NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft date: 6/30/25

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Thursday, July 10, 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 its May 1 and May 22 Minutes *—Joshua Guillory (LA)*	Attachment 1 Attachment 2
2..	Consider Adoption of the Travel Market Conduct Annual Statement (MCAS) Proposal Received from the Subject Matter Expert Group *—Joshua Guillory (LA)*	Attachment 3 Attachment 4
3..	Discuss How to Care for Discretionary Groups on the Other Health MCAS *—Joshua Guillory (LA)*	Attachment 5
4.	Discuss Submission of a Proposal Form to Address Clarification of Reporting of Blanket Polices on the Other Health MCAS—*Joshua Guillory (LA)*	Attachment 6
5.	Review the Adjusted Validation Calculation Proposed by Rhode Island *—Joshua Guillory (LA)*	Attachment 7

6. Discuss the Next Line of Business for the Working Group to Review and the Formation of an SME Group to Begin Work
—Joshua Guillory (LA)

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

8. Adjournment

Draft: 5/16/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 1, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 1, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Rachael Lozano (FL); Chris Heisler (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Jo A. LeDuc, Julie Hesser, and Teresa Kroll (MO); Robert McCullough (NE); Jon Wycoff (NV); Karen Veronikis (PA); Tony Dorschner (SD); Laura Klanian (VA); Mary Kay Rodriguez (WI); and Letha Tate (WV). Also participating was: Brian Werbeloff (RI).

1. Adopted its April 3 Minutes

The Working Group met April 3 and took the following action: 1) adopted its March 6 minutes; 2) reviewed the subject matter expert (SME) group's proposed draft other health MCAS revisions; 3) considered adoption of changes to the private passenger auto (PPA) Market Conduct Annual Statement (MCAS) blank; 4) discussed comments received regarding the travel MCAS Blank; 5) discussed the Center for Economic Justice (CEJ) proposal form on the lender-placed insurance (LPI) MCAS and the reporting of a subsequent individual policy or certificate following the expiration of the term of the previous individual policy or certificate; and 6) discussed other matters, including inconsistencies in the MCAS data elements.

Dorschner made a motion, seconded by Klanian, to adopt the Working Group's April 3 minutes (Attachment 01). The motion passed unanimously.

2. Considered Adoption of the MCAS Other Health Blank and Data Call and Definitions Proposal

Kirsten Wolfford (American Council of Life Insurers—ACLI) highlighted two main concerns with the latest edits to the MCAS other health blank and data call and definitions proposal: 1) collecting data on closed blocks of business may not significantly aid regulators and could impact overall data quality, given its limited relevance to current market activity; and 2) data related to employer groups may be less useful compared to data from individual and association markets, where stronger data quality is observed. Both comments aim to streamline data collection and improve MCAS data quality. Wolfford offered to answer any questions.

Amy Killelea (Individual Consumer Advocate) spoke on behalf of several health-focused consumer representatives and summarized their collective comments. Killelea said that she and Lucy Culp (The Leukemia & Lymphoma Society—LLA) participated in the SME group and supported the edits presented, particularly those proposed by Missouri. The consumer representatives believe the draft strikes an appropriate balance in handling the complex and new data requests and emphasize that collecting this data is important from a consumer perspective. Killelea reiterated her support for including the employer market in MCAS reporting, aligning with earlier comments. Killelea said the consumer representatives believe that the compromises in the draft adequately address concerns about data collection feasibility and strongly recommend keeping the employer market inclusion.

LeDuc noted that the SME group's submitted comments were detailed and largely self-explanatory. They highlighted suggestions for additional consistency edits, particularly to add "during the period" language after several data elements to maintain uniformity throughout the blank, in line with earlier SME recommendations. They also suggested improving the description of discretionary groups by deferring to the legal definition rather

than attempting to redefine it in the blank. This approach would provide clarity and meet states' needs without causing confusion.

Kroll addressed proposed changes to Schedule 3, supporting the removal of the "non-claim claim" terminology and rephrasing it to "total number of all claims received during the period." Kroll said Missouri believes this revision would clarify reporting for both the states and industry. She explained that the clean claim definition was more industry-driven and not reflective of actual market activity. Since clean claims can be delayed by industry practices, it was previously decided to remove the clean claim definition. The proposed language change would further clarify the data collection process and better align with earlier discussions.

Rodriguez, who led the SME group, raised a question regarding the treatment of discretionary groups. She noted that the industry had difficulty identifying these groups. She suggested clarifying the instructions by specifying associations, trusts, individual, and employer groups, and designating all others as discretionary groups, while also stating that data on discretionary groups would not be collected. This approach would help simplify and clarify reporting requirements.

LeDuc responded to Rodriguez, explaining that the original intent was to define discretionary groups based on the reporting jurisdiction's existing definitions. She emphasized that companies should be able to determine discretionary group status per state requirements, as some states require approval of such groups. Relying on state-specific definitions would provide clearer guidance and proper reporting, rather than attempting to create a new, uniform definition.

Guzman asked for clarification regarding the proposed edits from Missouri, specifically regarding what changes would be made to the definition sheet concerning discretionary groups under their proposed edits.

Hal Marsh (NAIC) noted that another option would be to remove the discretionary policy bullet point entirely and asked whether the Working Group intended to keep or remove it.

Guzman confirmed this was the source of his confusion.

LeDuc stated Missouri could accept either approach but noted that some items originally listed as discretionary policies were not considered discretionary in Missouri.

Rodriguez agreed, adding that excluding those items and defining discretionary groups according to each reporting jurisdiction would provide greater clarity.

Guzman proposed adopting the edits, including Missouri's changes, with the understanding that discretionary policies would still be excluded and that the definition would be based on the reporting jurisdiction. He indicated he had already discussed this with Commissioner Marie Grant (MD) and was prepared to make a motion to adopt.

Guillory asked for a second to the motion.

Since no second was received, the motion was tabled. Guillory asked all members to review the proposed changes and options before the next meeting, noting that a decision would need to be made at that time.

3. Adopted the MCAS PPA Blank and Data Call and Definitions Proposal

LeDuc explained that a clarification was proposed to align the new data element referring to enrollment in telematics products with the deck definition, as no standalone definition for telematics existed.

Guillory asked for comments and mentioned that an additional item to consider is whether the homeowners MCAS non-standard question should also be moved to the underwriting section for consistency, as it would allow for numerical percentage reporting.

LeDuc requested to table the homeowners issue until the Working Group's next meeting to review Missouri's homeowner data first. No objections were raised.

Guzman said he supported Missouri's edits, including the addition of "usage-based" alongside "telematics." He also pointed out a possible discrepancy regarding whether non-standard policies should be counted as issued or in force at the end of the period. Guillory and others discussed and agreed that counting the policies as "in force at the end of the period" was more consistent.

Guzman made a motion, seconded by Hesser, to adopt the private passenger auto (PPA) MCAS edits with Missouri's changes and to revise the language to reflect "policies in force at the end of the period" instead of "issued during the period." The motion passed unanimously, and the Working Group agreed to forward the edits with Guzman's amendment.

4. Considered the Adoption of the MCAS LPI Proposal

Guillory introduced Amendment Six of the MCAS LPI proposal, which addresses an issue where companies were incorrectly reporting policies expiring at the end of their term as cancellations to make data reconcile. The proposal includes: 1) clarifications to the definition of cancellations (e.g., coverage ending at term completion is not a cancellation); 2) new definitions for coverage renewed, term of coverage completed, individual policies written, and certificates written during the period; and 3) the addition of new data elements related to certificates and policies whose coverage terms were completed or renewed during the period. Guillory noted that comments on the proposal were posted on the Working Group's web page, with feedback received from Birny Birnbaum (Center for Economic Justice—CEJ) and LeDuc. Guillory said that since Birnbaum was not present on the call, only written comments would be considered. He invited LeDuc to discuss her feedback.

LeDuc summarized that Missouri had submitted detailed comments indicating both support and questions regarding the amendment. She noted that Birnbaum had provided additional information related to their remaining concerns about the benefits of tracking the number of certificates or policies renewed. However, Missouri had not yet had time to fully review this information. She suggested it might be helpful for Birnbaum to explain the benefits directly at a future meeting and welcomed input from other states or interested parties on the issue.

Werbeloff explained that the issue originated from a company's reporting practice in Rhode Island and acknowledged there may be inconsistencies across companies in how expirations and renewals are reported. He outlined Birnbaum's reasoning for tracking policies and certificates renewed to help regulators determine whether short-term products are being used as long-term coverage. Werbeloff said he supported Birnbaum's overall proposal but emphasized that the key priorities are clarifying the definition of cancellations to exclude expirations and adding elements to separately capture term completions.

Werbeloff suggested a compromise, including: 1) adopting clarifications on cancellations; 2) defining "term of coverage completed;" 3) adding a note to clarify that renewals should be reported as new policies/certificates; and 4) adding two new data points (for term completions). Werbeloff noted that while Birnbaum's full proposal is reasonable and useful, the renewal tracking component is nice to have but not essential for correcting current data inconsistencies.

Guillory proposed splitting the amendment into two parts for separate consideration. The first part to consider is adoption of the revised definition of cancellations, the new definition for “term of coverage completed,” and the addition of two data elements to report the number of certificates and individual policies for which coverage is completed during the period. Guillory noted that these changes would resolve the validation issues and allow for correct reporting. The second part to consider is the addition of definitions for coverage renewed, individual policies written during the period, certificates written during the period, and related new data elements for reporting renewed coverage. Guillory asked if there were any concerns with this two-part approach.

Werbeloff agreed with Guillory’s proposal to divide the amendment into two parts. He recommended that if the Working Group moves forward with only the smaller portion, then updating the definition of cancellations, defining “term of coverage completed,” and adding two related data points, an additional clarification should be included. Specifically, he proposed adding a note under the term of coverage completed definition stating that a reissue or renewal should be reported as a new policy or certificate issued. Werbeloff explained that this clarification would help ensure consistent reporting if the broader set of changes related to coverage renewed is not adopted.

Guillory confirmed that it would be helpful to include the clarification suggested by Werbeloff and noted that any motion to adopt could include that edit. Guillory restated that the first group for consideration includes: 1) a revised definition of cancellations; 2) a new definition for “term of coverage completed;” 3) data elements for the number of certificates with term of coverage completed; and 4) data elements for the number of individual policies with term of coverage completed. Guillory asked if there were any additional comments or questions about these four items and then called for a motion to adopt them, either as originally written or with Werbeloff’s proposed clarification.

Moran made a motion, seconded by LeDuc, to accept the four changes to the proposal. The motion passed unanimously.

Teresa Cooper (NAIC) clarified that the motion did not include Werbeloff’s suggested additional clarification.

Guillory opened a discussion on the second set of proposed changes regarding definitions and data elements for coverage renewed. No motion was made.

Lisa Brown (American Property Casualty Insurance Association—APCIA) commented that defining renewals as new coverage could cause confusion. She said she preferred Werbeloff's earlier suggested clarification instead. LeDuc expressed concerns that the "renewed" coverage data would not add regulatory value given state-specific authority limitations. Guzman suggested forming an SME group to further discuss the second set of changes due to their complexity.

Werbeloff agreed to table the broader proposal and suggested that further discussions focus on additional clarifying language to avoid inconsistencies in reporting.

Cooper asked Werbeloff to send his suggested wording so it could be posted for review before the next meeting.

Guillory confirmed there were no objections to tabling the second set of changes for further consideration at the next meeting.

5. Discussed the Consistency of the MCAS Complaints Data Element Wording

Guillory stated that the Working Group discussed inconsistencies in the wording of the data element that asks for complaints not submitted through the department of insurance (DOI). He said the most common wording across MCAS lines (annuity, homeowners, LPI, life, pet, private flood, PPA, and travel) is: 1) “Number of complaints received directly from any person or entity other than the DOI;” 2) “Variations exist in other lines;” 3) "Number of complaints received directly from any entity other than the DOI” (for disability income); 4) “Number of complaints received directly from consumers” (for long-term care); and 5) "Number of complaints received by company other than through the DOI (Other Health and STLD Lines).” It was noted that the original intent was for these data elements to use consistent wording across all lines. Comments were received from LeDuc regarding understanding the variations.

Guillory opened the floor for comments regarding the wording of the data element for complaints not submitted through the DOI, noting that Birnbaum had submitted written comments.

Guzman expressed support for using consistent wording across all lines of business and agreed with Missouri's earlier comments. He emphasized that the intent has always been to capture complaints not reported through the DOI and recommended standardizing the wording.

Guzman made a motion, seconded by LeDuc, to adopt the most common existing wording, "Number of complaints received directly from any person or entity other than the DOI," across all relevant MCAS lines, including disability income, long-term care (LTC), other health, and short-term, limited duration (STLD). Clarifications were made to ensure the Working Group understood the change applied only to the wording for consistency, not removing any existing DOI complaint counts. The motion passed unanimously.

The change will referred to the Market Regulation and Consumer Affairs (D) Committee for final approval.

Discussed Other Matters

Guillory noted that, due to time constraints, discussion of the following items would be postponed to the next meeting: 1) pet MCAS reporting, including clarification on question no. 109 related to partial payments due to maximum benefit limits; and 2) an update from the SME group reviewing comments on MCAS travel reporting.

Guzman confirmed that the SME group completed its work, resulting in only one proposed change that can easily be addressed at the next meeting.

LeDuc requested that the next meeting also include a discussion on eliminating the requirement for companies to report non-consumer DOI complaints and DOI complaints generally. She said she will provide specific language for this discussion.

Guillory asked Marsh to add LeDuc’s request to the next meeting agenda.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 5/28/2025

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 22, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 22, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Rachael Lozano (FL); Chris Heisler (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Jo A. LeDuc, Julie Heser, and Teresa Kroll (MO); Robert McCullough (NE); Jonathan Wycoff (NV); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Laura Klanian and Melissa Gerachis (VA); Mary Kay Rodriguez (WI); and Letha Tate (WV). Also participating were: Zack Palank (OK); and Brian Werbeloff (RI).

1. Adopted the MCAS Other Health Blank and Data Call and Definitions Proposal

Guillory stated that during the Working Group's May 1 meeting, a motion was made to adopt the proposed revisions to the other health Market Conduct Annual Statement (MCAS). However, the motion did not receive a second and, therefore, did not move forward. The main area of concern appeared to be the reporting of discretionary groups. For the current meeting, the plan is to first consider all edits proposed by the health subject matter expert (SME) group and Missouri, excluding discretionary group reporting. The Working Group will then discuss and consider discretionary group reporting separately. Guillory opened the floor for questions, comments, or discussions from Working Group members, other state regulators, and interested parties regarding the proposed edits, excluding those related to discretionary groups. No comments were noted at that time.

Guillory asked for a motion to adopt all edits proposed by the other health SME group and Missouri, excluding those regarding discretionary group reporting.

Guzman made a motion, seconded by Gerachis, to adopt the proposed edits, excluding those regarding discretionary group reporting (Attachment --). The motion passed unanimously.

Guillory moved on to discuss the reporting of discretionary group data in the other health MCAS. He stated that the health SME group proposed adding an exclusion to eliminate the reporting of discretionary group data. Missouri did not oppose the exclusion but pointed out that discretionary groups are defined differently by each state. Guillory stated that Missouri recommended excluding groups as defined by the reporting jurisdiction, rather than using a fixed list of example groups.

Rodriguez confirmed that she had submitted comments regarding the discretionary group reporting issue. She expressed concern that allowing companies to report discretionary groups based on each state's definition would render national comparisons meaningless. She supported other recommendations that companies should not report discretionary groups as defined by each state. Rodriguez proposed two alternative approaches: 1) excluding all health insurance policies/certificates not considered association, trust, individual, or employer groups—limiting reporting to just those categories; or 2) creating an "Other" category to capture any groups outside of association, trust, individual, and employer group definitions if regulators still want some discretionary group information.

Guillory asked for a motion for the handling of discretionary group reporting in the other health MCAS.

Guillory noted that since no motion was made, the topic of discretionary group reporting will not be advanced to the larger committee or plenaries for the 2026/2027 reporting year. The Working Group will consider whether to

keep the item on the agenda for future discussion or take further action at a later date. The issue will be clarified and addressed later.

2. Adopted Changes to the Homeowners MCAS Reporting

Guillory stated that during its May 1 meeting, the Working Group approved rewording the non-standard interrogatory in the private passenger auto (PPA) MCAS question no. 8, "If Yes, what percentage of your business is non-standard?" to ask for the number of non-standard policies in force during the period rather than the percentage. The Working Group also moved question no. 8 to the underwriting section. For consistency, it was proposed that the same edits be applied to the homeowners MCAS.

Guzman expressed support for the proposed change to the homeowners MCAS for the sake of consistency. He noted that reporting an actual number rather than a percentage would provide additional value to regulators, particularly in prioritizing companies. He agreed that it would make sense to apply the same edit to the homeowners MCAS as was approved for the PPA MCAS.

Kroll shared that, based on a review of state records, only seven companies have reported non-standard homeowners business in Missouri over the past several years. She noted this indicates the non-standard homeowners market is much smaller than the PPA market. Kroll suggested that this difference may affect the value or relevance of making the same change for the homeowners MCAS and encouraged the Working Group to consider whether the update is truly beneficial.

Guillory asked for a motion to adopt the proposed changes to homeowners MCAS reporting.

Guzman made a motion, seconded by Moore, to adopt the proposed changes to homeowners MCAS reporting. The motion passed, with Missouri opposing.

3. Considered Adoption of the MCAS LPI Proposal Related to Coverage Renewed

Guillory noted that comments were received regarding the proposal form posted on the Working Group's web page. He reviewed items that were approved during the Working Group's May 1 meeting to address a validation issue and help insurers correctly identify policies and certificates where the term of coverage was completed during the period. Approved changes included: 1) a revised definition for "cancellations;" 2) a new definition for "term of coverage completed;" and 3) two new data elements: a) number of certificates for which coverage was completed during the period; and b) number of individual policies for which coverage was completed during the period. He stated that the three remaining items from the proposal are now under consideration: 1) new definitions for "coverage renewed," "individual policies written during the period," and "certificates written during the period;" 2) a new data element for the number of certificates issued for coverage renewed during the period; and 3) a new data element for the number of individual policies issued for coverage renewed during the period. He referenced the meeting materials, where approved and proposed items are clearly identified.

Birny Birnbaum (Center for Economic Justice—CEJ) offered a recap of the data edit issue raised by insurers. He said some insurers were unsure how to classify policies that reached the end of their term, leading to inconsistencies. He said some insurers treat them as cancellations, while others do not. The lack of appropriate data elements created challenges in completing the data validation edit. During its most recent meeting, the Working Group adopted several data elements to address this issue. Birnbaum reviewed the remaining items under consideration, which focused on identifying whether coverage under group policies or individual lender-placed insurance (LPI) policies was renewed. These additions would make the data edits more accurate and reliable. They would also help regulators better understand market trends, such as increases in LPI renewals,

which could signal inadequate consumer notification by insurers or market access problems for consumers seeking voluntary coverage.

Birnbaum cited the Wells Fargo/National General LPI case as an example where better data could have enabled insurance regulators to catch issues earlier than federal financial regulators. He emphasized that the proposed data elements would be extremely helpful to regulators and strongly encouraged their adoption. He also clarified that the proposed items labeled “individual policies written during the period” and “certificates written during the period” are not entirely new elements but enhanced definitions of existing elements already included in the MCAS.

Werbeloff acknowledged the usefulness of Birnbaum’s proposal, which was discussed at the prior meeting, but also noted industry concerns about adding new data elements. He presented an alternative approach aimed at addressing those concerns. Rather than adding new data elements, the Working Group could provide clarifying guidance regarding how to treat renewals/reissues with no gap in coverage. Specifically, guidance is needed on whether these should be counted as new policies or certificates issued. He explained that without this clarification, there's ambiguity in how insurers should interpret and report these transactions. He emphasized the need for clear instructions to ensure consistency in data reporting and error resolution, especially in the context of existing formulas (e.g., beginning number of certificates plus newly issued certificates minus cancellations equals ending number of certificates). He proposed the following one-line addition for clarity: "Note: Following the term of coverage completed, a reissue/renewal should be reported as a new policy or certificate issued.” Werbeloff said that while he was still supportive of Birnbaum’s proposal, this alternative minor clarification could help fix the data issue if the committee opts not to adopt the full set of proposed data elements.

Hesser stated that Missouri is not opposed to the proposed new data fields, but she expressed concern over the terminology used, specifically the use of the term "renewed." She noted that coverages are often described as expiring rather than renewing, which makes the term "renewed" potentially misleading. Missouri suggested using alternative terminology, such as "continued" or something else that would be more accurate.

Birnbaum responded by suggesting the term "coverage reissued" as a possible alternative. Hesser agreed that “reissued” would be preferable to "renewed" and would address Missouri's concern.

Birnbaum expressed appreciation for Werbeloff’s efforts and acknowledged his role in initiating the discussion. Birnbaum stated, however, that adding a single sentence of guidance under "term of coverage completed" would not sufficiently address the issue. Doing so places guidance in the wrong context, leading to potential confusion. He emphasized that the proposed data elements already include the precise, detailed guidance that the industry has requested. For example, the definition includes all individual policies issued, including those issued in error or reissued, before any cancellations. Birnbaum argued that including this guidance as a separate data element is critical to ensure clarity and consistent interpretation. Without a separate element, confusion may persist from having to embed the information in unrelated data fields. He concluded by urging regulators to adopt the full proposal, with the terminology changed from "coverage renewed" to "coverage reissued" in response to earlier feedback.

Guillory invited a motion regarding the proposed changes, reminding participants to clarify whether the motion included Werbeloff's suggested language and whether it used "reissued" instead of "renewed," as suggested by Hesser and Birnbaum.

No motion was made. Guillory indicated that the Working Group may try to hold one more meeting before the June 2 deadline to finalize a decision on the remaining items. He emphasized the need for a firm decision to avoid inconsistent or piecemeal implementation.

Werbeloff added a follow-up comment, noting that if no additional changes are finalized before the deadline, the Working Group should plan to discuss guidance for the NAIC in a future meeting. Specifically, the guidance would address error code handling related to whether certificates with completed coverage terms should be subtracted in the end-of-period calculation. This decision would influence whether reissued certificates are counted as newly issued. He stressed the importance of providing this clarity, either via guidance or system error logic.

4. Discussed the Removal of the MCAS Complaints Data Element for Collecting the Number of Complaints Received Directly from the DOI

Teresa Cooper (NAIC) confirmed that complaint data is available in Snowflake and will be accessible in ThoughtSpot soon. She stated that pulling accurate data depends on correctly using complaint coding structures.

Palank expressed concerns about other health coverage codes being incomplete (e.g., having no specific codes for specified disease, indemnity, or hospital surgical expenses). He said that there were discrepancies in complaint counts between the Complaints Database System (CDS) and MCAS for short-term, limited-duration (STLD) in 2023, as 61 companies reported STLD complaints through CDS but only 16 reported STLD complaints through the MCAS. Despite more companies reporting through the CDS, it had 14% fewer total complaints than the MCAS. Among those that did report in the MCAS, CDS reflected 38% fewer complaints. These differences raised concerns about data accuracy and consistency, reinforcing the need to continue collecting complaint data for LPI, STLD, and other health via the MCAS.

Guillory asked if there were any motions to: 1) remove the data element from all lines of business; 2) remove it from specific lines only; or 3) retain it but standardize the wording.

No motion was made, so the data elements will remain unchanged for now. Members were encouraged to send further comments to Hal Marsh (NAIC) for future discussion or updates.

5. Adopted a Motion to Update the Definition of “Partial Payment”

Guillory introduced an inconsistency in the pet MCAS reporting, specifically with question no. 109, which asks for the number of claims closed with partial payment due to maximum benefit limits. However, the current definition of "partial payment" excludes claims reduced for this reason, creating a contradiction. Regulators had originally added this data element to capture claims detail after pet insurers indicated they could not provide breakdowns by coverage type. The intent was to differentiate less concerning denial reasons (e.g., maximum benefit limits) from other claims-handling issues. Guillory proposed resolving the contradiction by striking the exclusion in the definition and aligning it with the data element language.

Cooper agreed that clarification was needed due to the conflicting language.

Lozano made a motion, seconded by Dorschner, to update the definition of “partial payment” by removing the exclusion for maximum benefit limit reductions, noting it could be revisited next year as this is a new data element. The motion passed. Missouri abstained, citing a lack of awareness that a vote would be taken.

6. Received an Update and Proposal from the MCAS Travel SME Group

Guzman provided an update on the travel MCAS SME group. The group met once in an open discussion format involving both regulators and industry representatives to address concerns raised, particularly by Caren Alvarado (Crum & Forster). The only recommended change from the SME group was to merge three interrogatory questions

related to entity types used in travel insurance (i.e., third-party administrators [TPAs], managing general agents [MGAs], and travel administrators), consolidating them into a single question. Guillory clarified that these proposed edits will be exposed at a later date and are not being considered for the 2026 data year.

No additional comments or questions were raised from Working Group members, other regulators, or interested parties. Stakeholders were encouraged to submit feedback during the future exposure period.

7. Discussed Other Matters

Cooper raised the final outstanding item of whether to schedule another call to address additional LPI items or defer the discussion to the next data year.

Guillory noted there is still confusion among Working Group members and that a meeting in the immediate future likely would not resolve the remaining issues. He opened the floor for feedback on scheduling.

Coker asked if the recently adopted changes addressed the original concern.

Guillory deferred to Birnbaum, who said the changes were partially helpful, but additional guidance is still needed.

Werbeloff, who raised the initial concern, clarified that the primary issue was mathematical, specifically related to inflated cancellation ratios, and has now been addressed. There is a secondary concern for potential inflation of policies issued, which he agreed could be addressed through future guidance and error code adjustments, possibly in the next data year cycle. He suggested refining the error code logic and offered to send a recommendation to Marsh.

Guillory and Werbeloff agreed that even if language changes do not happen before the June deadline, refining the error code logic will serve as a useful backup. Werbeloff said he would send proposed error code updates for consideration.

Birnbaum asked whether the newly approved data elements will ensure the edit check functions correctly. Cooper confirmed that the updated validations will include subtraction of the new data element and should resolve the error issue. She welcomed further guidance from Werbeloff.

The Working Group acknowledged significant progress in resolving LPI reporting issues and agreed to address remaining minor concerns and potential guidance updates in the next reporting cycle.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

MCAS Market Conduct Annual Statement

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~~

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

~~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

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

~~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.

How Discretionary Groups are currently referred to in the Other Health MCAS Data Call and Definitions. (There is currently no reference to discretionary groups in the Other Health MCAS Blank)

- **Report by Residency**: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situsued. (Page 7, Version 2024.0.6)

How Discretionary Groups could be referenced based on proposals from SME Group and Missouri:

- **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.
- **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.

- **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.

Comments from Missouri related to Discretionary Groups (email dated April 16, 2025)

The Exclusion of Discretionary Groups:
The definitions for "Other Health" (page 12 of the Instructions) and "Association/Trust" (page 13 of the Instructions) added the following exclusions:

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

Discretionary policies are not clearly defined, except for a few examples and the mention of "other Discretionary groups." This wording leaves the definition open to interpretation. Furthermore, the current instructions conflicts with Missouri law, as labor unions, financial institutions, and creditor groups are not considered discretionary groups in Missouri.

Since different states may have varying definitions of "Discretionary Group," insurers should instead rely on the legal definitions relevant to the state in which they are reporting to determine what is included or excluded. We recommend removing specific examples from the definition and replacing it with something along the lines of "(i.e., discretionary groups as defined by the reporting jurisdiction)".

We understand this may create challenges. Alternatively, it would be reasonable to remove Discretionary Groups altogether from the excluded groups list on the Other Health blank.

In addition, the Report by Residency instruction on page 12 includes references to 'discretionary groups'. If discretionary groups are to be excluded from reporting, these references should be deleted.

Comments from Wisconsin related to Discretionary Groups (email dated May 2, 2025)

Wisconsin recommends that companies should not report discretionary groups as defined in each state, because the national comparison would be useless at that point.

Here is an alternative option:

- Exclude all health insurance policies/certificates not considered Associations/Trusts, Individual or Employer Group Products.

In case regulators don't want to do away with the reporting element altogether:

- Create an "Other" bucket where companies report all health insurance policies/certificates not considered Associations/Trusts, Individual or Employer Group Products or Discretionary Groups. (this means we wouldn't really be comparing apples to apples)
- Create a bucket for each "other" type of group by name, i.e. one bucket for labor unions, one for financial institutions, etc.

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: 7/3/2025	
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 7/3/2025 ☐ Accepted ☐ Rejected by MCAS Blanks WG Chair ☒ Posted to Web Page for Public Exposure/Comment – Date 7/3/2025 ☐ 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	To be Assigned

Proposal Contact Information

Name of Contact Person	Raymond Guzman
Name of Organization	Maryland Insurance Administration
Email Address	Raymond.guzman@maryland.gov
Phone Number	410-468-2322
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:
The Data Call & Definitions for the Other Health line of business should have the definition for "Other Health" updated with the following addendum: "… Hospital/Surgical/Medical Expense; Blanket Policies for Short-Term Events are Excluded

PROVIDE THE REASON FOR THE CHANGE:
The NAIC and state DOIs have an informal understanding that blanket policies for short-term events should be excluded; however, this is not formally stipulated in the Data Call & Definitions.

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

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:
https://content.naic.org/sites/default/files/inline-files/MCAS%20Data%20Call%20Other%20Health%202023.2.2.pdf < This is the document that should be updated.

Current Validation Logic

70112	Error	Single-Interest Auto (SIA): Q60 must equal Q58 + Q59 - Q61 - Q62.	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70114	Error	Single-Interest Auto (SIA): Q68 must equal Q66 + Q67 - Q69 - Q70.	For Single-Interest Auto (SIA) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.

New Validation Logic

70112	Error	Single-Interest Auto (SIA): Q60 must equal Q58 + Q59 - **Q60** - Q61 - Q62.	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less **certificates for which Term of Coverage completed during the period**, flat-cancelled during the period, and cancelled for any other reason during the period.
70114	Error	Single-Interest Auto (SIA): Q70 must equal Q67 + Q68 - **Q69** - Q71 - Q72.	For Single-Interest Auto (SIA) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less **individual policies which Term of Coverage completed during the period**, flat-cancelled during the period, and cancelled for any other reason during the period.