NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft date: 5/6/25

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Thursday, May 22, 2025
3:00 – 4:30 p.m. ET / 2:00 – 3:30 p.m. CT / 1:00 – 2:30 p.m. MT / 12:00 – 1:30 p.m. PT

ROLL CALL

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

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

AGENDA

1.	Consider Adoption of the Market Conduct Annual Statement (MCAS) Other Health Blank and Data Call and Definitions Proposal—*Joshua Guillory (LA)*	Attachment 1 Attachment 2
2.	Discuss and Consider Moving Homeowner MCAS Question No. 8, "If Yes, what percentage of your business is non-standard?" from the Interrogatories Section to the Underwriting Activity Section—*Joshua Guillory (LA)*	
3.	Consider Adoption of the MCAS Lender-Placed Insurance (LPI) Proposal Related to Coverage Renewed—*Joshua Guillory (LA)*	Attachment 3 Attachment 4
5.	Discuss and Consider Removal of the MCAS Complaints Data Element for Collecting Number of Complaints Received Directly from the Department of Insurance (DOI)—*Joshua Guillory (LA)*	Attachment 5

6. Discuss Reporting of Claims Closed with Partial Payment Due to Maximum Benefit Limit on the Pet MCAS—*Joshua Guillory (LA)* — Attachment 6

7. Receive an Update and Proposal from the MCAS Travel Subject Matter Expert (SME) Group—*Raymond A. Guzman (MD)* — Attachment 7, Attachment 8

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

9. Adjournment

MCAS Market Conduct Annual Statement

Legend
Black font = Text from Existing Blank
~~Red, strikethrough~~ = Proposed Deletion
Blue font = Proposed Change from SME Group
Purple font = Proposed Change from Missouri

Other Health Insurance (2026)

Other Health Insurance Interrogatories

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

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

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

Other Health Insurance (2026)

Policy/Certificate Administration

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

Claims Administration (Including Pharmacy)

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

Other Health Insurance (2026)

Consumer Complaints and Lawsuits

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

Marketing and Sales

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

Other Health Insurance Attestation

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

MCAS Market Conduct Annual Statement

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Legend
Black font = Text from Existing Blank
~~Red, strikethrough~~ = Proposed Deletion
Blue font = Proposed Change from SME Group
Purple font = Proposed Change from Missouri

Contact Information

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

Schedule 1 – Interrogatories – Individual Products

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Schedule 1 – Interrogatories – Associations/Trusts Products

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

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

Schedule 1 – Interrogatories – Employer Group Products

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Schedule 1 – Interrogatories – Third Party Administrators/Vendors

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Schedule 1 – Interrogatories – General

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

Products

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Schedule 2 – Policy/Certificate Administration

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

~~2-60~~ 2-115	Number of covered lives impacted by rescissions during the period (only answer for individual products)
~~2-61~~ 2-116	Number of policies/certificates in force at the end of the period
~~2-62~~ 2-117	Number of covered lives on policies/certificates in force at the end of the period (only answer for individual and association products)

Schedule 3 – Claims Administration (Including Pharmacy)

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Schedule 4 – Consumer Complaints and Lawsuits

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

Schedule 5 – Marketing and Sales

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

~~5-99~~ 5-152	Unearned commissions returned to company on policies/certificates sold during the period

Schedule 6– Other Health Insurance Attestation

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

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

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

General Definitions:

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

Exclude the following from Other Health MCAS reporting:

- Discretionary policies (i.e., ~~Labor Unions, Financial Institutions, Debtors, other Discretionary groups~~ discretionary groups as defined by the reporting jurisdiction) (MO also proposes removing the Discretionary polices bullet point entirely)
- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

Health-Accident Only - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability (not disability income), or hospital and

medical care caused by or necessitated as a result of accident or specified kinds of accident

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

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

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

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

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

Exclude the following from Other Health MCAS reporting:

- Discretionary policies (i.e., ~~Labor Unions, Financial Institutions, Debtors, other Discretionary groups~~ discretionary groups as defined by the reporting jurisdiction) (MO also proposes removing the Discretionary polices bullet point entirely)
- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

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

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

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

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

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

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

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

Third party Entity – Licensed Administrators, licensed producers, vendors

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

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

Schedule 2 Definitions (Policy/Certificate Administration):

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

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Schedule 3 Definitions (Claims Administration):

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

Claim Clarifications:

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

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

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

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

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

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

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

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

Schedule 4 Definitions (Consumer Complaints and Lawsuits):

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Clean Claim - A "clean claim" refers to a claim submitted without any errors or missing information, meaning it can be processed and paid promptly without requiring additional investigation or development by the claims processor; essentially, a complete and accurate claim with all necessary details filled in correctly. (MO proposes removing this definition entirely since the changes proposed by MO would not include it in the blank)

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

Include:

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

Lawsuit—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Other Health Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Schedule 5 Definitions (Marketing and Sales)

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

Schedule 6– Other Health Insurance Attestation

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

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

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

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

NAIC USE ONLY

Proposal Submission Date: 2/28/2025	
Proposed Effective Data Year for Reporting: 2025 Data Year	
Proposed ☒ Substantive Change ☐ Non-Substantive Change/Clarification	
Proposal Number	2025.1
Proposal Status	All Submissions ☒ Received – Date 2/28/2025 ☒ Accepted ☐ Rejected by MCAS Blanks WG Chair ☒ Posted to Web Page for Public Exposure/Comment – Date 3/3/2025 ☐ 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	A portion of the proposal was adopted by the MCAS Blanks (D) Working Group on 5/1/25 as follows: 1) Revised definition of "Cancellations", 2) New definition for "Term of Coverage Completed", 3) New data element: "Number of certificates for which Term of Coverage Completed during the period", 4) New data element: "Number of individual policies for which Term of Coverage Completed during the period"

Proposal Contact Information

Name of Contact Person	Birny Birnbaum
Name of Organization	Center for Economic Justice
Email Address	birny@cej-online.org
Phone Number	5129121327
Affiliation Type	☐ State Regulator ☐ NAIC Staff ☐ Other Regulator ☐ Reporting Company ☐ Industry Trade Association ☒ Consumer Representative ☐ Other

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

APPLICABLE LINE(S) OF BUSINESS:

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

PROVIDE A CONCISE STATEMENT OF THE PROPOSED CHANGE:

There has been confusion about how an insurer should report the issuance of a subsequent LPI individual policy or certificate on the same property following the expiration of the term of the previous individual

policy or certificate. The proposal clarifies that such policies do not involve cancellations and adds data elements to further clarify reporting. See attached memo for details.

PROVIDE THE REASON FOR THE CHANGE:

See concise statement

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

Proposal from the Center for Economic Justice to

Address End of Coverage Issues on the Lender-Placed MCAS

February 28, 2025

Background

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

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

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

Coverage Cancellation and New Coverage Issuance

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

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

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

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

Proposed New or Revised Definitions

Approved by MCAS Blanks WG 5/1/25 Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage. Coverage under an individual policy or a certificate under a group policy ending at the end of the term of coverage is not a cancellation, even if the coverage is renewed through a subsequent individual policy or certificate. See also Flat Cancellation

To Be Considered 5/22/25 Coverage Renewed – Includes only those new coverage individual policies and certificates issued for the same property at the end of the term of coverage for the prior individual policy or certificate on that property. Include Coverage Renewed individual policies and certificates in individual policies written and certificates written during the period, respectively.

Approved by MCAS Blanks WG 5/1/25 Term of Coverage Completed – Include individual policies and certificates for which the term of coverage was completed and ended during the period.

To Be Considered 5/22/25 Individual Policies Written During the Period – Include all individual policies issued during the period before any flat or other cancellations, even if issued in error. Include all individual policies with Coverage Renewed.

To Be Considered 5/22/25 Certificates Written During the Period – Include all certificates issued during the period before any flat or other cancellations, even if issued in error. Include all certificates with Coverage Renewed.

Proposed New Data Elements

Approved by MCAS Blanks WG 5/1/25 3-59A Number of certificates for which Term of Coverage Completed during the period

To Be Considered 5/22/25 3-59B Number of certificates issued for Coverage Renewed during the period

Approved by MCAS Blanks WG 5/1/25 3-67A Number of individual policies for which Term of Coverage Completed during the period

To Be Considered 5/22/25 3-67B Number of individual policies issued for Coverage Renewed during the period

MCAS Complaint Data Element for Complaints Received Directly from the DOI.

LPI	Number of complaints received directly from the DOI
*Other Health	Number of complaints received through DOI
STLD	Number of complaints received through DOI
Travel	Number of complaints received directly from the DOI

* The Other Health proposal from the SME group eliminates this data element.

2024 MCAS Pet Insurance Blank

Claims Activity Schedule

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

2024 MCAS Pet Data Call and Definitions

Definitions for the Purposes of MCAS reporting (pg 13)

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

- 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.

MCAS Market Conduct Annual Statement

Travel (2027)

Travel Interrogatories

		Yes/No Response	Explanation
01	Were there policies/certificates in force during the reporting period that provide travel insurance coverage?		--
02	Has the company had a significant event/business strategy that would affect data for this reporting period?		--
03	If yes, add additional comments.	--	
04	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?		--
05	If yes, add additional comments.	--	
06	How does the company treat subsequent supplemental or additional payments on previously closed claims?	--	
07	Does the company use third party administrators (TPAs), managing general agents (MGAs), and/or travel administrators for purposes of supporting the travel insurance business being reported?		--
08	If yes, provide the names and functions of each ~~TPA~~.	--	
~~09~~	~~Does the company use managing general agents (MGAs) for purposes of supporting the travel insurance business being reported?~~		--
~~10~~	~~If yes, provide the names and functions of each MGA.~~	--	
~~11~~	~~Does the company use travel administrators for purposes of supporting the travel insurance business being reported?~~		--
~~12~~	~~If yes, provide the names and functions of each travel administrator.~~	--	
~~13~~ 09	Number of Travel Retailers offering and disseminating Travel Insurance on behalf of the Company at the end of the reporting period.	--	
~~14~~ 10	Additional state specific Claims comments (optional).	--	
~~15~~ 11	Additional state specific Lawsuit and Complaints comments (optional).	--	
~~16~~ 12	Additional state specific Underwriting comments (optional).	--	

Travel Claims Activity, Counts Reported by Claimant, by Coverage

		Trip Cancellation		Trip Interruption		Trip Delay		Baggage Loss/Delay		Emergency Medical/Dental				Emergency Transportation/Repatriation		Other	
		Domestic	International	Domestic	International	Domestic	International	Domestic	International	Domestic		International		Domestic	International	Domestic	International
										Excess	Primary	Excess	Primary				
~~17~~	13	Number of claims open at the beginning of the period.															
~~18~~	14	Number of claims opened during the period.															
~~19~~	15	Number of claims closed during the period, with payment.															
~~20~~	16	Number of claims closed during the period, without payment.															
~~21~~	17	Number of claims open at the end of the period.															
~~22~~	18	Median days to final payment.															
~~23~~	19	Number of claims closed with payment within 0-30 days.															
~~24~~	20	Number of claims closed with payment within 31-90 days.															
~~25~~	21	Number of claims closed with payment beyond 90 days.															
~~26~~	22	Number of claims closed without payment within 0-30 days.															

Travel (2027)

Travel Claims Activity, Counts Reported by Claimant, by Coverage Continued

		Trip		Trip		Trip		Baggage		Emergency				Emergency		Other	
		Domestic	International	Domestic	International	Domestic	International	Domestic	International	Domestic		International		Domestic	International	Domestic	International
										Excess	Primary	Excess	Primary				
~~27~~	23	Number of claims closed without payment within 31-90 days.															
~~28~~	24	Number of claims closed without payment beyond 90 days.															
~~29~~	25	Dollar amount of claims closed with payment.															

Travel Lawsuits and Complaints

			Total
~~30~~	26	Number of lawsuits open at the beginning of the period.	
~~31~~	27	Number of lawsuits opened during the period.	
~~32~~	28	Number of lawsuits closed during the period.	
~~33~~	29	Number of lawsuits open at the end of the period.	
~~34~~	30	Number of lawsuits closed with consideration for the consumer.	
~~35~~	31	Number of complaints received directly from the DOI.	
~~36~~	32	Number of complaints received directly from any person or entity other than the DOI.	

Travel (2027)

Travel Underwriting

			Total
~~37~~	33	Number of individual policies in force at the beginning of the period.	
~~38~~	34	Number of group policies (other than blanket policies) in force at the beginning of the period.	
~~39~~	35	Number of blanket policies in force at the beginning of the period.	
~~40~~	36	Number of policies/certificates in force during the reporting period.	
~~41~~	37	Number of individuals insured under all policies at the beginning of the period.	
~~42~~	38	Number of individual policies and certificates from group policies cancelled by the consumer during the period.	
~~43~~	39	Number of individual policies and certificates from group policies expired during the period.	
~~44~~	40	Number of individual policies and certificates from group policies in force at end of the period.	
~~45~~	41	Dollar amount of direct premium written during the period for individual policies.	
~~46~~	42	Dollar amount of direct premium written during the period for group policies (other than blanket).	
~~47~~	43	Dollar amount of direct premium written during the period for blanket policies.	

Travel Attestation

			First Name	Middle Name	Last Name	Suffix	Title	Comments
~~48~~	44	First Attestor Information.						--
~~49~~	45	Second Attestor Information.						--
~~50~~	46	Overall Comments for the Filing Period.	--	--	--	--	--	

MCAS Market Conduct Annual Statement

Property & Casualty Market Conduct Annual Statement
Travel Insurance Data Call & Definitions

Line of Business: Travel
Reporting Period: January 1, 2027 through December 31, 2027
Filing Deadline: April 30, 2028

Contact Information

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

Schedule 1 – Interrogatories

ID	Description	Response
1-01	Were there policies/certificates in force during the reporting period that provide travel insurance coverage?	Yes/No
1-02	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-03	If yes, add additional comments	Comment
1-04	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-05	If yes, add additional comments	Comment
1-06	How does the company treat subsequent supplemental or additional payments on previously closed claims?	Comment
1-07	Does the company use third party administrators (TPAs), managing general agents (MGAs), and/or travel administrators for purposes of supporting the travel insurance business being reported?	Yes/No
1-08	If yes, provide the names and functions of each ~~TPA~~.	Comment
~~1-09~~	~~Does the company use managing general agents (MGAs) for purposes of supporting the travel insurance business being reported?~~	~~Yes/No~~
~~1-10~~	~~If yes, provide the names and functions of each MGA.~~	~~Comment~~
~~1-11~~	~~Does the company use travel administrators for purposes of supporting the travel insurance business being reported?~~	~~Yes/No~~
~~1-12~~	~~If yes, provide the names and functions of each travel administrator.~~	~~Comment~~

~~1-13~~ 1-09	Number of Travel Retailers offering and disseminating Travel Insurance on behalf of the Company at the end of the reporting period.	Comment
~~1-14~~ 1-10	Additional state specific Claims comments (optional)	Comment
~~1-15~~ 1-11	Additional state specific Lawsuit and Complaints comments (optional)	Comment
~~1-16~~ 1-12	Additional state specific Underwriting comments (optional)	Comment

Coverages

Trip Cancellation
Trip Interruption
Trip Delay
Baggage Loss/Delay
Emergency Medical/Dental
Emergency Transportation/Repatriation
Other

Other Breakouts:

1) Each coverage listed is also broken out by Domestic vs. International coverage
2) Emergency Medical/Dental coverage is also broken out by Primary vs. Excess/Secondary coverage

Schedule 2—Travel Claims Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim.

ID	Description
~~2-17~~ 2-13	Number of claims open at the beginning of the period
~~2-18~~ 2-14	Number of claims opened during the period
~~2-19~~ 2-15	Number of claims closed during the period, with payment
~~2-20~~ 2-16	Number of claims closed during the period, without payment
~~2-21~~ 2-17	Number of claims open at the end of the period
~~2-22~~ 2-18	Median days to final payment
~~2-23~~ 2-19	Number of claims closed with payment within 0-30 days

~~2-24~~ 2-20	Number of claims closed with payment within 31-90 days
~~2-25~~ 2-21	Number of claims closed with payment beyond 90 days
~~2-26~~ 2-22	Number of claims closed without payment within 0-30 days
~~2-27~~ 2-23	Number of claims closed without payment within 31-90 days
~~2-28~~ 2-24	Number of claims closed without payment beyond 90 days
~~2-29~~ 2-25	Dollar amount of claims closed with payment

Schedule 3 – Lawsuits and Complaints

ID	Description
~~3-30~~ 3-26	Number of lawsuits open at the beginning of the period
~~3-31~~ 3-27	Number of lawsuits opened during the period
~~3-32~~ 3-28	Number of lawsuits closed during the period
~~3-33~~ 3-29	Number of lawsuits open at the end of the period
~~3-34~~ 3-30	Number of lawsuits closed with consideration for the consumer
~~3-35~~ 3-31	Number of complaints received directly from the DOI
~~3-36~~ 3-32	Number of complaints received directly from any person or entity other than the DOI

Schedule 4 – Underwriting

ID	Description
~~4-37~~ 4-33	Number of individual policies in force at the beginning of the period
~~4-38~~ 4-34	Number of group policies (other than blanket policies) in force at the beginning of the period
~~4-39~~ 4-35	Number of blanket policies in force at the beginning of the period
~~4-40~~ 4-36	Number of policies/certificates in force during the reporting period

~~4-41~~ 4-37	Number of individuals insured under all policies at the beginning of the period
~~4-42~~ 4-38	Number of individual policies and certificates from group policies cancelled by the consumer during the period
~~4-43~~ 4-39	Number of individual policies and certificates from group policies expired during the period
~~4-44~~ 4-40	Number of individual policies and certificates from group policies in force at end of the period
~~4-45~~ 4-41	Dollar amount of direct premium written during the period for individual policies
~~4-46~~ 4-42	Dollar amount of direct premium written during the period for group policies (other than blanket)
~~4-47~~ 4-43	Dollar amount of direct premium written during the period for blanket policies

Schedule 5 – Travel Attestation

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

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

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

Property & Casualty Market Conduct Annual Statement Travel Insurance Data Call & Definitions

ID	Description
~~5-48~~ 5-44	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~5-49~~ 5-45	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~5-50~~ 5-46	Overall Comments for the Period

In determining what business to report for a particular jurisdiction, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Participation Requirements: All companies licensed and reporting any travel insurance within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Definitions:

Travel Insurance - Means insurance coverage for personal risks incident to planned travel.

Include:

- Interruption or cancellation of trip or event;
- Loss of baggage or personal effects;
- Damages to accommodations or rental vehicles;
- Sickness, accident, disability or death occurring during travel;
- Emergency evacuation;
- Repatriation of remains; or
- Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Exclude:

- Major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months, including for example, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

Blanket Travel Insurance - Means a policy of Travel Insurance issued to any Eligible Group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the Eligible Group without a separate charge to

individual members of the Eligible Group.

Coverages - For the following terms, the NAIC asks that the insurer use definitions that meet industry standards. To the extent the insurer's definitions differ from industry standards, the NAIC asks that the insurer provide those definitions.

Trip Cancellation
Trip Interruption
Trip Delay
Baggage Loss/Delay
Emergency Medical / Dental
Emergency Transportation/Repatriation
Primary Coverage
Excess/Secondary Coverage

Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Exclude:

- An event reported for "information only."
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

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

Exclude:

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

Clarifications:

- If a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:

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

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

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

Include:

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

Complaints Received Directly from any Person or Entity Other than the Department of Insurance – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the jurisdiction's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

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

Complaints Received Directly from the Department of Insurance – All complaints:

- As identified by the DOI as a complaint.
- Sent or otherwise forwarded by the DOI to the reporting company.

Date of Final Payment – The date final payment was issued to the insured/claimant.
Calculation Clarification:

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.
    - The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

Date the Claim was Reported – The date an insured or claimant first reported his or her claim to either the company or insurance agent.

Domestic Coverage - overage for travel originating and contained within the United States including travel directly to and from mainland United States to Hawaii, Alaska and United States territories.

Group Travel Insurance - Means Travel Insurance issued to any Eligible Group as defined by state law.

International Coverage - Coverage for any travel other than Domestic.

Property & Casualty Market Conduct Annual Statement Travel Insurance Data Call & Definitions

Premium Written During Period – The total premium written before any reductions for refunds for travel insurance during the reporting period.

In-force – A master policy, individual policy, or certificate in effect during the reporting period.

Lawsuit – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits in the Travel MCAS blank:

- Include only lawsuits brought by an applicant for insurance or a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each jurisdiction in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

Lawsuits Closed During the Period with Consideration for the Consumer – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant or policyholder in an amount greater than offered by the reporting company before the lawsuit was brought.

Median Days to Final Payment – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:

- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:

- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:

- Subrogation payments.

Calculation Clarification / Example:

- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

Claim	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6	Nbr 7
Days to Settle	2	4	4	5	6	8	20

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

Claim	Nbr 1	Nbr 2	Nbr 3	Nbr 4	Nbr 5	Nbr 6
Days to Settle	2	4	5	6	8	20

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Property & Casualty Market Conduct Annual Statement Travel Insurance Data Call & Definitions

Example: A carrier reports the following closing times for paid claims.

Closing Time	# of Claims
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval "61-90 days." Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

Travel Retailer - Means a business entity that makes, arranges or offers planned travel and may offer and disseminate Travel Insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.