NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 5/16/22

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Thursday, May 26, 2022
12:00 – 2:00 p.m. ET / 11:00 a.m. – 1:00 p.m. CT / 10:00 a.m.– 12:00 p.m. MT / 9:00 a.m. – 11:00 a.m. PT

ROLL CALL

Erica Weyhenmeyer, Chair	Illinois	Martin Swanson	Nebraska
Rebecca Rebholz, Vice Chair	Wisconsin	Hermoliva Abejar	Nevada
Maria Ailor	Arizona	Leatrice Geckler	New Mexico
Crystal Phelps/Teri Ann Mecca	Arkansas	Guy Self	Ohio
Scott Woods	Florida	Gary Jones/August Hall/ Jeffrey Arnold	Pennsylvania
Scott Sanders/Elizabeth Nunes	Georgia		
October Nickel	Idaho	Michael Bailes/Rachel Moore	South Carolina
Tate Flott	Kansas	Larry D. Deiter/Candy Holbrook	South Dakota
Lori Cunningham	Kentucky	Shelli Isiminger	Tennessee
Dawna Kokosinski	Maryland	Shelley Wiseman	Utah
Mary Lou Moran	Massachusetts	Melissa Gerachis/Will Felvey	Virginia
Jill Huisken	Michigan	John Haworth/Jason Carr	Washington
Paul Hanson	Minnesota	Letha Tate	West Virginia
Jennifer Hopper/Teresa Kroll	Missouri		

NAIC Support Staff: Teresa Cooper

AGENDA

1.	Consider Adoption of its April 28 Minutes—*Erica Weyhenmeyer (IL)*	Attachment 1
2.	Consider Draft Life Market Conduct Annual Statement (MCAS) Edits on Accelerated Underwriting (AU)—*Erica Weyhenmeyer (IL)*	Attachment 2
3.	Consider Draft Other Health Data Call and Definitions —*Mary Kay Rodriguez (WI)*	Attachment 3
4.	Consider Edits to the Lawsuit Definition for the Home and Auto MCAS —*Erica Weyhenmeyer (IL)*	Attachment 4
5.	Review the MCAS Blanks (D) Working Group Charges and Process for Submitting Requests for Edits to the MCAS Data Call and Definitions— *Erica Weyhenmeyer (IL)*	Attachment 5
6.	Discuss Any Other Matters Brought Before the Working Group —*Erica Weyhenmeyer (IL)*	
7.	Adjournment	

Draft: 5/16/22

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 28, 2022

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 28, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Alex May (FL); Tate Flott (KS); Ron Kreiter (KY); Dawna Kokosinski (MD); Jeff Hayden (MI); Jennifer Hopper (MO); Leatrice Geckler (NM); Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes and Rachel Moore (SC); Tony Dorschner (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); and Letha Tate (WV). Also participating were: Shane Quinlan (NC); and Mary Kay Rodriguez (WI).

1. Adopted its March 17 Minutes

The Working Group met March 17 and took the following action: 1) adopted its Nov. 22, 2021, minutes; 2) received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU); 3) received an update on the Other Health Drafting Group; 4) adopted the proposal for digital claims interrogatories for the homeowners and private passenger auto (PPA) lines of business; 5) discussed the proposed lawsuit definitions and placement of the lawsuit data elements for the homeowners and PPA MCAS; and 6) received guidance regarding the new number of lawsuits closed with consideration for the consumer data element for the homeowners and PPA MCAS lines of business.

Ms. Rebholz made a motion, seconded by Ms. Isiminger, to adopt the Working Group's March 17 minutes. The motion passed unanimously.

2. Received an Update on the Life MCAS Draft Edits for AU

Ms. Weyhenmeyer stated the AU subject matter expert (SME) group met on April 13 to begin discussing the definition of AU now that the Accelerated Underwriting (A) Working Group has adopted a definition. She stated the Accelerated Underwriting (A) Working Group's adopted definition does not fit the needs of MCAS reporting, so work will need to be done with the definition. Ms. Weyhenmeyer stated since the April 13 meeting, the American Council of Life Insurers (ACLI) has submitted a draft definition that will be discussed further during the next SME call, which is scheduled for May 2.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that deadlines to be aware of are June 1 for this Working Group and Aug. 1 for the Market Regulation and Consumer Affairs (D) Committee, so this Working Group would need to get something out by June 1 in order for 2023 data to be reported in 2024. Ms. Weyhenmeyer stated the SME group is planning on meeting twice in May in an effort to meet these deadlines.

3. Received an Update on the Other Health Draft Group

Randy Helder (NAIC) stated the Other Health Drafting Group posted the other health MCAS draft in early April under exposure drafts on the MCAS web page for review. He stated it is similar to other data call and definitions in terms of the scope, but he said that some of the interrogatories are devoted to gathering information on how products are marketed and the relationships of the company with the marketers. He stated there are also questions regarding how the products are administered, such as whether the company contracts with third-party administrators (TPAs) and the identification of the TPAs used. Mr. Helder stated there are questions regarding

whether the company distributes products through independent agents, captive agents, and employees. He said there are also questions regarding whether fees are included in the reported premium, and if not, what fees are charged to policyholders and certificate holders. He stated the products being covered are: accident only, accidental death and dismemberment, specified disease -limited benefit/critical illness, hospital/other indemnity, and hospital/surgical/medical expense. Mr. Helder stated the blank is intended to collect information on products that are purchased directly by individuals, purchased through an association for individuals, or through an employer group. He stated there are sections regarding policy/certificate administration and claims administration that are similar to other MCAS blanks. Mr. Helder stated there is a data element for the aggregate dollar amount of paid claims during the period because there was some discussion about developing a loss ratio based on that which could not otherwise be obtained. He stated there are also sections for consumer complaints and lawsuits, as well as marketing and sales. He stated the participation requirement is $50,000 of health insurance premium and that a report by residency requirement is also outlined in the blank. Mr. Helder stated the definitions are similar to other MCAS blanks.

Rikki Pelta (American Council of Life Insurers—ACLI) stated it would be helpful to know how the loss ratios are being calculated and advised that this blank will require significant updates to administrative systems that collect this data by companies. She stated even if the due date is longer, companies will still have to have their systems updated by the end of this year, which is a big task.

Mr. Quinlan stated North Carolina does not have jurisdiction over policies issued in other states and expressed concern regarding reporting by residency. Ms. Rodriguez stated there are several states in the same situation and that one of the focuses of this blank is to see how consumers are finding products and being serviced, regardless of where the situs state is.

Ms. Hopper stated that on the report by residency requirement, it mentions forms issued to discretionary groups, associations, or trusts, but it does not mention other group coverage types, such as employer groups or multiple employer trusts. He stated that typically those are broken out separately. Ms. Rodriguez stated the focus was more on associations because many states felt that other health products sold through associations needed to be scrutinized more than employer group products. Ms. Hopper asked for clarification on the question related to the issuer and association's contractual relationship. She also asked why the System for Electronic Rates & Forms Filing (SERFF) filing number was being requested and why identifying the basis for not filing in a particular state was being asked. Ms. Rodriguez stated that she and Mr. Helder would review all of her questions and comments with SME group. Mr. Helder stated those responses would be posted to the MCAS blanks web page and shared prior to the next Working Group meeting.

Ms. Weyhenmeyer stated any comments related to the Other Health Draft should be submitted to Teresa Cooper (NAIC) no later than May 13.

4. Discussed Possible Edits to the Lawsuit Definition for all MCAS Lines of Business That Contain Lawsuit Reporting

Ms. Weyhenmeyer stated an SME group met to discuss edits to the home and auto MCAS definition of lawsuit to include non-claim-related suits. She stated while reviewing comments from the American Property Casualty Insurance Association (APCIA), it was found that all MCAS lawsuit definitions include a bullet that reads: "If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits." She stated the APCIA requested that this language be clarified to account for instances where there are multiple policies involved that are issued by different insurers.

Lisa Brown (APCIA) stated the way the current bullet is written implies that a single reporting company might be responsible for reporting on another company's policies. She stated Mr. Birnbaum made a good point during an SME group meeting when he asked why a single lawsuit that touches multiple policies would be counted more than once, when what is being counted is lawsuits and not policies. She stated that if the data to be collected will continue to be lawsuits that account for multiple policies, then the language should state: "If a lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits." She then stated in hindsight, counting a single lawsuit multiple times may not be appropriate. Mr. Birnbaum stated it really seems inappropriate to count a single lawsuit against more than one policy as more than one lawsuit, as it increases the actual number of lawsuits. He expressed concern about how a company would count lawsuits this way as it could require their manual involvement. Ms. Weyhenmeyer asked if this is the way the lawsuit language reads in the other blanks except for health, and Ms. Cooper confirmed that is correct.

Ms. Rebholz stated the APCIA's proposed language seems to provide clarification and that more time may be needed to review this further. Ms. Brown will send the proposed language to Ms. Cooper for the SME group to review further and bring back to the Working Group for consideration. Ms. Weyhenmeyer asked if a vote to change the lawsuit language in all of the MCAS blanks if needed and where it applies could be done in one vote, and Ms. Cooper stated it could as along as the motion was clearly outlined in that way. Ms. LeDuc stated she reviewed the 2019 Homeowners Data Call and Definitions and that she is not seeing the definition outlined there this way. She said that it may be helpful to look into the history for clarification. Ms. Cooper stated she would review this information.

5. Adopted the Proposed Lawsuit Definitions and Placement of Lawsuit Data Elements for the Homeowners and Auto MCAS

Ms. Weyhenmeyer stated the Working Group needs to discuss the Homeowner and Auto lawsuit reporting and definition edits in more depth. She stated the documentation for this discussion was in the meeting materials as Attachments Three and Four (Attachment XX). She stated the homeowner and auto SME group first presented its lawsuit reporting and definition proposal to the Working Group in November 2021, and that the proposal simplifies the lawsuit reporting and its definition as much as possible. She stated the SME group proposed the following: 1) removal of the lawsuit data elements from the claims reporting section; 2) creation of a new reporting section for the lawsuit data elements; 3) reporting the lawsuit data elements by claims coverage type as has been done in the past; 4) adding reporting for "non-claim related lawsuits"; and 4) updating the definition of lawsuits to accommodate the new reporting structure. The SME group also proposed the addition of an interrogatory to capture comments for the newly added lawsuit section.

Ms. Weyhenmeyer stated during the Working Group's March 17 meeting, comments were heard from Lisa Brown (APCIA). She stated that as a result of Ms. Brown's comments, it was decided to reconvene the SME group to address the submitted comments. The SME group met on April 12 and April 20. Ms. Weyhenmeyer stated that one of the APCIA's comments indicated concern that the word "agent" should be defined in the bullet that reads: "Include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer or its agent as a defendant." She stated as a result of this comment, the SME group proposes that "or its agent" be removed from the bullet item in question. She stated another one of the APCIA's comments indicated concern about interpleader actions. The proposed definition provides for the exclusion of "arbitrations, mediation, appraisal, or any other form of dispute resolution not brought in a court of law." The APCIA asked for the exclusion to be amended to exclude homeowners and private passenger appraisal matters filed in a court of law and interpleader actions filed by an insurance company. Ms. Weyhenmeyer stated that after discussion, the SME group proposes that the exclusion bullets be updated to ensure interpleader actions are excluded from reporting. Mr. Birnbaum stated that the CEJ supports the proposed changes.

Ms. Rebholz made a motion, seconded by Ms. Johnson to adopt the proposed lawsuit definition and placement of lawsuit data elements in the homeowners and auto MCAS. Ms. Brown asked if the motion includes adopting counting multiple policies as multiple lawsuits, and Ms. Weyhenmeyer stated it did not; it was only regarding the edits to remove "or its agent" and to edit the exclusion bullets to ensure interpleader actions are excluded from reporting. Ms. Cooper clarified it also includes breaking out the lawsuit reporting to include the other than claims-related lawsuits and updating the definition as shown in the meeting materials, but not to the bullet discussed in the previous agenda item, which will be considered at a later date. The motion passed unanimously.

6. Discussed Other Matters

Ms. Weyhenmeyer stated some state-specific concerns had been raised that may need some clarification in the frequently asked questions (FAQ) document. She stated contact was made with state insurance regulators in Pennsylvania and Michigan regarding the concerns raised. The Pennsylvania state insurance regulator said companies could reach out and ask questions as needed regarding their writ of summons reporting. The Michigan state insurance regulator said they would draft language to be provided in the FAQ to address lawsuits filed by a medical provider for payment under personal injury protection (PIP) coverage.

Ms. Brown stated that in Pennsylvania, the writ of summons is just a notice and does not indicate a cause of action. She asked how companies will know whether to count it as a claim or non-claim if they do not know what the potential suit is about. Ms. Cooper some additional conversation on this topic will take place to see if additional clarifying language would be helpful.

Ms. Brown stated she wanted the state insurance regulators to understand that the lawsuit definition edits would require some heavy programming and process changes to pull out the non-claims-related lawsuits, especially for the larger insurers. Mr. Birnbaum stated the guidelines are set up so that companies have five months to prepare to collect information after approved by the Market Regulation and Consumer Affairs (D) Committee and then start reporting it two years after that approval. He stated the MCAS is a critical part of market analysis and market regulation and that when there are changes, companies should take it just as seriously as changes to the annual financial statement. Ms. Pelta stated her earlier comments regarding timeline concerns were related to the other health MCAS since some of the interrogatories and data elements have not been traditionally collected in other lines of business.

Ms. Weyhenmeyer stated she, Mr. Helder, and Ms. LeDuc gave a presentation at the Insurance Regulatory Examiners Society (IRES) foundation regarding changes to the homeowners and auto MCAS blanks for digital claims. She stated some clarifying questions came up that will be discussed in more detail with the Working Group at a later meeting. Ms. LeDuc asked Ms. Brown to start asking companies what questions they have regarding what constitutes a digital claim versus a hybrid claim so that those questions can be addressed.

Having no further business, the MCAS Blanks (D) Working Group adjourned.

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2022/WG Mtg 0428/MCAS Blanks WG Minutes 0428

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

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

Reporting Period: January 1, 2023 through December 31, 2023

Filing Deadline: April 30, 2024

Contact Information

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

Life and Annuity Product Types

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

In addition, some data elements are broken out by Accelerated Underwriting vs. Other than Accelerated Underwriting.

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Life & Annuities Data Call & Definitions

Schedule 1A—Life Interrogatories

ID	Description	Comments
Interrogatories General		
1A-01	Individual Life Cash Value – Does the company have data to report for this product type?	Yes/No
1A-02	Individual Life Non-Cash Value – Does the company have data to report for this product type?	Yes/No
1A-03	Is there a reason that the reported Individual Life Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
1A-04	If yes, add additional comments	Comment
1A-05	Is there a reason that the reported Individual Life Non-Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
1A-06	If yes, add additional comments	Comment
1A-07	Does the company use third party administrators (TPAs) for purposes of supporting the individual life business being reported?	Yes/No
1A-08	If yes, provide the names and functions of each TPA.	Comment
1A-09	Did the company use MCAS accelerated underwriting during the reporting period? If yes, complete the MCAS Accelerated Underwriting interrogatories.	Yes/No
Interrogatories MCAS Accelerated Underwriting		
1A-10	Did the company use MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, or 3-Both Cash Value and Non-Cash Value products	1/2/3
1A-11	Did the company utilize Application Data as inputs in its MCAS accelerated underwriting algorithm (excluding application data used only for purposes of identifying a consumer to obtain third-party data) for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-12	Did the company utilize Medical Data in its MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-13	If 1, 2 or 3, list the data categories and sources of data associated with Medical Data	Comment
1A-14	Did the company utilize FCRA compliant non-medical third-party data in its MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-15	If 1, 2 or 3, list the data categories and sources of data	Comment

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Life & Annuities Data Call & Definitions

	associated with FCRA compliant non-medical third-party data	
1A-16	Did the company utilize other non-medical third-party data in its MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-17	If 1, 2 or 3, list the data categories and sources of data associated with other non-medical third-party data	Comment

Interrogatories Comments

1A-18	Individual Life Cash Value comments	Comment
1A-19	Individual Life Non-Cash Value comments	Comment

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

ID	Description
1B-20	Number of New Replacement Policies Issued During the Period (Include only the number of replacement insurance policies issued)
1B-21	Number of Internal Replacements Issued During the Period
1B-22	Number of External Replacements of Unaffiliated Company Policies Issued During the Period.
1B-23	Number of External Replacements of Affiliated Company Policies Issued During the Period.
1B-24	Number of Policies Replaced Where Age of Insured at Replacement was <65 (Only applies to ICVP)
1B-25	Number of Policies Replaced Where Age of Insured at Replacement was Age 65 and Over (Only applies to ICVP)
1B-26	Number of Policies Surrendered Under 2 Years from Policy Issue (Only applies to ICVP)
1B-27	Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue (Only applies to ICVP)
1B-28	Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue (Only applies to ICVP)
1B-29	Number of Policies Surrendered More Than 10 Years from Policy Issue (Only applies to ICVP)
1B-30	Total Number of Policies Surrendered During the Period (Only applies to ICVP)
1B-31	Number of Policies Surrendered with a Surrender Fee (Only applies to ICVP)
1B-32	Number of Policies Issued During the Period where age of insured at issue was <65 (Only applies to ICVP)
1B-33	Number of Policies Issued During the Period where age of insured at issue was Age 65 and over (Only applies to ICVP)
1B-34	Number of Complaints Received Directly from Any Person or Entity Other than the DOI
1B-35	Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date the Claim was Received (Include claims where the final decision was

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Life & Annuities Data Call & Definitions

	payment in full, and full payment was made within 30 days from when the claim was received)
1B-36	Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the claim was received)
1B-37	Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the claim was received)
1B-38	Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the date of due proof of loss occurred)
1B-39	Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the date of due proof of loss occurred)
1B-40	Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the date of due proof of loss occurred)
1B-41	Number of Death Claims Denied, Resisted or Compromised During the Period
1B-42	Number of Death Claims Closed with Payment During the Period, which Occurred within the Contestability Period
1B-43	Number of Death Claims Denied During the Period, which Occurred within the Contestability Period
1B-44	Total Number of Death Claims Received During the Period (Include any claim received during the period as determined by the first date the claim was opened on the company system)
1B-45	Number of Lawsuits Open at the Beginning of the Period
1B-46	Number of Lawsuits Opened During the Period
1B-47	Number of Lawsuits Closed During the Period
1B-48	Number of Lawsuits Closed During the Period with Consideration for the Customer
1B-49	Number of Lawsuits Open at the End of the Period

Schedule 1C—Individual Life Cash Value (ICVP) and Non-Cash Value (INCVP) Products with MCAS Accelerated Underwriting vs. Other Than MCAS Accelerated Underwriting Breakout

1C-50	Total Number of New Policies Issued by the Company During the Period
1C-51	Number of Policies Applied for During the Period
1C-52	Number of Free Looks During the Period
1C-53	Number of Policies In-Force at the End of the Period (The number of active policies that the company has outstanding at the end of the reporting period)

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1C-54	Dollar Amount of Direct Premium During the Period
1C-55	Dollar Amount of Insurance Issued During the Period (Face Amount)
1C-56	Dollar Amount of Insurance In-Force at the End of the Period (Face Amount)

Schedule 2A—Annuity Interrogatories

ID	Description	Comments
2A-01	Individual Indexed Fixed Annuities – Does the company have data to report for this product type?	Yes/No
2A-02	Individual Other Fixed Annuities – Does the company have data to report for this product type?	Yes/No
2A-03	Individual Indexed Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-04	Individual Other Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-05	Is there a reason that the reported Individual (Indexed or Other) Fixed Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
2A-06	If yes, add additional comments	Comment
2A-07	Is there a reason that the reported Individual (Indexed or Other) Variable Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
2A-08	If yes, add additional comments	Comment
2A-09	Does the company use third party administrators (TPAs) for purposes of supporting the individual annuity business being reported?	Yes/No
2A-10	If yes, provide the names and functions of each TPA.	Comment
2A-11	Individual Fixed Annuities comments	Comment
2A-12	Individual Variable Annuities comments	Comment

Schedule 2B—Individual Indexed Fixed Annuities (IIFA), Individual Other Fixed Annuities (IOFA), Individual Indexed Variable Annuities (IIVA), and Individual Other Variable Annuities (IOVA)

ID	Description
2B-13	Number of New Replacement Contracts Issued During the Period (Include only the number of replacement annuity contracts issued)
2B-14	Number of Internal Replacement Contracts Issued During the Period
2B-15	Number of External Replacements of Unaffiliated Company Contracts Issued During the Period.

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Life & Annuities Data Call & Definitions

2B-16	Number of External Replacements of Affiliated Company Contracts Issued During the Period.
2B-17	Number of Contracts Replaced Where Age of Annuitant at Replacement was < 65
2B-18	Number of Contracts Replaced Where Age of Annuitant at Replacement was 65 to 80
2B-19	Number of Contracts Replaced Where Age of Annuitant at Replacement was > 80
2B-20	Number of New Immediate Contracts Issued During the Period
2B-21	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was < 65
2B-22	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
2B-23	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
2B-24	Total Number of New Deferred Contracts Issued by the Company During the Period
2B-25	Number of Contracts Surrendered Under 2 Years from Issuance
2B-26	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
2B-27	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance
2B-28	Number of Contracts Surrendered Over 10 Years from Issuance
2B-29	Total Number of Contracts Surrendered During the Period
2B-30	Total Number of Contracts Surrendered with a Surrender Fee
2B-31	Number of Contracts Applied for During the Period
2B-32	Number of Free Looks During the Period
2B-33	Number of Contracts In-Force at the End of the Period (The number of active contracts that the company has outstanding at the end of the reporting period)
2B-34	Dollar Amount of Annuity Considerations During the Period
2B-35	Number of Complaints Received Directly From Any Person or Entity Other than the DOI
2B-36	Number of Lawsuits Open at the Beginning of the Period
2B-37	Number of Lawsuits Opened During the Period
2B-38	Number of Lawsuits Closed During the Period
2B-39	Number of Lawsuits Closed During the Period with Consideration for the Customer
2B-40	Number of Lawsuits Open at the End of the Period

In determining what business to report for a particular state, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages and in accordance with each applicable state's regulations.

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Definitions:

MCAS Accelerated Underwriting - For this MCAS, data should be reported as Accelerated Underwriting when artificial intelligence and/or machine learning which utilizes, in whole or in part, Other Non-medical Third-party Data and/or FCRA Compliant Non-medical Third-party Data in the underwriting of life insurance; including when used in combination with Application Data or Medical Data.

MCAS Accelerated Underwriting is a subset of Life insurance Accelerated Underwriting as defined in a 2022 NAIC educational paper on the topic. That broader definition is:
Accelerated Underwriting[1] - Accelerated underwriting is the use of big data, artificial intelligence, and machine learning to underwrite life insurance in an expedited manner. The process generally uses predictive models and machine learning algorithms to analyze applicant data, which may include the use of nontraditional, non-medical data, provided either by the applicant directly or obtained through external sources. The process is typically used to replace all or part of traditional underwriting in life insurance and to allow some applications to have certain medical requirements waived, such as paramedical exams and fluid collection.

Data utilized in accelerated underwriting algorithms:

- **Application data**: Information provided by or on behalf of the consumer in response to questions on the application for insurance, including any supplemental application forms, including medical information provided on the application.
- **Medical data**: Medical information related to the consumer and collected from third parties with the authorization of the consumer, such as but not limited to health records and prescription records.
- **FCRA Compliant non-medical third-party data**: Non-medical data related to the consumer that is provided by a consumer reporting agency in a consumer report that is subject to the Fair Credit Reporting Act (FCRA) requirements and protections. Examples – 1) category of data is a motor vehicle report, and the source of the data is a state department of motor vehicles or a third-party vendor, 2) category of data is consumer credit information and the source of the data is Experian or TransUnion.
- **Other non-medical third-party data**: Any non-medical data not reported in the three categories listed above. Examples – 1) category of non-medical third-party data is social media and the source of those data is Facebook or Carpe Data, 2) category is facial analytics and the source is a video interview application used by insurer.

Annuity – A contract under which an insurance company promises to make a series of periodic payments to a named individual in exchange for a premium or a series of premiums. Data is being requested for individual annuities only; data for group annuity contracts are not being requested.

[1] Source: Accelerated Underwriting (AU) Educational Report by the NAIC Accelerated Underwriting (A) Working Group, 2022

Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

Annuity Considerations – Funds deposited to or used to purchase annuity contracts issued by the company. For the purpose of this statement, annuity considerations should be determined in the same manner used for the state pages of the company's financial annual statement. Do not report "Other Considerations" or "Deposit-Type Contract" considerations. MCAS requires that you report only allocated considerations on contracts that have a mortality or morbidity risk.

Cash Value Product – A life insurance policy that generates a cash value element. Term life policies with cash value are considered cash value products.

Claim – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Claims with multiple beneficiaries should be counted as one claim. If a single insured dies and has multiple policies (for individual life products), a claim should be reported for each of the insured's policies (for example, if an insured had 3 individual life policies (2 cash value products and one non-cash value product), 3 claims would be reported (2 claims under schedule 1B ICVP and 1 claim under schedule 1B INCVP.)

It does not include events that were reported for "information only" or an inquiry of coverage since a claim has not actually been presented (opened) for payment.

Claim Closed with Payment – A claim where the final decision was payment of the claim.

Complaint – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state'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

Contestability Period – The period of time before a policy's incontestability clause becomes effective. During this period, a company may contest a claim based upon material misrepresentation or concealment during the policy application process. The contestability period is usually 2 years.

- Do not report claims on guaranteed issue life policies
- Do not report claims that are contested after the incontestability clause is in effect.

Conversion – The process by which a policyholder exercises his/her right under the policy contract to exchange a policy without submitting evidence of insurability. In most cases this involves exchanging a term policy for a permanent policy (e.g., whole life insurance, universal life, variable.)

Corporate Owned Life Insurance – Insurance on the life of an individual, paid for by the company, with the company being a beneficiary under the policy. Corporate Owned Life Insurance policies are included in the scope of this statement and should be reported in the applicable schedule.

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Date Claim Received – The date the company, or a third party acting on the company's behalf, is notified of the claim.

Date of Due Proof of Loss – The date the company received the necessary proof of loss on which to base a claim determination.

Denied Claim - A claim where a demand for payment was made but payment was not made under the contract.

Direct Written Premium – The actual amount of direct premiums written during the reporting period and should be determined in the same manner used for the financial annual statement. Data for subject business reported by the company on the financial annual statement should be reported for the purposes of this project regardless of any 1) reinsurance agreements or 2) arrangements to administer the business that may exist with another insurer. (See also: "Life Insurance Premium" and "Annuity Considerations")

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

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

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

Face Amount – Sum of insurance provided by a policy at death or maturity. In determining the face amount to be reported, companies should follow the same methodology/definitions used to file the financial annual statement and its corresponding state pages. For example, the face amount would include the basic policy plus any riders or amounts for policies with increasing death benefits if these amounts in addition to the basic policy are reported on the company's financial annual statement.

Fixed Annuity – An annuity under which the insurer guarantees that at least a defined amount of monthly annuity benefit will be provided for each dollar applied to purchasing the annuity.

Free Look – A set number of days provided in an insurance or annuity contract that allows time for the purchaser to review the contract provisions with the right to return the contract for a full refund of all monies paid. Report the number of policies or contracts that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.

Immediate Annuity – An annuity (either fixed or variable) that begins its payment stream to the policyholder within 12 months after a single premium is paid. Immediate annuities are included within the scope of this statement and should be reported as a new immediate

contract issued when issued during the reporting period. In addition, immediate annuities still in force at the end of the period should be included as well.

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

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

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

Issued During the Period - Report the number of policies that have an issue date within the reporting period.

- When reporting the policies/contracts that are broken out by the age of the insured or annuitant
    - for joint policies/contracts, use the age of the oldest insured or annuitant for determining the age category
- Internal and external replacements should be reported as new policies or contracts issued during the reporting period as well as reported in the number of internal and external replacements.

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

For purposes of reporting lawsuits for Life & Annuities products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.

- Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

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

Life Insurance Premiums – Funds used to purchase life insurance products issued by the company. Exclude Group Life and Credit Life premiums. For the purpose of this statement, life insurance premiums should be determined in the same manner used for the state pages of the company's financial annual statement.

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which file 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 an insurance holding company.

Non-Cash Value Product – A life insurance policy that does not contain a cash value element. Do not include life insurance covering only Accidental Death and Dismemberment (AD&D.)

Policies/Contracts Applied For – Applications for life insurance or annuities that are submitted to the company which have or will result in a formal offer of an insurance or annuity contract or a formal declination of the application by the company. Applications that are declined by a broker-dealer or producer and never reviewed by the company are not included in this count.

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

Include:

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

Do not include:

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

Resisted Claim – A claim is considered resisted when it is in dispute and not resolved on the financial statement date for the reporting period. Where the company is holding up payment for

sufficient evidence or where a beneficiary has made a claim and then withdraws it, such items should be considered as in the course of settlement.

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

Term Life Insurance – Life insurance that provides a death benefit if the insured dies during the specified period.

Universal Life Insurance – A form of whole life insurance that is characterized by flexible premiums, flexible face amounts and flexible death benefit amounts and its unbundling of the pricing factor.

Variable Annuity – An annuity under which the amount of the contract's accumulated value and the amount of the monthly annuity benefit payment fluctuate in accordance with the performance of a separate account.

Variable Life Insurance – A form of whole life insurance under which the death benefit and the cash value of the policy fluctuate according to the investment performance of a separate account.

Variable Universal Life Insurance – A form of whole life insurance that combines the premium and death benefit flexibility of universal life insurance with the investment flexibility and risk of variable life insurance.

Withdrawal – For annuity contracts, see Surrendered Policy/Contract.

Whole Life Insurance – Life insurance that provides lifetime insurance coverage. Whole life insurance policies generally build cash value and cover a person for as long as he or she lives if premiums are paid as required. It would include life insurance policies that start accumulating cash value once the insured reaches a certain age as specified in the terms of the policy.

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

Line of Business: Other Health Insurance

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

Filing Deadline: month dd, yyyy

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

1-01	Are you currently marketing these products in this jurisdiction?	Yes/No
1-02	Do the products you are reporting on in response to this blank include closed or frozen blocks of business?	Yes/No
1-03	If yes, list the closed or frozen blocks of business?	Comment
1-04	Number of Other Health products offered to residents in this state	Number
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.	Comment
1-06	For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?	Yes/No
1-07	If yes, list the associations	Comment
1-08	If yes, do you have a contractual relationship with any association?	Comment
1-09	If yes, please identify which associations	Comment
1-10	If yes, does the contract allow any association to market the product?	Yes/No
1-11	If yes, please identify which associations	
1-12	If yes, does the contract allow any association to collect policy or contract premiums?	Yes/No
1-13	If yes, does the contract allow any association to collect and pay commissions?	Yes/No
1-14	If yes, please identify which associations	Comment
1-15	If yes, does the contract allow any association to adjudicate~~handle~~ claims?	Yes/No
1-16	if yes, please identify which associations	Comment

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

1-17	Has the company filed the associations by-laws and articles of incorporation in their state of domicile?	Yes/No
1-18	Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?	Yes/No
1-19	If yes please provide the state, and the SERFF tracking number, if applicable	Comment
1-20	Has the company filed the association by-laws and articles of incorporation in the filing state?	Yes/No
1-21	Has the company filed the certificate of insurance in the filing state, if applicable?	Yes/No
1-22	Does the company contract with third-party administrators for administrative services related to Other Health products?	Yes/No
1-23	If yes, does the company issue Other Health products through administrators/TPAs?	Yes/No
1-24	If yes, how many administrators/TPAs?	Number
1-25	If yes, ~~L~~list the TPAs and provide~~with~~ their respective National Producer Number (NPN), if required by the state	Comment
1-26	If yes, does your company contract claims services related to Other Health products?	Yes/No
1-27	If yes, does your company contract complaints-related services related to Other Health products?	Yes/No
1-28	If yes, does your company contract medical underwriting services related to Other Health products?	Yes/No
1-29	If yes, does your company contract pricing services related to Other Health products?	Yes/No
1-30	If yes, does your company contract producer appointment services related to Other Health products?	Yes/No
1-31	If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?	Yes/No
1-32	If yes, does your company contract policyholder services related to Other Health products?	Yes/No
1-33	If yes, does your company contract premium collection services related to Other Health products?	Yes/No
1-34	Does your company audit third parties to whom you have delegated responsibilities?	Yes/No
1-35	If yes, please provide frequency of audits	Comment
1-36	Does your company distribute its product through independent agents?	Yes/No
1-37	Does your company distribute its products through captive agents?	Yes/No
1-38	Does your company distribute its products through its employees?	Yes/No
1-39	Does the company use pre-existing condition exclusions?	Yes/No
1-40	If yes, identify which products	Comment

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

1-41	Does the company contract with ~~agents~~ producers to collect premium or bind coverage on behalf of the company?	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.	
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.	
1-44	Additional state specific 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**
Association ADD	**Accidental Death and Dismemberment. Purchased through an association**
Association SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased through an association**
Association H-H/OI	**Hospital/Other Indemnity. Purchased through an association**
Association H-HSME	**Hospital/Surgical/Medical Expense. Purchased through an association**
Employer Group H-AO	**Accident Only. Purchased through an employer group**
Employer Group ADD	**Accidental Death and Dismemberment. Purchased through an employer group**
Employer Group SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased through an employer group**
Employer Group H-H/OI	**Hospital/Other Indemnity. Purchased through an employer group**

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

Employer Group H-HSME	Hospital/Surgical/Medical Expense. Purchased through an employer group

Schedule 2 – Policy/Certificate Administration

2-1	Net written premium
2-2	Earned premiums for reporting year
2-3	Number of policies/certificates in force at the beginning of the period
2-4	Number of covered lives on policies/certificates in force at the beginning of the period
2-5	Number of new policy/certificate applications/enrollments received during the period
2-6	Number of new policy/certificates issued during the period
2-7	Number of new policies/certificates denied during the period
2-8	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-9	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder
2-10	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the period
2-11	Number of policies/certificates cancelled during the free look period
2-12	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-13	Number of policy/certificate terminations and cancellations due to non-payment of premium
2-14	Number of covered lives on policies/certificates cancelled by the company due to non-payment of premium during the period
2-15	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
~~2-16~~	~~Number of covered lives on policies/certificates cancelled by the company due to non-payment of premium during the period~~
2-167~~7~~	Number of rescissions
2-178~~8~~	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder ~~(only answer for individual products)~~
2-189~~9~~	Number of covered lives impacted on terminations and cancellations due to non-payment ~~(only answer for individual products)~~
2-1920~~20~~	Number of covered lives impacted by rescissions ~~(only answer for individual products)~~

2-201	Number of policies/certificates in force at the end of the period
2-212	Number of covered lives on policies/certificates in force at the end of the period

Schedule 3 – Claims Administration (Including Pharmacy)

3-1	Number of claims pending at the beginning of the period
3-2	Number of claims received (include non-clean claims)
3-3	Total number of claims denied, rejected or returned
3-4	Number of denied, rejected, or returned as non-covered or beyond benefit limitation
3-5	Number of denied, rejected, or returned as subject to pre-existing condition exclusion
3-6	Number denied, rejected, or returned due to failure to provide adequate documentation
3-7	Number denied, rejected, or returned due to being within the waiting period (do not answer for ADD products)
3-8	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
3-9	Number of claims pending at end of the period
3-10	Median number of days from receipt of claim to decision for denied claims
3-11	Average number of days from receipt of claim to decision for denied claims
3-12	Median number of days from receipt of claim to decision for approved claims
3-13	Average number of days from receipt of claim to decision for approved claims
3-14	Number of claims paid
3-15	Aggregate dollar amount of paid claims during the period
3-16	Number of claims where the claims payment was reduced by premium owed
3-17	Dollar amount of claims payments applied to unpaid premiums.

Schedule 4 – Consumer Complaints and Lawsuits

4-1	Number of complaints received by Company (other than through the DOI)
4-2	Number of complaints received through DOI
4-3	Number of complaints resulting in claims reprocessing
4-4	Number of lawsuits open at beginning of the period
4-5	Number of lawsuits opened during the period

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

4-6	Number of lawsuits closed during the period
4-7	Number of lawsuits closed during the period with consideration for the consumer
4-8	Number of lawsuits open at end of the period

Schedule 5 – Marketing and Sales

5-1	Number of individual applications/enrollments pending at the beginning of the period
5-~~2~~3	Number of applications/enrollments received during the period
5-~~3~~4	Number of individual applications/enrollments denied during the period for any reason
5-~~4~~5	Number of individual applications/enrollments denied during the period - health status or condition
5-~~5~~6	Number of individual applications/enrollments approved during the period
5-~~6~~7	Number of individual applications/enrollments pending at the end of the period
5-~~7~~8	Number of applications/enrollments received via phone (audio only) (only answer for individual products)
5-~~8~~9	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) (only answer for individual products)
5-~~9~~10	Number of applications/enrollments received online (electronically) (only answer for individual products)
5-1~~0~~1	Number of applications~~-~~/enrollments received by mail during the period (only answer for individual products)
5-1~~1~~2	Number of applications/enrollments received by any other method during the period (only answer for individual products)
5-1~~2~~3	Commissions paid during reporting period (dollar amount of commissions incurred during the period)
5-1~~3~~4	Unearned commissions returned to company on policies/certificates sold during the period

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

Report by Residency: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to

discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is sitused.

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

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

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).

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

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

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

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

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

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)

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.

Schedule 2 Definitions (Policy/Certificate Administration):

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

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

Schedule 3 Definitions (Claims Administration):

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

Claim Clarifications:

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

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

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

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

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

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

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

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

Schedules 4 Definitions (Consumer Complaints and Lawsuits):

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 seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy 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.

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.

Homeowner and Private Passenger Auto
MCAS Lawsuit Definition
With Proposed Bullet Deletion for the 2023 Data Year

Definitions:
In determining what business to report for a particular state, 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. Exclude lender-placed or creditor-placed policies.

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

Exclude:
- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, interpleader actions, and declaratory judgment actions filed or brought by an insurer.
- Arbitrations, mediation, appraisal, or any other form of dispute resolution not brought in a court of law.

For purposes of reporting lawsuit for Homeowner / Private Passenger Auto products:
- Include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer as a defendant.
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- ~~If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits.~~
- With the exception of class action lawsuits, report a lawsuit with two or more complainants as one lawsuit.
- With the exception of class action lawsuits, report a lawsuit in the jurisdiction in which the policy was issued.
- Report claim related lawsuits broken out by coverage as outlined in the schedule.
- Report non-claim related lawsuits in aggregate as outlined in the schedule.

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 state the number of class action lawsuits included in the data and the general cause of the action.

Market Conduct Annual Statement Blanks (D) Working Group

2022 Adopted Charges

1. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than three years and update them, as necessary.
2. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

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

Proposal Contact Information

Name of Contact Person	Click or tap here to enter text.
Name of Organization	Click or tap here to enter text.
Email Address	Click or tap here to enter text.
Phone Number	Click or tap here to enter text.
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	☐ Homeowners	☐ Long-Term Care
☐ Disability Income	☐ Lender Placed Auto and Home	☐ Private Flood
☐ Health	☐ Life	☐ Private Passenger Auto

PROVIDE A CONCISE STATEMENT OF THE PROPOSED CHANGE:
Click or tap here to enter text.

PROVIDE THE REASON FOR THE CHANGE:
Click or tap here to enter text.

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