumer Representative <input type="checkbox"/> Other

PROPOSAL IS FOR: Data Element Data Definitions Data Validation

APPLICABLE LINE(S) OF BUSINESS:

<input type="checkbox"/> Annuity	<input type="checkbox"/> Lender Placed Auto and Home	<input type="checkbox"/> Private Flood
<input type="checkbox"/> Disability Income	<input type="checkbox"/> Life	<input type="checkbox"/> Private Passenger Auto
<input type="checkbox"/> Health	<input type="checkbox"/> Long-Term Care	<input type="checkbox"/> Travel
<input type="checkbox"/> Homeowners	<input type="checkbox"/> Other Health	<input type="checkbox"/> STLD
<input checked="" type="checkbox"/> 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.

NAIC MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
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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.

Long-Term Care Data Call and Definitions – Areas for Review

1. Handling of class action lawsuit reporting
2. Actively Writing – New Interrogatory questions
3. Managing General Agent (MGA) – An insurance producer authorized by an insurance company to manage all or part of the insurer’s business. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs. (From Pet MCAS)
4. Third Party Administrator (TPA) - From the MCAS FAQs: For MCAS purposes, the definition of third-party administrators (TPAs) should be used broadly for any purpose for which a company uses a TPA. This may include, but is not limited to, marketing, claims, underwriting, or other administrative functions.
5. Cancellations / Terminations:

From Homeowner MCAS DCDs:

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium or non-sufficient funds.
 - o These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)
- Policies cancelled at the insured’s request.
- Policies cancelled for underwriting reasons.

Exclude: Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.

From Health MCAS DCDs

Number of policy terminations and cancellations initiated by the policyholder–

Number of policies terminated at the insured's request.

Number of policy terminations and cancellations due to non-payment of premium

– Number of policies terminated because the insured never paid, or stopped paying, the required premium for coverage.

6. Adverse Determination – From Health DCDs

A rescission, or a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a

Long-Term Care Data Call and Definitions – Areas for Review

member's, or eligible dependent's, eligibility to participate in a plan, and including a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

7. Overturned Decision – From Health DCDs

A reversal of a denial of an adverse determination by a health carrier or its designee utilization review organization.

8. Upheld Decision – From Health DCDs

A denial of an adverse determination that has been found to be supported by a health carrier or its designee utilization review organization.

9. Possibly remove definition of Lapse if question #22 is removed from the blank.

Current Data Reporting FAQs - Long-Term Care MCAS

What is the difference between “pending” benefit payment requests versus “pending” claimant request determinations for Long-Term Care?

The section on claimant request determinations is to be done on a “per claimant” basis which means that we are counting each individual who makes one or more requests for coverage under a policy or contract. It is NOT the actual benefit payment request. A benefit payment request is a request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment.

Is Schedule 6 on the Long-Term Care referring to the amount of time between a benefit payment request and when the company makes the payment? Or is it the amount of time between subsequent payments after the initial payment?

The data elements in Schedule 6 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes payment for an approved claimant (after satisfaction of the waiting or elimination period, if any).

Long-Term Care Data Call and Definitions – Areas for Review

Are the number of benefit payment requests received during the reporting period referring to every transaction/payment made on any one policy with Long-Term Care?

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

**Proposed FAQ to address the reporting of Accident-Only
coverage on the Other Health MCAS Blank**

Submitted 04/22/2026

Does the definition of Other Health include Occupational Accident insurance issued to independent contractors? No, Occupational Accident insurance is excluded from the definition of Other Health.