Draft date: 10/28/25

*Virtual Meeting*

**MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP**
Thursday, November 6, 2025
1:00 – 2:00 p.m. ET / 12:00 – 1:00 p.m. CT / 11:00 a.m. – 12:00 p.m. MT / 10:00 – 11:00 a.m. PT

**ROLL CALL**

| | | | |
|---|---|---|---|
| Joshua Guillory, Chair | Louisiana | Elouisa Macias/ | New Mexico |
| Tolanda McNeal, Vice Chair | Arizona | Margaret Pena | |
| Teri Ann Mecca/Lori Plant | Arkansas | Guy Self | Ohio |
| Sheryl Parker | Florida | Spencer Peacock | Oregon |
| Elizabeth Nunes/ | Georgia | Gary Jones/August Hall/ | Pennsylvania |
| Paula Shamburger | | Karen Veronikis | |
| Chris Heisler | Illinois | Gwendolyn Fuller-McGriff/ | South Carolina |
| Charles Thomas | Kansas | Rachel Moore | |
| Lori Cunningham | Kentucky | Larry D. Deiter | South Dakota |
| Raymond A. Guzman | Maryland | Rhonda Bowling-Black | Tennessee |
| Mary Lou Moran | Massachusetts | Shelley Wiseman | Utah |
| Danielle Torres | Michigan | Melissa Gerachis | Virginia |
| Jo A. LeDuc/Julie Hesser | Missouri | Sandy Ray | Washington |
| Martin Swanson | Nebraska | Letha Tate | West Virginia |
| Jonathan Wycoff | Nevada | Rebecca Rebholz | Wisconsin |

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

**AGENDA**

| | | |
|---|---|---|
| 1. | Consider Adoption of its Oct. 2 Minutes—*Joshua Guillory (LA)* | Attachment 1 |
| 2. | Discuss the "Required to File" Procedures for Market Conduct Annual Statement Filings<br>*— Joshua Guillory (LA)* | Attachment 2 |
| 3. | Continue the Review of the Long-Term Care (LTC) MCAS<br>*—Joshua Guillory (LA)* | Attachment 3<br>Attachment 4<br>Attachment 5 |
| 4. | Discuss Any Other Matters Brought Before the Working Group<br>*—Joshua Guillory (LA)* | |
| 5. | Adjournment | |

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Draft: 10/14/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
October 2, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 2, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda McNeal, Vice Chair (AZ); Lori Plant (AR); Rachael Lozano (FL); Elizabeth Nunes (GA); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Jo A. LeDuc (MO); Jonathan Wycoff (NV); Ryan McConnell (OH); Karen Veronikis (PA); Tara Nixon (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Shelley Wiseman (UT); Darcy Paskey (WI); and Letha Tate (WV). Also participating were: Sherry Manning and John Curry (NC).

1. Adopted its Sept. 11 Minutes

The Working Group met Sept. 11 and took the following action: 1) adopted its Aug. 7 minutes; 2) discussed the handling of expatriate policies on the health Market Conduct Annual Statement (MCAS); and 3) discussed the formation of a subject matter expert (SME) group to begin work on the long-term care (LTC) MCAS.

Wycoff made a motion, seconded by Guzman, to adopt the Working Group's Sept. 11 minutes (Attachment 1). The motion passed unanimously.

2. Adopted the Draft Clarification to Health MCAS Data Call and Definitions to Address the Handling of Expatriate Policies

Guillory explained that the proposed addition serves as a clarification rather than a substantive change. Therefore, if the Working Group approves it, the note can be incorporated without following the full revision timeline. The clarification would be added to the 2025 health MCAS data call and definitions, along with a note indicating that the Working Group reviewed and approved it.

Guillory then opened the floor for questions or comments from Working Group members or state regulators regarding the draft clarification.

Moran thanked the Working Group for its efforts in addressing this matter, noting that Massachusetts appreciated the work and was primarily focused on ensuring consistency across reporting. She expressed gratitude to everyone involved for clarifying the language.

Guillory thanked Moran for her comments and reiterated that the clarification was valuable in ensuring shared understanding among states. He added that it is always beneficial to make sure the intent is clear for both current and future reference.

Hearing no further discussion or comments from Working Group members or interested parties, Guillory moved to proceed with formal action.

LeDuc made a motion, seconded by Moran, to approve the draft clarification. The motion passed unanimously.

Guillory confirmed that the approved clarification will be added to the health MCAS data call and definitions.

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

Teresa Cooper (NAIC) explained the background of the required-to-file process. She said that when the NAIC started collecting MCAS data centrally, the team needed a consistent method to determine which companies were expected to file. At that time, MCAS included only four lines of business: private passenger auto (PPA), homeowners, individual life, and individual annuity.

Cooper stated that the NAIC identified premium references within the financial statements that could be used to determine whether a company met the threshold for filing. However, this approach presented challenges. For example, some companies reported homeowners premium under a different line of business or had PPA premium associated with other types of coverage not included in MCAS. These inconsistencies resulted in inaccurate required-to-file indicators, forcing companies to submit waiver requests each year that states then had to review. As MCAS expanded to additional lines of business, including several health-related lines, the process became increasingly complex. It became difficult to find consistent financial statement references that applied across all 13 lines of business, leading to programming and data accuracy challenges.

Cooper said that to improve consistency, the NAIC developed the MCAS premium exhibit, a supplement to the financial statement. The original intent was for this exhibit to include actual MCAS premium data. However, after discussions with industry, the reporting requirement was reduced to a "yes" or "no" response, indicating whether a company had MCAS-reportable premium in a given state and line of business. This change was proposed to and approved by the Financial Analysis Solvency Tools (E) Working Group and subsequently implemented.

Cooper stated that, in the current process, companies submit their financial statements and the MCAS premium exhibit by March 1. The exhibit responses determine whether a company is marked as required-to-file within the MCAS application. Regulators then use this information to identify expected filings.

Cooper acknowledged that this process still presents challenges. Some companies leave responses blank or incorrectly report their filing status due to internal miscommunication between financial and market data staff. As a result, some companies that should file are incorrectly excluded, while others may incorrectly appear as required. This creates gaps in the data and requires additional follow-up by state regulators. She added that there is no perfect solution for determining the required-to-file status. Both the original and current approaches have weaknesses that lead to inaccurate indicators. Cooper emphasized the importance of finding a process that best serves regulators while remaining manageable for companies.

Cooper also noted that the NAIC is in the process of modernizing its Financial Data Repository (FDR), which will affect MCAS data handling. Depending on the direction the Working Group decides to take, the implementation of any revised required-to-file procedures will need to be incorporated into that new system. Cooper concluded her remarks by offering to answer any questions.

Manning explained that North Carolina has concerns with the current required-to-file process. Under the existing system, if a company answers "no" to the MCAS premium exhibit question on page 101 of the financial statement, it is not placed in required-to-file status. Manning noted that this can lead to situations where companies either forget to make a selection or make an incorrect selection, unintentionally excluding themselves from the waiver determination process. She explained that this process creates additional work for states, which must query data after the filing period to identify missing filings and contact companies directly to ensure compliance. Additionally, companies that should have been allowed to request a waiver but left the exhibit question blank cannot access the MCAS filing portal to do so, since they are not flagged as required-to-file. As a result, North Carolina's analysts have had to manually track and reconcile filings outside the system, which is time-consuming and inefficient.

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Sherry emphasized that prior to this change, all waiver requests were handled within the portal, and the new process places an unnecessary burden on state analysts.

Guillory proposed allowing a two-week comment period for members to gather feedback and provide written input. He encouraged regulators to review the issue internally and send comments or concerns to Hal Marsh (NAIC), who would compile the responses.

4. Reviewed the LTC MCAS

A. Data Availability for Lines of Business

Guillory asked if companies have data to report for standalone LTC, life hybrid, and annuity hybrid.

Nunes asked about the ability to add explanations for "yes" and "no" responses. Cooper responded that comments are optional and can be used to explain warnings during submission.

B. Significant Events or Business Strategy Changes

LeDuc noted potential duplication of existing questions on significant events or business strategy changes.

Wycoff suggested adding a standalone question on significant rate increases.

C. Suggested Standalone Question: Significant Rate Increases

McNeal proposed including "substantial rate increases that resulted in benefit selection changes" as a standalone question. Guillory confirmed this could be considered as a separate question in future meetings. LeDuc recommended separating that question from the "data anomaly" question to avoid overlap.

Paskey suggested defining "significant rate change" if it is added as a standalone question.

McNeal referenced model language linking substantial rate increases to benefit disclosure.

Kirsten Wolfford (American Council of Life Insurers—ACLI) cautioned that narrative context questions could create a reporting burden and inconsistency.

D. Other Interrogatory Questions

Regarding the active writing of policies at year-end, Guzman supported adding the "yes" or "no" question. McNeal agreed that "yes" and "no" answers are preferable from an industry perspective. LeDuc said she preferred breaking down by each line of business for consistency.

Regarding the number of class action lawsuits, Jennette and McNeal supported moving the question to the lawsuit section for clarity and analysis. Guzman noted the potential duplication if the question is left in the interrogatories; he recommended bifurcation.

Regarding the use of managing general agents (MGAs)/third-party administrators (TPAs), LeDuc opposed requiring the list of names and stated support for only "yes" and "no" responses. Jennette and Guzman agreed, stating that detailed names are not typically needed for company selection.

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E. General Information Section (Questions 19–30)

Guillory reviewed the metrics on policies/contracts in force, new business, lapses, rescissions, replacements, and complaints.

Wolfford raised the issue of complaints received via social media. Cooper clarified that the guidance on complaints received via social media is that they count if the consumer reasonably expects a response.

Curry suggested capturing lapses initiated by consumers separately from natural lapses to monitor potential loss of consumer protections. Curry confirmed this would be considered in future discussions.

Guillory outlined the Working Group's next steps: 1) continue reviewing LTC MCAS sections in future meetings; and 2) defer decisions on additions/changes to votes at later meetings. He encouraged participants to submit additional feedback via email to Marsh for inclusion in the Working Group's next 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

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**Required to File (RTF) Options:** Below is a listing of options for deciding whether a company should be indicated as required to file each MCAS line of business. There may be other options not currently listed.

1. Show all filings applicable to an insurer's financial annual statement (FAS) type as RTF.

   Advantages:

   - No RTFs will be missed.
   - Each insurer would be responsible for determining whether it is required to file and to submit waiver requests if they did not meet the reporting premium threshold for a line of business within each participating jurisdiction.

   Disadvantages:

   - Some Lines of Business will be incorrectly indicated as RTF.
   - State regulators would need to decide whether to approve or deny each requested waiver request.

   MCAS Lines of Business RTF according to the FAS type that is submitted

| Line of Business | Life/ Fraternal | Property/ Casualty | Health |
|---|---|---|---|
| Annuity | X | | |
| Disability Income | X | X | X |
| Health | X | X | X |
| Homeowners | | X | |
| LPI Home & Auto | | X | |
| Life | X | | X |
| Long-Term Care | X | X | X |
| Other Health | X | X | X |
| Pet | | X | |
| Private Flood | | X | |
| Private Passenger Auto | | X | |
| Short-Term Limited Duration | X | X | X |
| Travel | | X | |

2. Use financial premium references from the FAS to determine insurers' RTF status.

   Advantages:
   - Original method of determining the RTF. It is familiar and intuitive.

   Disadvantages:
   - The premium threshold can be triggered due to premium reported on the FAS that is not applicable to MCAS.
     - Antique autos.
     - Lender placed home and auto included on the property state page lines.
   - The premium threshold may not be triggered due to FAS reporting:
     - MCAS applicable premium is reported in an unexpected place on the FAS.
     - Insurer does not report premium on the A&H Policy Experience Exhibit.
     - Premium is only reported on national basis, and not by state.

3. Continue using the MCAS Premium Exhibit reported with the FAS.

   Advantages:
   - This is the current process. No changes would need to be made.
   - Puts responsibility on the insurer who knows its business best.

   Disadvantages:
   - The same issues currently seen will continue.
   - Company employees responsible for FAS reporting may not communicate with those responsible for MCAS reporting.
   - No penalties associated with not filing the exhibit.

4. Continue to use the MCAS Premium Exhibit reported with the FAS but add a requirement to report the amount of MCAS reportable premium within the exhibit by jurisdiction and line of business.

   Advantages:
   - Forces the company to put more consideration into their response.
   - Provides a cross-check with the reported MCAS premium.

   Disadvantages:
   - Insurers may not accurately report on the exhibit.
   - More time-consuming for companies.

- Provides no additional benefit in determining RTF.

5. Require states to identify company/jurisdiction/line of business level required to file data based on their review of available information.

   Advantages:
   - Could provide greater assurance of accurate RTF indicators.

   Disadvantages:
   - Substantial investment of state resources and time would be needed.
   - States would have varied levels of resources available which would lead to varied levels of RTF accuracy.

6. States consistently fine insurers that fail to submit required MCAS filings.

   Advantages:
   - Insurers feel greater need to report MCAS data.
   - Encourages greater accuracy

   Disadvantages:
   - Substantial investment of state resources and time would be needed.

7. After choosing a method of populating the RTF indicators, assign responsibilities to state regulators and/or NAIC staff to review/analyze available information to identify companies that should possibly be reporting, but are not identified as RTF.

   Advantages:
   - Could provide greater assurance of accurate RTF indicators.

   Disadvantages:
   - Substantial state and/or NAIC staff resources would be needed to develop the process and also to implement it.

Notes:

- If the Working Group approves a change to the process for determining required to file indicators, an implementation period will be required. It may not be possible to implement the changes for the collection of 2025 MCAS data.

- The NAIC is beginning work to update the way data is collected for the financial annual statement and MCAS. This will not impact reporting of required to file information for states, but may impact the way companies are able to view their required to file indicators. Implementation of the new collection process is currently planned to complete for collection of 2028 data in 2029.

MCAS Market Conduct Annual Statement

# Long-Term Care (2025)

## Long-Term Care Interrogatories

| | | Yes/No Response | Explanation |
|---|---|---|---|
| 01 | Does the company have data to report for Stand-Alone Long-Term Care? | | -- |
| 02 | Does the company have data to report for Life Long-Term Care Hybrid? | | -- |
| 03 | Does the company have data to report for Annuity Long-Term Care Hybrid? | | -- |
| 04 | Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? | | -- |
| 05 | If yes, add additional comments. | -- | |
| 06 | Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? | | -- |
| 07 | If yes, add additional comments. | -- | |
| 08 | Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? | | -- |
| 09 | If yes, add additional comments. | -- | |
| 10 | Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? | | -- |
| 11 | If yes, add additional comments. | -- | |
| 12 | Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? | | -- |
| 13 | If yes, add additional comments. | -- | |
| 14 | Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? | | -- |
| 15 | If yes, add additional comments. | -- | |
| 16 | Additional state specific Stand-Alone Long-Term Care comments (optional). | -- | |
| 17 | Additional state specific Life Long-Term Care Hybrid comments (optional). | -- | |
| 18 | Additional state specific Annuity Long-Term Care Hybrid comments (optional). | -- | |

## Long-Term Care General Information

| | | Stand-Alone LTC | Life LTC Hybrid | Annuity LTC Hybrid |
|---|---|---|---|---|
| 19 | Number of policies/contracts in-force as of the beginning of the reporting period. | | | |
| 20 | Number of new business policies/contracts issued during the period. | | | |
| 21 | Number of free look cancellations during the period. | | | |
| 22 | Number of lapses during the period. | | | |
| 23 | Number of rescissions during the period. | | | |
| 24 | Number of policies/contracts in-force as of the end of the reporting period. | | | |
| 25 | Number of internal replacements during the period. | | | |
| 26 | Number of external replacements during the period. | -- | | |
| 27 | Number of policies/contracts replaced where age of insured at replacement was < 65. | -- | | |
| 28 | Number of policies/contracts replaced where age of insured at replacement was between 65 and 80. | -- | | |
| 29 | Number of policies/contracts replaced where age of insured at replacement was > 80. | | | |
| 30 | Number of complaints received directly from consumers. | | | |

## Long-Term Care Claimants and Claimant Requests Activity

| | | Stand-Alone LTC | Life LTC Hybrid | Annuity LTC Hybrid |
|---|---|---|---|---|
| 31 | Number of claimants approved for benefits as of the beginning of the period. | | | |
| 32 | Number of claimants with pending claimant request determinations as of the beginning of the period. | | | |
| 33 | Number of new claimants during the period. | | | |
| 34 | Number of claimants with pending claimant request determinations as of the end of the period. | | | |
| 35 | Number of claimants approved for benefits as of the end of the period. | | | |
| 36 | Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death). | | | |
| 37 | Number of claimant requests denied or not paid because of preexisting condition exclusion. | | | |
| 38 | Number of claimant requests denied or not paid because of elimination or waiting period not met. | | | |

# Long-Term Care (2025)

## Long-Term Care Claimants and Claimant Requests Activity Continued

| | | Stand-Alone LTC | Life LTC Hybrid | Annuity LTC Hybrid |
|---|---|---|---|---|
| 39 | Number of claimant requests denied or not paid because services provided not covered under the policy. | | | |
| 40 | Number of claimant requests denied or not paid because provider or facility not qualified under the policy. | | | |
| 41 | Number of claimant requests denied or not paid because benefits eligibility criteria not met. | | | |
| 42 | All other claimant requests denied or closed without payment. | | | |
| 43 | Number of claim request determinations made within 0-30 days. | | | |
| 44 | Number of claim request determinations made within 31-60 days. | | | |
| 45 | Number of claim request determinations made within 61-90 days. | | | |
| 46 | Number of claim request determinations made beyond 90 days. | | | |

## Long-Term Care Benefit Payment Requests Activity

| | | Stand-Alone LTC | Life LTC Hybrid | Annuity LTC Hybrid |
|---|---|---|---|---|
| 47 | Number of benefit payment requests pending as of the beginning of the period. | | | |
| 48 | Number of benefit payment requests received during the period. | | | |
| 49 | Number of benefit payment requests denied or not paid during the period. | | | |
| 50 | Number of benefit payment requests pending as of the end of the period. | | | |
| 51 | Number of benefit payment requests paid within 0-30 days. | | | |
| 52 | Number of benefit payment requests paid within 31-60 days. | | | |
| 53 | Number of benefit payment requests paid within 61-90 days. | | | |
| 54 | Number of benefit payment requests paid beyond 90 days. | | | |
| 55 | Number of benefit payment requests denied or not paid within 0-30 days. | | | |
| 56 | Number of benefit payment requests denied or not paid within 31-60 days. | | | |
| 57 | Number of benefit payment requests denied or not paid within 61-90 days. | | | |
| 58 | Number of benefit payment requests denied or not paid beyond 90 days. | | | |

## Long-Term Care Lawsuit Activity

| | | Stand-Alone LTC | Life LTC Hybrid | Annuity LTC Hybrid |
|---|---|---|---|---|
| 59 | Number of lawsuits open as of the beginning of the period. | | | |
| 60 | Number of lawsuits opened during the period. | | | |
| 61 | Number of lawsuits closed during the period - total. | | | |
| 62 | Number of lawsuits closed during the reporting period with consideration for the consumer. | | | |
| 63 | Number of lawsuits open as of the end of the period. | | | |

## Long-Term Care Attestation

| | | First Name | Middle Name | Last Name | Suffix | Title | Comments |
|---|---|---|---|---|---|---|---|
| 64 | First Attestor Information. | | | | | | -- |
| 65 | Second Attestor Information. | | | | | | -- |
| 66 | Overall comments for the filing period. | -- | -- | -- | -- | -- | |

MCAS Market Conduct Annual Statement

# Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

**Line of Business:** Individual Stand-Alone Long-Term Care
Individual Long-Term Care Hybrid Products
Life-LTC Hybrid Products
Annuity-LTC Hybrid Products

**Reporting Period:** January 1, 2025 through December 31, 2025
**Filing Deadline:** April 30, 2026

## 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. |

## Long-Term Care Product Types

| Product Identifier | Explanation of Product Identifiers |
|---|---|
| SALTC | Stand-Alone – Long-Term Care Products |
| LifeLTC | Life – Long-Term Care Hybrid Products |
| AnnLTC | Annuity – Long-Term Care Hybrid Products |

## Schedule 1 - Interrogatories

| ID | Description | Response |
|---|---|---|
| 1-1 | Does the company have data to report for Stand-Alone Long-Term Care? | Yes/No |
| 1-2 | Does the company have data to report for Life Long-Term Care Hybrid? | Yes/No |
| 1-3 | Does the company have data to report for Annuity Long-Term Care Hybrid? | Yes/No |
| 1-4 | Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period? | Yes/No |
| 1-5 | If yes, add additional comments. | Comment |
| 1-6 | Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? | Yes/No |
| 1-7 | If yes, add additional comments. | Comment |

| | | |
|---|---|---|
| 1-8 | Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period? | Yes/No |
| 1-9 | If yes, add additional comments. | Comment |
| 1-10 | Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? | Yes/No |
| 1-11 | If yes, add additional comments. | Comment |
| 1-12 | Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? | Yes/No |
| 1-13 | If yes, add additional comments. | Comment |
| 1-14 | Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period? | Yes/No |
| 1-15 | If yes, add additional comments. | Comment |
| 1-16 | Additional state specific Stand-Alone Long-Term Care comments (optional). | Comment |
| 1-17 | Additional state specific Life Long-Term Care Hybrid comments (optional). | Comment |
| 1-18 | Additional state specific Annuity Long-Term Care Hybrid comments (optional). | Comment |

## Schedule 2 - General Information

| ID | Description |
|---|---|
| 2-19 | Number of policies/contracts in-force as of the beginning of the reporting period. |
| 2-20 | Number of new business policies/contracts issued during the period. |
| 2-21 | Number of free look cancellations during the period. |
| 2-22 | Number of lapses during the period. |
| 2-23 | Number of rescissions during the period. |
| 2-24 | Number of policies/contracts in-force as of the end of the reporting period. |
| 2-25 | Number of internal replacements during the period. |
| 2-26 | Number of external replacements during the period. |
| 2-27 | Number of policies/contracts replaced where age of insured at replacement was < 65. |
| 2-28 | Number of policies/contracts replaced where age of insured at replacement was between 65 and 80. |
| 2-29 | Number of policies/contracts replaced where age of insured at replacement was > 80. |
| 2-30 | Number of complaints received directly from consumers. |

# Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

## Schedule 3 - Claimants

| ID | Description |
|---|---|
| 3-31 | Number of claimants approved for benefits as of the beginning of the period. |
| 3-32 | Number of claimants with pending claimant request determinations as of the beginning of the period. |
| 3-33 | Number of new claimants during the period. |
| 3-34 | Number of claimants with pending claimant request determinations as of the end of the period. |
| 3-35 | Number of claimants approved for benefits as of the end of the period. |

## Schedule 4 - Claimant Requests Denied/Not Paid

| ID | Description |
|---|---|
| 4-36 | Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death). |
| 4-37 | Number of claimant requests denied or not paid because of preexisting condition exclusion. |
| 4-38 | Number of claimant requests denied or not paid because of elimination or waiting period not met. |
| 4-39 | Number of claimant requests denied or not paid because services provided not covered under the policy. |
| 4-40 | Number of claimant requests denied or not paid because provider or facility not qualified under the policy. |
| 4-41 | Number of claimant requests denied or not paid because benefits eligibility criteria not met. |
| 4-42 | All other claimant requests denied or closed without payment. |

## Schedule 5 - Claimant Request Determinations Timeliness

| ID | Description |
|---|---|
| 5-43 | Number of claim request determinations made within 0-30 days. |
| 5-44 | Number of claim request determinations made within 31-60 days. |
| 5-45 | Number of claim request determinations made within 61-90 days. |
| 5-46 | Number of claim request determinations made beyond 90 days. |

## Schedule 6 - Benefit Payment Requests

| ID | Description |
|---|---|
| 6-47 | Number of benefit payment requests pending as of the beginning of the period. |
| 6-48 | Number of benefit payment requests received during the period. |
| 6-49 | Number of benefit payment requests denied or not paid during the period. |
| 6-50 | Number of benefit payment requests pending as of the end of the period. |

# Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

## Schedule 7 - Benefit Payment Request Timeliness

| ID | Description |
|---|---|
| 7-51 | Number of benefit payment requests paid within 0-30 days. |
| 7-52 | Number of benefit payment requests paid within 31-60 days. |
| 7-53 | Number of benefit payment requests paid within 61-90 days. |
| 7-54 | Number of benefit payment requests paid beyond 90 days. |
| 7-55 | Number of benefit payment requests denied or not paid within 0-30 days. |
| 7-56 | Number of benefit payment requests denied or not paid within 31-60 days |
| 7-57 | Number of benefit payment requests denied or not paid within 61-90 days. |
| 7-58 | Number of benefit payment requests denied or not paid beyond 90 days. |

## Schedule 8 - Lawsuit Activity

| ID | Description |
|---|---|
| 8-59 | Number of lawsuits open as of the beginning of the period. |
| 8-60 | Number of lawsuits opened during the period. |
| 8-61 | Number of lawsuits closed during the period - total. |
| 8-62 | Number of lawsuits closed during the reporting period with consideration for the consumer. |
| 8-63 | Number of lawsuits open as of the end of the period. |

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

## Schedule 9 - Long-Term Care 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.

# Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

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.

| ID | Description |
|---|---|
| 9-64 | First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title). |
| 9-65 | Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title). |
| 9-66 | Overall comments for the filing period. |

## General Instructions – All LTC Products:

For the purpose of the MCAS Long-term care insurance reporting blank:

1. "Long-term care insurance" means that as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), with the exception that long-term care insurance riders attached to a life insurance policy or an annuity contract, and group insurance plans are not included.
2. Schedules 3, 4 and 5 refer to claimants and claimant requests. A claimant request is the initial request for LTC benefits under the policy or contract. It is the determination by the insurer that the claimant is entitled to benefits under the policy or contract.
3. Reporting for schedules 3 through 5 is to be done on a "per claimant" basis (counts each individual who makes one or a series of requests or demands for payment of benefits under a policy) [Model #641, Appendix E]
4. Schedules 6 and 7 refer to individual benefit payment requests following the initial determination by the insurer that the claimant is entitled to benefits under the policy or contract. The purpose of the schedules is to differentiate between initial coverage request activities (Schedules 3, 4 and 5) and benefit payment request activities (Schedules 6 and 7) once the insurer has affirmed the initial coverage requests.
5. Reporting for schedules 6 and 7 is to be done on a "per transaction" basis (counts each benefit payment request pending and benefit payment made). [Model #641, Appendix E]

# Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

## General Instructions – Life and Annuity Hybrid LTC

1. For purposes of the LTC Hybrid Product MCAS, "LTC Hybrid Product" means those products providing Long-Term Care insurance as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), as part of a Life-LTC hybrid insurance policy or Annuity-LTC hybrid contract. Such LTC hybrid benefits may be built into the life policy or annuity contract, or may be attached to such policy or contract by a rider. Report experience for Life-LTC hybrid products separately from Annuity-LTC hybrid products in the schedules provided. Report experience on individual LTC hybrid policies and contracts only. Do not report experience on group policies and contracts.
2. For Schedule 2, report experience for all policies or contracts with LTC hybrid benefits. For all data elements in Schedule 2, report the number of policies or contracts with Life-LTC hybrid or Annuity-LTC hybrid benefits and which meet the definition of the specific data element. For example, for data element 2-19 in the Life-LTC hybrid schedules, report the number of life insurance policies with LTC benefits in force at the beginning of the reporting period. For data element 2-19 in the Annuity-LTC hybrid schedules, report the number of annuity contracts with LTC benefits in force at the beginning of the reporting period. For data element 2-20, report the number of new business policies or contracts with LTC hybrid benefits.
3. For Schedules 3 through 7, report the experience for those policies or contracts with LTC hybrid benefits and report experience only for the LTC benefit portion of the policy or contract. For example, report experience for claimants, claimant requests denied/not paid, claimant request determination timeliness, benefit payment requests, and benefit payment request timeliness only for the LTC benefit portion of the LTC hybrid product.
4. For Schedule 8, report experience for those policies or contracts with some form of LTC benefit. Report lawsuit experience for all lawsuits related to the LTC product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.

## Definitions:

**Benefit Payment Request**—A request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. (See Claimant Request and Claimant Request Determination, below.) Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment request. The data elements in Schedule 4 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes payment for an approved claimant (after satisfaction of the waiting or elimination period, if any).

**Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions**

**Claimant** - An insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests.

**Claimant Request** - A request or demand for payment made by an insured, or a representative of the insured, for a loss that may be included within the terms of coverage of the LTC stand-alone or LTC hybrid policy or contract. It does not include events that were reported by the insured for "information only" or an inquiry of coverage when a claim has not actually been presented (opened) for payment. If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.

**Claimant Request Determination** - A determination as to whether an insured has met a contractual provision of an LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity. For purposes of this blank, the term applies to the initial claimant request, and captures the period of time from notice of claim to the benefit trigger/claimant request determination date. For claimant requests that are denied/not paid, report the period of time from the date of notice of claim to the date the claimant was notified of the determination to deny or not pay the claim.

**Claimant Request Denied or Not Paid because Benefit Eligibility Criteria Not Met** - A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract, that a benefit trigger has not been met, or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided.

**Claimant Request Denied or Not Paid Because Claimant Did Not Pursue** - A claimant or policyholder made a request or demand for payment for the purpose of receiving a benefit trigger/claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again (inactivity could be the result of death.)

**Claimant Request Denied or Not Paid Because Elimination or Waiting Period Not Met** - A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract that the elimination/waiting period had not yet elapsed.

**Claimant Request Denied or Not Paid Because Services Provided Not Covered** - Expenses incurred for services and support which are not eligible for reimbursement under the LTC benefit of a policy or contract, such as an expense incurred for home

health care when the policy or contract only provides benefits for nursing home confinements.

**Claimant Request Denied or Not Paid Because of Preexisting Condition Exclusion** - A denial of coverage because benefits for the medical advice or treatment recommended by, or received from a provider of health care services are subject to a restriction as a pre-existing condition for a period of time following the effective date of coverage of an insured person.

**Claimant Request Denied or Not Paid Because Provider or Facility Not Qualified** - A long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract.
**Complaint**—Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

**Denied or Not Paid** - A request or demand for payment that is not paid for any reason.

- Under Schedule 4, if a denial could be reported under more than one of the categories, report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant's request was denied, the denial should not be counted more than once.
- Under Schedule 5, exclude denials for failure to meet the waiting or elimination period or because of an applicable preexisting condition.

The term does not include a request or demand for payment that is in excess of the applicable contractual limits.

**Elimination Period** - A period of time, as specified in the policy or contract, during which the insured incurs qualified long-term care services and support for which benefits are not payable until the end of such period.

**Free Look** - A set number of days provided in an insurance policy or contract that allows time for the owner/purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.

**Lapse** - The termination of the entire policy or contract or the termination of the LTC benefit of the policy or contract due to nonpayment of premium.

**Lawsuit** - An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.
For purposes of reporting lawsuits for LTC hybrid products:

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

**Lawsuits Closed During the Period with Consideration for the Consumer** - A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.
**New Business Policy or Contract**—A newly written agreement that puts insurance coverage into effect under a policy or contract during the reporting period

**Pending Claim** - A claim that has not yet been paid or denied.

**Replacement** - Replacement of any life policy, annuity contract or LTC policy already in force with a new policy or contract with LTC insurance coverage.

- External Replacement—If the policy or contract to be replaced was issued by another insurer.
- Internal Replacement—If the policy or contract to be replaced was issued by your company.

For Data Elements 2-25 (Number of Internal Replacements) and 2-26 (Number of External Replacements), report the number of policies included in data element 2-20 (Number of new business policies) which are replacements of any type of life, annuity or long-term care policies.

**Rescission** - Invalidation of a policy or contract or invalidation of the LTC coverage portion of a policy or contract by an insurer, in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640).

**Waiting Period** - See definition of Elimination Period.

The data elements listed below are considerations for the Long-Term Care (LTC) MCAS Blank and Data Call and Definitions, based on data elements currently being captured on other lines of business

## Interrogatories

- Is there a reason that the reported LTC (Stand Alone, Life Hybrid, Annuity Hybrid) information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; significant rate changes; shifting market strategies; underwriting changes, etc)?
    - If yes, provide explanation:
        - Is this question duplicating the information asked for in Q's 4 – 15?
            - This question gives an open form to provide any additional information not addressed in 4-15
    - Provide examples of how this question is worded in other LOBs to provide understanding of how it's being used

- Have you had any significant rate changes (Stand alone question)
- Was the company still actively writing policies in the state at year end?
    - Can this question be written so that it breaks down according to Stand Alone, Life Hybrid, Annuity Hybrid?
- Number of class action lawsuits?
    - ACLI – How would this data element be relevant to the MCAS? What are the origins of this question?
    - Should this be in Interrogatories or a different section
        - If an Interrogatories, will either get text or a Yes/No response
        - If we elect to add, should consider moving to a different section to allow for a number response
        - Move to Lawsuit
        - Definition of Lawsuit in LTC DCD – would the definition need to be reworded so that this question is not duplicative
            - Separate class action lawsuits out
    - Determine which LOB has this question listed as an Interrogatory?
        - Does this question need to be moved in all other LOBs?
            - Reported in Interrogatories in DI? Should it be moved?
- Does the company use Managing General Agents (MGAs)?
    - If yes, list the names of the MGAs
        - MO – Having companies provide names is not useful information. States can go directly to the company if there is an issue. Asking for names creates too much information.

        - Use the Yes or No question, but avoid asking for the list of names.
- Does the company use Third Party Administrators (TPAs)?
    - If yes, list the names of the TPAs.

Add definition of significant rate change (model law references substantial rate increase)

## General Information

ACLI – Current definition of complaints. How should a company handle complaints that are received through social media? (Q30)

There is an FAQ related to this issue.

### Q22 -

*Related to data captured for applications*:

- Direct written premium during the period.
- Direct written premium earned during the period.
- Number of applications pending at the beginning of the period.
- Number of applications pending at the end of the period.
- Number of applications received.
- Number of applications denied during the period (some lines of business capture reasons for the denied applications).

If the above data elements are included, data element #20 – "Number of new business policies/contracts issued during the period." should be considered and possibly adjusted to "Number of applications approved during the period."

*Related to data captured for cancellations*:

- In place of data element #22 – "Number of lapses during the period."
    - Consider:
        - Number of policies terminated or cancelled due to non-payment.
        - Number of policies terminated or cancelled by the insurer for reasons other than non-payment or free looks.
        - Number of policies terminated or cancelled at the request of the insured.

*Related to data captured for complaints*:

- Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews).
- Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews).

- Number of customer requested appeals on final adverse determinations to an external review organization.
- Number of final adverse determinations overturned upon request for external review.
- Number of final adverse determinations upheld upon request for external review.