

Date: 8/24/2020

Conference Call

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP

Wednesday, August 26, 2020

2:00 p.m. ET / 1:00 p.m. CT / 12:00 p.m. MT / 11:00 a.m. PT

ROLL CALL

Rebecca Rebholz, Chair	Wisconsin	Paul Hanson	Minnesota
October Nickel, Vice Chair	Idaho	Brent Kabler/Teresa Kroll	Missouri
Maria Ailor	Arizona	Todd Oberholtzer	Ohio
Jimmy Harris/Ryan James/ Russ Galbraith	Arkansas	Katie Dzurec	Pennsylvania
Kurt Swan	Connecticut	Michael Bailes	South Carolina
Scott Woods	Florida	Lisa Borchert/Ned Gaines/ John Haworth	Washington
Lori Cunningham	Kentucky	Letha Tate	West Virginia

NAIC Support Staff: Tressa Smith/Teresa Cooper

AGENDA

1. Consider Adoption of its July 31 Minutes—*Rebecca Rebholz (WI)* Attachment A
2. Discuss Creation of the Travel Insurance Market Conduct Annual Statement (MCAS) Blank and Data Call and Definitions—*Rebecca Rebholz (WI)*
3. Consider Draft Homeowners MCAS Clarification—*Rebecca Rebholz (WI)* Attachment B
4. Consider Addition of National Producer Number (NPN) Reporting—*Rebecca Rebholz (WI)*
 - Third-Party Administrators (TPAs) within the Homeowners, Private Passenger Auto, and Life & Annuities MCAS
 - Managing General Agents (MGAs) within the Homeowners and Private Passenger Auto MCAS
5. Discuss Possible Placement Changes for the Lawsuit and Complaint Data Elements within the Homeowners and Private Passenger Auto MCAS—*Rebecca Rebholz (WI)*
6. Discuss Addition of “Accelerated Underwriting” Definition and Data Elements to the Life MCAS —*Rebecca Rebholz (WI)* Attachment C
7. Discuss Addition of Digital Claims Settlement Reporting in the Homeowners and Private Passenger Auto MCAS —*Rebecca Rebholz (WI)* Attachment D
8. Discuss Any Other Matters Brought Before the Working Group—*Rebecca Rebholz (WI)*
9. Adjournment

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Draft: 8/7/20

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Summer National Meeting
July 31, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 31, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Sharon P. Clark and Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Todd Oberholtzer (OH); Katie Dzurec (PA); Michael Bailes (SC); and John Haworth (WA).

1. Adopted its June 24 Minutes

The Working Group met June 24 and took the following action: 1) adopted its May 28, May 27, May 21 and May 20 minutes; 2) discussed Market Conduct Annual Statement (MCAS) Data Call and Definitions clarifications needed after adoption of changes to the Life, Annuity, Homeowners and Auto MCAS lines of business; and 3) adopted a motion to edit part of the first sentence of the definition for Individual Indexed Variable Annuity from “offers some principal protection” to “may offer some principal protection.”

Mr. Haworth made a motion, seconded by Mr. Swan, to adopt the Working Group’s June 24 minutes (Attachment). The motion passed unanimously.

2. Discussed Possible Clarifications for Recently Adopted MCAS Updates

- a. The first item discussed was clarification on how the definitions of the types of insurance (TOIs) are to be used within reporting for the data elements added in the Homeowners underwriting section. Four new data elements were added during the June 24 call: 1) the number of dwelling fire policies in force at the end of the period; 2) the number of homeowner policies in force at the end of the period; 3) the number of tenant/renter/condo policies in force at the end of the period; and 4) the number of all other residential property policies in force at the end of the period. Draft language was included in the call materials, and it was also posted to the Working Group’s web page for review. Ms. Rebholz stated that a note could be added at the beginning of the definitions section of the Data Call and Definitions to clarify how the definitions should be used. There were no comments by Working Group members, interested state insurance regulators, or interested parties. Any thoughts, suggestions or comments on this topic were requested to be submitted to Teresa Cooper (NAIC) by Aug. 19 for consideration.

3. Discussed Possible MCAS Updates Previously Tabled

- a. The first item for discussion was related to the third-party administrator (TPA) and managing general agent (MGA) reporting that was previously adopted for the Life, Annuity, Homeowner and Auto Interrogatories. For the Life and Annuity MCAS, an interrogatory was added to ask if the company uses TPAs; if so, it was asked to name each TPA and its function. For the Home and Auto MCAS, two interrogatories were added. One was to ask if the company uses MGAs; if so, it was asked to name each MGA. The other added interrogatory was to ask if the company uses TPAs; if so, it was asked to name each TPA.

Ms. Rebholz stated that Ms. Nickel has also suggested adding an interrogatory for the inclusion of the TPA’s and MGA’s national producer number (NPN). Mr. Hanson asked if all TPAs and MGAs would have an NPN. Ms. Nickel stated that she believes they are required to have an NPN. Mr. Haworth stated that some states do not license TPAs, so they may be tracked differently as a result. Any thoughts, comments or suggestions on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

- b. The next item discussed was the suggestion from the Center for Economic Justice (CEJ), to add definitions and data elements related to accelerated underwriting to the Life MCAS reporting. Comments for this suggestion were included in the meeting materials for the call. The suggested definition is: “accelerated underwriting means underwriting or pricing of life insurance in whole or in part on non-medical data obtained from other than the applicant or policyholder and includes, among other things, facial analytics, social media and consumer credit information.”

Birny Birnbaum (CEJ) stated that the life insurance industry is using non-medical, non-traditional data to develop models that replicate its traditional underwriting. Issues associated with accelerated underwriting may be of interest to market regulators. The proposal includes a definition for accelerated underwriting and three interrogatories. The suggestion would be that some of the data elements would be reported separately for accelerated underwriting related business versus non-accelerated underwriting business. For example, there is currently a data element for the total number of new policies issued by the company during the period; the proposal would suggest separating this into two data elements: one for the total number of policies issued by the company during the period utilizing accelerated underwriting and one for the total number of policies issued by the company during the period utilizing other than accelerated underwriting.

David Leifer (American Council of Life Insurers—ACLI) stated that there is a lot of work going on related to this subject among other NAIC working groups. He does not know if the definition proposed for accelerated underwriting is accurate, and he suggested working with other groups that are discussing this topic before making any final decisions here. Mr. Birnbaum stated that the CEJ has only proposed this, and if the Working Group decides this is an issue that should be considered as part of the MCAS blanks, the definition of accelerated underwriting will then be developed. He said he does not believe this subject should be delayed, as working on this now means that the earliest reporting would be 2022 data reported in 2023.

Brendan Bridgeland (Center for Insurance Research—CIR) stated support for Mr. Birnbaum’s proposal. He stated that consumers should have some idea of what is going into their rating and underwriting and why they have been denied access. For example, there could be duplicate factors disqualifying someone, such as a credit score in addition to a personal bankruptcy. Mr. Bridgeland stated that it would be useful to track the information proposed by the CEJ.

Commissioner Clark stated that the CEJ’s suggestion holds merit, and she would like the Working Group to consider collecting this data. Mr. Haworth stated that it is warranted to explore this topic because of the concerns with how different types of consumer information are being used, especially with the current economy. He stated that the Working Group can collaborate with others to create a definition, along with inserting terms for predictive analytics and a couple of others regarding algorithms. Ms. Nickel agreed. Any thoughts, comments or suggestions on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

- c. The next item discussed was related to the placement of lawsuit and complaints data elements within the Home and Auto MCAS. There is concern that complaint counts are not reported accurately. Previous discussion noted four options. The first option discussed was to create a new reporting section for lawsuits and complaints. The concern with this option is that complaints are currently reported in total in the underwriting section, while lawsuits are reported by coverage in the claims section. Other lines require reporting of complaints by coverage. The second option discussed was to move the complaints questions to the interrogatories. The concern with this option is that it could cause issues when trending past data, and it would be inconsistent with other MCAS lines of business. The third option discussed was to add clarification to the complaint definition. The fourth option was to change the claims section title to be “Claims and Total Complaints section.”

Mr. Haworth stated that he does not see a need to make a change here. Ms. Nickel stated that she believes the concern here is that carriers are not reporting this data correctly. Mr. Haworth stated that he has seen situations in which the company does not have a correct way of tracking what a complaint is, by definition, so the department of insurance (DOI) shows more complaints than the company because of underlying reporting issues within the company.

Mr. Birnbaum stated that one of the concerns that was raised is that the current placement suggests that companies only report certain types of lawsuits or certain types of complaints. By pulling this information out into a section called “complaints and lawsuits,” it would be much clearer to reporting companies that the MCAS is looking for any type of complaint, or any type of lawsuit, regardless of whether it is related to claims, underwriting, or any other matter. Any thoughts, suggestions or comments on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

- d. The next item discussed was the suggestion from the CEJ to break claims data elements for Homeowner Dwelling and Personal Property coverages into Digital Claims Settlements and Other than Digital Claims Settlement. This suggestion is detailed within the CEJ’s May 25 comment letter, which was included in the meeting materials.

Mr. Birnbaum stated that a digital claims settlement, sometimes referred to as virtual claim handling, refers to a loss appraisal not involving a human on-site inspection of the property, but it is based on digital information, including photos taken by the insured or claimant, a plane or drone, or information provided by sensors or cameras within or near the property. For some cars, if there is an accident, the car will be able to send information to the insurer, who can run information through an algorithm and almost instantaneously produce a claim settlement proposal for the insured. While there are some great potential benefits, there are also some consumer protection issues, such as whether these digital/virtual claims settlements are fair or significantly different from those that involve a human being. Because of this change in claim settlements, the CEJ is suggesting that for homeowners and auto, the claim data elements be broken out into digital claims settlement and other than digital claims settlement. Then market analysts can determine whether any significant differences exist by company or by industry in the nature of the timing or the outcomes for digital claims settlements versus other than digital claims settlements. The CEJ proposal included a definition for each category and gave an example of how the two categories might be presented in the MCAS. Mr. Birnbaum discussed the definitions proposed, and he provided examples. He added that the volume of these types of claims has grown as a result of the pandemic, and it is unlikely that there will be a movement back to fewer digital claims.

Ms. Nickel stated that it would be a good idea to consider this because digital claims will likely increase as time goes on. She stated that considering the effects of underwriting on this topic would be something to think about going forward as well. Ms. Cunningham agreed that consideration of digital practices regarding underwriting would be useful. Mr. Haworth asked if the CEJ proposal applies to homeowners and auto lines. He stated that customers are using applications to submit photos of auto damages, and he pointed out the need to consider how supplements on claims would be addressed. Mr. Birnbaum stated that the proposal does apply to homeowners and auto. Ms. Rebholz stated that in Wisconsin, auto repair facilities are stating that they see a high number of supplemental claims on digital claims settlements because the initial settlement does not address the full scope of the damage. Mr. Birnbaum stated that there would be a presentation during the NAIC/Consumer Liaison Committee meeting on Aug. 14 regarding the issue of digital claims settlements for auto if anyone would like to learn more on this issue. Any thoughts, suggestions or comments on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

4. Discussed Other Matters

Richard L. Bates (State Farm Insurance) stated that State Farm recently learned that there was an adopted change to the Auto MCAS to add a data element for claims closed without payment when the damage is below the deductible. He asked what the purpose of adding this data element is, how the data would be used, and if the industry was consulted on if they could produce this information and the extent to which it would be accurate. He stated that there would be significant costs imposed on carriers, and therefore consumers, in trying to understand the regulatory concern here.

Ms. Nickel stated that it is important for state insurance regulators to know how many claims are being denied, and separating out claims that were closed just because they were below the deductible was a way to better understand the data being presented by carriers and determine if further analysis of a carrier is warranted. She also stated that there were industry representatives present for the discussion on this topic and the call was open to anyone that wanted to participate. She stated that if Mr. Bates could provide an analysis, comments, and any additional feedback from State Farm and/or other carriers by Aug. 19, they would be reviewed and considered. She also stated that if he has any suggestions that would remedy this issue for state insurance regulators and be suitable for insurers, those ideas would be welcome.

Mr. Birnbaum stated that this seems like a useful distinction. He explained that there can be a variety of reasons a claim is closed without payment, and if claims closed without payment due to being below the deductible are separated out, the remaining data on other claims closed without payment is more meaningful. He asked Mr. Bates how much State Farm would have to raise its rates to provide this information to state insurance regulators. Mr. Bates stated that he did not know and would check on that. He stated that he is looking at the assumption that there is always an ability for insurers to provide the reasons for claims closed without payment, and he suspects that State Farm will be able to satisfy some of that. He explained that there are times when a claim can close without payment below the deductible, and the insurer would not know that is the reason because the policyholder decided not to pursue their claim after filing it, as perhaps the policyholder learned the damages were below the deductible but never shared that with the insurer.

Ms. Rebholz stated that there is a ratio for claims closed without payment compared to the total number of claims closed. She stated that part of the discussion on this issue related to separating out claims closed without payment due to being below the

deductible to ensure this ratio accurately reflected the claims that were being closed without payment for other reasons so that a carrier would not appear as an outlier just because they had so many high deductible plans.

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

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Draft Homeowner MCAS Clarification for Discussion

Please note: In the Underwriting Section there are questions asking for policies in-force by type of policy. These are asking for a count of the policies in-force that meet the specifications to be included on the MCAS. Please use the following as a guide to determine which policy types should be reported for each question:

- (3-45) Number of dwelling fire policies in force at the end of the period.
 - Include dwelling policies that meet the definition of a dwelling policy as defined within this document. This would typically include policies written on forms DP-1, DP-2 and DP-3.
- (3-46) Number of homeowner policies in force at the end of the period.
 - Include homeowner policies that meet the definition of a homeowner policy as defined within this document. This would typically include policies written on forms HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8.
- (3-47) Number of tenant/renter/condo policies in force at the end of the period.
 - Include tenant/renter/condo policies that meet the definition of a tenant/renter/condo policy as defined within this document. This would typically include policies written on forms HO-4 and HO-6.
- (3-48) Number of all other residential property policies in force at the end of the period.
 - Include other policies that meet the specifics of MCAS reporting, but that do not fall into one of the categories requested in questions 3-45, 3-46 and 3-47. If your company only write policies that fall into the forms specified for questions 3-45, 3-46 and 3-47, this number may be 0.

Comments for the Center for Economic Justice

To the NAIC Market Conduct Annual Statement Blanks Working Group

Proposed Revisions to Life, Annuity, Auto and Homeowners MCAS Reporting

May 18, 2020

The Center for Economic Justice (CEJ) submits the following comments and recommendation for improvements to MCAS data collection, generally, and for the auto, homeowners, life and annuities lines of business, specifically.

Additional Data Elements – Accelerated Underwriting – Life Insurance

Life insurers started utilizing accelerated underwriting a few years ago – the use of non-medical data sources to create algorithms for underwriting and pricing. These data sources have included consumer credit data, social media, facial analytics and more. Some of the data sources used by insurers are not subject to the disclosure and consumer protection provisions of the Fair Credit Reporting Act. While accelerated underwriting holds the promise of faster decision-making and broader access, the use of black-box algorithms with little or no regulatory oversight also raises the potential for unfair and unfairly discriminatory treatment of applicants and policyholders. To enable regulators to monitor the effects of accelerated underwriting, we the following additional definition and data elements for MCAS life insurance:

Definition: Accelerated underwriting means underwriting or pricing of life insurance in whole or in part on non-medical data obtained from other than the applicant or policyholder and includes, among other things, facial analytics, social media and consumer credit information.

Interrogatories:

- Does the company use accelerated underwriting for life insurance? Y/N
- If the company uses accelerated underwriting for life insurance, for what product categories is it used?
- If the company uses accelerated underwriting for life insurance, list the data sources used and vendors supplying data or algorithms.

For data elements 1B-19 through 1B-27, replicate each data element for accelerated underwriting experience. For example, in addition to current 1B-20:

1B-20A: Total Number of New Policies Issued By the Company during the Period Utilizing Accelerated Underwriting.

CEJ Recommendation: Add Data Elements, Interrogatories and Definition to the Life MCAS for Accelerated Underwriting.



Comments for the Center for Economic Justice
To the NAIC Market Conduct Annual Statement Blanks Working Group
Proposed Revisions to Auto and Homeowners MCAS Reporting

May 25, 2020

The Center for Economic Justice submits the following recommendations for changes to the private passenger auto and homeowners MCAS interrogatories, coverages, data elements and definitions. The proposals are substantively identical for both lines of insurance. In keeping with the process utilized by the working group to review each line of business separately, CEJ presents our recommendations separately for private passenger auto and for homeowners.

Recommendations for Changes to Homeowners MCAS

3. Break Claims Data Elements 2-17 through 2-34 into Digital Claims Settlement and Other Than Digital Claims Settlement *for Dwelling and Personal Property Coverages Only*.

Description and Rationale: CEJ recommends splitting claims data experience between digital claims settlement and other than digital claims settlement. Digital claims settlement, sometimes referred to as virtual claims handling, refers to loss appraisal not involving a human on-site inspection of the property, but based on digital information, including, for example, photos taken by the insured or claimant or photos taken by a plane or drone or information provided by sensors or cameras within or near the property. We propose this additional break-out of claims only the dwelling and personal property coverages.

The purposes of segregating digital-only from human-involved claims settlements are, one, to assess the outcomes for consumers from digital-only claims settlement; and, two, to ensure that significant differences between digital-only and other than digital-only claim settlements are not masked by aggregate reporting. For example, one of the advertised benefits

of digital claims settlement is speed of settlement. If digital claims settlements are significantly faster than other-than-digital-only claims settlements, the aggregated claims data would mask these differences.

Definition:

Digital Claim Settlement means a claim involving a loss appraisal utilizing digital information only with no human on-site visual inspection or appraisal by the insurance company or independent adjuster of the vehicle or property. Examples of digital claim settlement include, but are not limited to, claim settlements based on photos taken by a claimant or insured or photos taken by a plane or drone or data provided by in-vehicle or in-property sensors with no in-person inspection or appraisal by the insurance company or independent adjuster.

Other Than Digital Claims Settlement means any claim other than a Digital Claim Settlement claim

Data Elements: The proposed change can be accommodated by creating two claims experience columns each for Dwelling and Personal Property coverages only for the claims activity data elements 2-17 through 2-34. The table below illustrates this approach.

ID	Description HOMEOWNERS MCAS	Digital Claims Settlement	Other Than Digital Claims Settlement
2-17	Number of claims open at the beginning of the period		
2-18	Number of claims opened during the period		
2-19	Number of claims closed during the period, with payment		
2-20	Number of claims closed during the period, without payment		
2-21	Number of claims open at the end of the period		
2-22	Median days to final payment		
2-23	Number of claims closed with payment within 0-30 days		
2-24	Number of claims closed with payment within 31-60 days		
2-25	Number of claims closed with payment within 61-90 days		
2-26	Number of claims closed with payment within 91-180 days		

2-27	Number of claims closed with payment within 181-365 days		
2-28	Number of claims closed with payment beyond 365 days		
2-29	Number of claims closed without payment within 0-30 days		
2-30	Number of claims closed without payment within 31-60 days		
2-31	Number of claims closed without payment within 61-90 days		
2-32	Number of claims closed without payment within 91-180 days		
2-33	Number of claims closed without payment within 181-365 days		
2-34	Number of claims closed without payment beyond 365 days		

4. Break “Number of Company-Initiated Non-Renewals During the Period” into
- Non-Renewals Based In Whole or In Part on Claims History;
 - Non-Renewals Based on Catastrophe Risk Exposure
 - Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information
 - All Other Company Initiated Non-Renewals

Description and Rationale: Insurers may non-renew a policy for a variety of reasons, each of which tells a different story about the insurer and/or the market. Market analysis would be significantly improved by segregating out company-initiated non-renewals for some of these different reasons. These additions are particularly relevant given new types of catastrophe risk exposure evaluations – e.g. wildfire – and the use of new algorithms based on non-insurance personal consumer information to assess customer lifetime value.

The current definitions include:

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.

Include:

- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:

- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:

- The number of non-renewals should be reported on a policy basis regardless of the number of autos insured under the policy.

New Definitions

Company-Initiative Non-Renewals Based in Whole or In Part on Claims History during the Period means a non-renewal initiated by the company based entirely or in part on the policyholder's claims history. For example, if the company-initiated non-renewal was based in part on claims history and in part on a change in credit score, report the non-renewal here.

Company-Initiative Non-Renewals Based on Catastrophe Risk Exposure during the Period means a non-renewal initiated by the company based entirely on an assessment of the policyholder's catastrophe risk exposure.

Company-Initiative Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information during the Period means a non-renewal initiated by the company based entirely on an algorithm or rule used by the company and based on non-insurance personal consumer information. Examples of such algorithms include a credit-based insurance score, a consumer lifetime value score or a consumer propensity for fraud score.

All Other Company-Initiative Non-Renewals during the Period means non-renewal initiated by the company for any other reason than the other three company-initiated non-renewal data elements.

Recommendations for Changes to Private Passenger Auto MCAS

3. Break Claims 2-21 through 2-38 into Digital Claims Settlement and Other Than Digital Claims Settlement for Property Damage, Collision and Comprehensive Coverages Only.

CEJ recommends splitting claims data experience between digital claims settlement and other than digital claims settlement. Digital claims settlement, sometimes referred to as virtual claims handling, refers to loss appraisal not involving a human on-site inspection of the vehicle or property, but based on digital information, including, for example, photos taken by the insured or claimant or photos taken by a plane or drone or information provided by sensors or cameras within or near the property or site of the accident. We propose this break-out only for property damage and physical damage coverages.

The purposes of segregating digital-only from human-involved claims settlements are, one, to assess the outcomes for consumers from digital-only claims settlement; and, two, to ensure that significant differences between digital-only and other than digital-only claim settlements are not masked by aggregate reporting. For example, one of the advertised benefits of digital claims settlement is speed of settlement. If digital claims settlements are significantly faster than other-than-digital-only claims settlements, the aggregated claims data would mask these differences.

Definition:

Digital Claim Settlement means a claim involving a loss appraisal utilizing digital information only with no human on-site visual inspection or appraisal by the insurance company or independent adjuster of the vehicle or property. Examples of digital claim settlement include, but are not limited to, claim settlements based on photos taken by a claimant or insured or photos taken by a plane or drone or data provided by in-vehicle or in-property sensors with no in-person inspection or appraisal by the insurance company or independent adjuster.

Other Than Digital Claims Settlement means any claim other than a Digital Claim Settlement claim

Data Elements: The proposed change can be accommodated by creating two coverage columns for Dwelling and Personal Property only for the claims activity data elements 2-21 through 2-38.

ID	Description	Digital Claims Settlement	Other Than Digital Claims Settlement
2-21	Number of claims open at the beginning of the period		
2-22	Number of claims opened during the period		
2-23	Number of claims closed during the period, with payment		
2-24	Number of claims closed during the period, without payment		

2-25	Number of claims open at the end of the period		
2-26	Median days to final payment		
2-27	Number of claims closed with payment within 0-30 days		
2-28	Number of claims closed with payment within 31-60 days		
2-29	Number of claims closed with payment within 61-90 days		
2-30	Number of claims closed with payment within 91-180 days		
2-31	Number of claims closed with payment within 181-365 days		
2-32	Number of claims closed with payment beyond 365 days		
2-33	Number of claims closed without payment within 0-30 days		
2-34	Number of claims closed without payment within 31-60 days		
2-35	Number of claims closed without payment within 61-90 days		
2-36	Number of claims closed without payment within 91-180 days		
2-37	Number of claims closed without payment within 181-365 days		
2-38	Number of claims closed without payment beyond 365 days		

4. Break “Number of Company-Initiated Non-Renewals During the Period” into
 - a. Non-Renewals Based In Whole or In Part on Claims History;
 - b. Non-Renewals Based on Catastrophe Risk Exposure
 - c. Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information
 - d. All Other Company Initiated Non-Renewals

Description and Rationale: Insurers may non-renew a policy for a variety of reasons, each of which tells a different story about the insurer and/or the market. Market analysis would be significantly improved by segregating out company-initiated non-renewals for some of these different reasons. These additions are particularly relevant given new types of catastrophe risk exposure evaluations – e.g. flooding – and the use of new algorithms based on non-insurance personal consumer information to assess customer lifetime value.

Definitions: The current definitions include:

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.

Include:

- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:

- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:

- The number of non-renewals should be reported on a policy basis regardless of the number of autos insured under the policy.

New Definitions

Company-Initiative Non-Renewals Based in Whole or In Part on Claims History during the Period means a non-renewal initiated by the company based entirely or in part on the policyholder’s claims history. For example, if the company-initiated non-renewal was based in part on claims history and in part on a change in credit score, report the non-renewal here.

Company-Initiative Non-Renewals Based in Whole or In Part on Catastrophe Risk Exposure during the Period means a non-renewal initiated by the company based entirely on an assessment of the policyholder’s catastrophe risk exposure.

Company-Initiative Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information during the Period means a non-renewal initiated by the company based entirely on an algorithm or rule used by the company and based on non-insurance personal consumer information. Examples of such algorithms include a credit-based insurance score, a consumer lifetime value score or a consumer propensity for fraud score.

All Other Company-Initiative Non-Renewals during the Period means non-renewal initiated by the company for any other reason than the other three company-initiated non-renewal data elements.