Draft: 4/16/21

Market Regulation and Consumer Affairs (D) Committee
Virtual 2021 Spring National Meeting
April 13, 2021

The Market Regulation and Consumer Affairs (D) Committee met April 13, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain (AR); Evan G. Daniels represented by Maria Ailor (AZ); Trinidad Navarro (DE); John F. King (GA); Dana Popish Severinghaus (IL); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing (MT); Jon Godfread (ND); Chris Nicolopoulos represented by Edwin Pugsley (NH); Carter Lawrence represented by David Combs (TN); Jonathan T. Pike (UT); and Michael S. Pieciak represented by Kevin Gaffney (VT). Also participating were: Russell Toal (NM); Jessica K. Altman (PA); Larry D. Deiter (SD); John Haworth (WA); and Rebecca Rebholz (WI).

1. Adopted its 2020 Fall National Meeting Minutes

Commissioner Clark made a motion, seconded by Commissioner Godfread, to adopt the Committee's Dec. 8, 2020, minutes (*see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Heard a Presentation on the Activity of Lead Generators in Health Insurance

Commissioner Navarro said for the past several months, state insurance regulators and officials from federal agencies have met to discuss improper marketing of health plans by various entities. He said prior to this ad hoc group, state insurance regulators in the health, market conduct and fraud areas were investigating these concerns, but not communicating with each other. He said after talking with the NAIC and other state insurance regulators, the states formed an ad hoc group designed to do two things. First, the ad hoc group was created to bring members of the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee together to share information regarding entities that were improperly marketing health insurance products, including the use of lead generators, unsolicited phone calls, internet solicitations, and other marketing methods occurring in each state. Commissioner Navarro said these discussions have identified common practices, themes and actors. He said the group invited members of the federal government to participate, including the Center for Consumer Information and Insurance Oversight (CCIIO), the U.S. Department of Labor (DOL), and the Federal Trade Commission (FTC). He said as a result of those discussions, schemes have been identified and administrative actions taken. Second, he said the ad hoc group identified a need to look at and perhaps update or create new model laws to address the aggressive and improper marketing of health plans and the oversight of lead generators. He said the ad hoc group agreed that lead generators, whether by mailers, phone calls or internet solicitations, were part of the insurance sales process, but some states were concerned whether they had jurisdiction over these entities. However, he said all states agreed that there needs to be some oversight. He said the NAIC white paper, *The Marketing of Insurance Over the Internet*, needs to be updated to reflect the changes in how the internet is used today and how some entities use the internet to market plans in ways not contemplated only a few years ago.

Commissioner Navarro said the Antifraud (D) Task Force will be considering a proposal to formalize the ad hoc group into a working group under the Task Force. He said the working group would address two goals. First, it would facilitate continued discussions of state and federal insurance regulators about the improper marketing of health plans. Commissioner Navarro said participation of interested state insurance regulators would encompass state insurance regulators from all areas of expertise, including, but not limited to, health, market conduct, antifraud and legal. He said the working group would meet in regulator-only sessions to continue these ongoing discussions and potential prosecutions. Second, he said the working group would be charged with either modifying existing model laws or creating a model law: to 1) address the usage of lead generators in the sale of insurance products; and 2) update marketing rules to modernize the regulation of those activities.

Superintendent Toal commended the work of Commissioner Navarro and his staff. Superintendent Toal noted that this is a critical problem. There are many misleading and unapproved products being marketed. Additionally, contacting a lead generator can generate hundreds of calls to an individual consumer. Superintendent Toal said he would support the efforts in any way he can. Commissioner Altman said this is a very troubling issue. She noted that after the passage of the federal American Rescue Plan Act of 2021 (ARPA), she received calls soliciting Bidencare products. She said the biggest challenge is with unregulated entities. She said the state insurance regulators need to hold regulated entities responsible for the actions of unregulated entities that market their plans improperly. She said she is unsure if state laws allow that. Katie Keith (Out2Enroll)

and Harold M. Ting (Healthcare Consumer Advocate) noted that the consumer representatives support the work and are willing to assist.

3. Adopted its Task Force and Working Group Reports

Commissioner Richardson said Damion Hughes (CO) will be the new chair of the Market Conduct Examination Guidelines (D) Working Group. She said the Working Group summary report is in the materials. She also noted that the Market Actions (D) Working Group and the Advisory Organization Examination Oversight (D) Working Group met in regulator-only session due to the nature of their discussions focusing on specific company practices. She said there are no written or verbal reports for these working groups.

a. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met March 24 and adopted its Nov. 16, 2020, minutes.

Commissioner Navarro said the Task Force received an update from the Antifraud Education Enhancement (D) Working Group. He said the Working Group hosted a webinar on Feb. 11 by CARCO regarding the mobile capabilities it can provide to state departments of insurance (DOIs) to assist in fighting insurance fraud. He said the Working Group will host the NAIC Investigator Safety training on June 2.

Commissioner Navarro said the Task Force received an update from the Antifraud Technology (D) Working Group. He said by finalizing the revisions to the *Antifraud Plan Guideline* (#1690), the Working Group completed the first step in its charge to "review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions." He said the Working Group will begin drafting a template for industry to use when creating their antifraud plan.

Commissioner Navarro said the Task Force discussed its 2021 charges and its continued monitoring of insurance fraud related to the COVID-19 pandemic. He said the Task Force will continue to monitor potential trends generated by the pandemic and hold meetings, as necessary, to bring general awareness at the state, industry and consumer levels.

Commissioner Navarro said the Task Force received an update on the NAIC Online Fraud Reporting System (OFRS) redesign. He said beta testing is scheduled to begin in April.

Commissioner Navarro said the Task Force received reports on matters of national interest to insurance fraud bureaus from the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

b. Market Information Systems (D) Task Force

Commissioner Kreidler said the Market Information Systems (D) Task Force met March 22 and reviewed its 2021 charges. He said the charge to "develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis" was delegated to the Market Information System Research and Development (D) Working Group. This was done because the Working Group has members with expertise in this field, and it meets more frequently than the Task Force. Commissioner Kreidler noted that the Task Force remains responsible for the final product.

Commissioner Kreidler said the Task Force adopted the report of the Market Information System Research and Development (D) Working Group. He said the Working Group reported that it adopted a proposal for coding changes to the Regulatory Information Retrieval Systems (RIRS). He said the proposal will be posted to the Task Force web page and will be considered for adoption by the Task Force during the Summer National Meeting. He said the Working Group also adopted a change to the Uniform System Enhancement Request (USER) form process, which aligns the process to the agile approach used by the NAIC.

Commissioner Kreidler said the Task Force also adopted the Market Information Systems (MIS) Data Analysis Metrics and Recommendations.

Commissioner Kreidler said the Task Force reviewed outstanding USER forms.

c. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force met on Mar. 26.

Director Deiter said during the meeting, the Task Force discussed state implementation of online examinations. He said 32 states have implemented online examinations, and three states are scheduled to implement online examinations by the end of April. Only three states decided not to implement remote online examinations. He said the Producer Licensing Uniformity (D) Working Group will be reviewing the examination standards in the NAIC *State Licensing Handbook* to ensure it is consistent with the state practices for implementing remote examinations.

Director Deiter said the Task Force heard a briefing on the National Association of Registered Agents and Brokers Reform Act of 2015 (NARAB Reform Act), which is a federal law that preempts state nonresident producer licensing laws and will establish nonresident producer licensing qualifications on a multi-state basis. He said the briefing addressed the impact on state producer licensing and included an overview of the NARAB Reform Act's structure and governance and the responsibilities of the NARAB board. He said with the change in administration at the federal level, both the NAIC and the National Insurance Producer Registry (NIPR) leadership are monitoring federal activity that would lead to the appointment of the 13 member NARAB board and formation of NARAB.

Director Deiter said the Task Force received a report from the Producer Licensing Uniformity (D) Working Group. He said the Working Group continues to focus on licensing standards for pet insurance. He said the Task Force also received a report from the Uniform Education (D) Working Group. He said the Working Group continues to focus on state implementation of the 2019 Continuing Education Reciprocity (CER) Agreement, which 44 jurisdictions have signed.

Director Deiter said the Task Force received a report from the NIPR Board of Directors. He said the NIPR Board of Directors approved its 2021–2023 Strategic Plan. He said the plan has the following three pillars: 1) engaged and empowered teams; 2) customer-focused excellence; and 3) high-quality and reliable technology. He noted that NIPR also reported the release of a major upgrade to its Attachment Warehouse application. Finally, NIPR reported $47.9 million in revenue in 2020, a 5.7% increase from 2019.

Director Deiter said the Task Force discussed procedures for amending NAIC Uniform Producer Licensing Applications, and it will have a revised draft to address the comments submitted by state insurance regulators and interested parties.

Director Deiter said the Task Force received comments from the American Council of Life Insurers (ACLI) on how the NAIC's initiatives on race and insurance relate to insurance producers and the desire to increase the number of minority producers. He said while not discussed by the Task Force, which met before the most recent meeting of the Special (EX) Committee on Race and Insurance, there have been three issues delegated to the Task Force from the Committee. He said the issues are: 1) the availability of producer licensing exams in foreign languages; 2) the steps exam vendors have taken to mitigate cultural bias; and 3) the number and location of producers by company compared to demographics in the same area.

d. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met Jan. 27, Feb. 25 and March 19.

Mr. Haworth said during these meetings, the Working Group adopted revisions to the *Market Conduct Annual Statement (MCAS) Best Practices Guide* (Best Practices Guide) (Attachment One). He said the Best Practices Guide had not been updated since its original adoption in 2014. He noted that among the revisions included identifying additional best practices, highlighting them in an appendix, and recommending a 14-day extension limitation. He said the Best Practices Guide is available on the Working Group's web page.

Mr. Haworth said the Working Group also adopted revisions to the market analysis chapters of the NAIC *Market Regulation Handbook* (Handbook) (Attachment Two). He said considering the changing technology available to market analysts, the Working Group revised four chapters in the Handbook. He said the revisions will be forwarded to the Market Conduct Examination Guidelines (D) Working Group.

Mr. Haworth said the Working Group also adopted two changes affecting MCAS filings. First, the Working Group adopted a proposal to require companies to complete their attestations by line of business and by state. Second, the Working Group adopted a 14-calendar day limitation on extension requests from companies. He said companies will still be able to request additional extensions, if necessary, but for no longer than 14 days at a stretch.

Mr. Haworth said the Working Group continues its discussions on providing technical market analysis training to state insurance regulators, and it is receiving comments on what training is needed by jurisdictions.

e. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met March 23.

Ms. Rebholz said the Working Group has four different subject matter expert (SME) groups currently working to finalize drafts for consideration by the Working Group. She said the SME groups are working on: 1) a new Other Health MCAS blank and data call and definitions; 2) a new Travel MCAS blank and data call and definitions; 3) new accelerated underwriting data elements and definitions for the Life MCAS blank; and 4) new digital claims data elements and definitions for the Private Passenger Auto and Homeowners MCAS blanks. She said the hope is to have these drafts exposed and considered by the Working Group prior to the June 1 deadline for updates to the MCAS for the 2022 data year.

Ms. Rebholz said the Working Group is discussing the placement of complaint and 1awsuit data elements within the Homeowners and Private Passenger Auto MCAS blanks and reviewing the MCAS lawsuit definitions.

f. Privacy Protections (D) Working Group

Lois E. Alexander (NAIC) said the Privacy Protections (D) Working Group met March 29 and adopted its 2020 Fall National Meeting minutes, which included a discussion of the initial draft gap analysis of consumer issues.

Ms. Alexander said the Working Group received NAIC status reports on federal and state privacy legislation. She said the federal report indicated that the U.S. Congress (Congress) believes there is a need for federal data privacy legislation, but differences in approaches have thwarted efforts to enact comprehensive legislation. She said the points of contention include: 1) whether and to what extent federal legislation should preempt state laws; and 2) whether the legislation should include a private right of action. She said the NAIC continues to engage with Congress, oppose preemptive legislative proposals, and inform Congress of the Working Group's efforts to update NAIC model laws. She said the NAIC continues to underscore the importance of not disregarding the existing state regulatory framework or inhibiting ongoing efforts in the states to develop laws and regulations in the best interest of consumers.

Ms. Alexander said the state report indicated that at least 30 states introduced data privacy legislation in 2020. She said many of them were comprehensive and similar to the California Consumer Privacy Act (CCPA). However, very few of them were enacted because the COVID-19 pandemic disrupted legislative sessions. Ms. Alexander said in 2021, bills have been introduced in 23 states that focus on business obligations stemming from consumer rights, but the bills vary in substance. She said many of the bills apply to for-profit businesses that: 1) have global annual gross revenues in excess of $23 million; 2) annually buy, sell or share the personal information of 50,000 or more consumers for commercial purposes; or 3) derive 50% or more of its global revenues from selling or sharing personal information. She said common issues have emerged, such as: 1) a requirement that covered entities perform a risk assessment; 2) providing for a private right of action; 3) addressing data security and privacy; 4) a resemblance to the General Data Protection Regulation (GDPR); and 5) exempting data collected in compliance with the Gramm-Leach-Bliley Act (GLBA), as well as entities subject to the GLBA. Other exemptions would only exclude the data collected in compliance with the GLBA, while still regulating the entity.

Ms. Alexander said the Working Group reviewed additional guidance through the Market Regulation and Consumer Affairs (D) Committee in the form of the NAIC member-adopted strategy for consumer data privacy protections. She said the strategy charges the Committee with: 1) summarizing consumer data privacy protections found in the *Health Information Privacy Model Act* (#55), the *NAIC Insurance Information and Privacy Protection Model Act* (#670), and the *Privacy of Consumer Financial and Health Information Regulation* (#672); and 2) identifying notice requirements of states, the European Union's (EU's) GDPR, and the CCPA and how insurers may be subject to these requirements. She said the Working Group has completed both charges.

Ms. Alexander said the strategy also charges the Committee with: 1) identifying corresponding consumer rights that attach to notice requirements, such as the right to opt out of data sharing, the right to correct or delete information, the right of data portability, and the right to restrict the use of data and how insurers may be subject to these requirements; 2) setting forth a policy statement on the minimum consumer data privacy protections that are appropriate for the business of insurance; and 3) delivering a report on the charges by the Fall National Meeting.

Ms. Alexander said the strategy additionally charges the Committee to: 1) engage with state attorneys general (AGs), Congress, and federal regulatory agencies on state and federal data privacy laws to minimize preemption provisions and maximize state insurance regulatory authority; and 2) reappoint the Working Group to revise NAIC models, as necessary, to incorporate

minimum consumer data privacy protections that are appropriate for the business of insurance. She said these last charges are also to be completed by the Fall National Meeting.

Ms. Alexander said the Working Group discussed comments concerning the gap analysis received after its Nov. 20, 2020, meeting. She said comments were received from ACLI, the Coalition of Health Carriers, the National Association of Mutual Insurance Companies (NAMIC), and the American Property Casualty Insurance Association (APCIA).

Ms. Alexander said the Working Group announced that a consumer privacy protections panel will speak at the virtual NAIC Insurance Summit in June.

Commissioner Richardson asked for a motion to adopt the reports of the Market Regulation and Consumer Affairs (D) Committee's task forces and working groups, including the following action items: 1) the MIS data Analysis Metrics and Recommendations adopted by the Market Information Systems (D) Task Force; 2) revisions to the Best Practices Guide adopted by the Market Analysis Procedures (D) Working Group; 3) revisions to the four market analysis chapters of the Handbook adopted by the Market Analysis Procedures (D) Working Group; 4) the 14 calendar-day limitation on MCAS filing extension requests adopted by the Market Analysis Procedures (D) Working Group; and 5) the requirement for companies to identify MCAS filing attesters by both line of business and by state to be implemented for the 2021 data to be reported in 2022, which was adopted by the Market Analysis Procedures (D) Working Group.

Commissioner Clark made a motion, seconded by Commissioner Pike, to adopt the following reports: 1) Antifraud (D) Task Force; 2) Market Information Systems (D) Task Force; 3) Producer Licensing (D) Task Force; 4) Market Analysis Procedures (D) Working Group (Attachment Three); 5) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Four); 6) Market Conduct Examination Guidelines (D) Working Group (Attachment Five); and 7) Privacy Protections (D) Working Group (Attachment Six). The motion passed unanimously.

4. Discussed Other Matters

Birny Birnbaum (Center for Economic Justice—CEJ) encouraged the Committee to become more engaged in the work of the Special (EX) Committee on Race and Insurance. He said the CEJ drafted a proposal for a comprehensive work plan to address systemic racism in insurance. Included within the proposal is the development of tools and resources for regulatory oversight. He said the development of the tools requires market regulation data collection that is sufficient to monitor consumer outcomes by prohibited class characteristics and the identification of gaps in regulatory skills and resources that are necessary for the analysis of disparate impact and proxy discrimination. He said both activities fall within the purview of the Market Regulation and Consumer Affairs (D) Committee.

Mr. Birnbaum said all aspects of insurance operations, such as marketing, claims and antifraud, are subject to racism and disparate impact. He said it is important for market regulators to be well represented in the work of the Special (EX) Committee on Race and Insurance.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

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Attachment Two

Draft: 5/25/21

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
Adopted by the Antifraud (D) Task Force, May 25, 2021

The Improper Marketing of Health Insurance (D) Working Group will:

A. Coordinate with regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, task forces, and working groups.
B. Review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.

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Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
Adopted by the MCAS Blanks (D) Working Group, May 26, 2021

Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

Line of Business: Short-Term Limited Duration Insurance

Reporting Period: January 1, 2022 through December 31, 2022

Filing Deadline: June 30, 2023

Contact Information

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

Schedule 1 - Interrogatories

1-01	List the states where your STLDI products are marketed	Comment
1-02	Does the company offer STLDI policies/certificates with up to a 90-day duration?	Yes/No
1-03	Does the company offer STLDI policies/certificates with 91- to 180-day duration?	Yes/No
1-04	Does the company offer STLDI policies/certificates with 181- to 364-day duration?	Yes/No
1-05	Number of STLDI forms offered to residents in this state	Comment
1-06	Number of STLDI forms offered in all states	Comment
1-07	Number of STLDI forms filed in this state	Comment
1-08	Number of STLDI forms filed in all states	Comment
1-09	List the states where your STLDI products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product and describe the basis for not filing	Comment
1-10	How many policy forms have waiting periods that apply to the entire policy/certificate?	Number
1-11	How many policy forms have waiting periods that apply per specific benefits?	Number
1-12	Do any waiting periods exceed the policy/certificate term?	Y/N
1-13	If the answer to #12 is yes, please explain	Comment
1-14	Does the company issue STLDI products through associations? If yes, list the associations	Yes/No
1-15	If #14 is yes, list the associations	Comment

Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

1-16	If #14 is yes, do you have a contractual relationship with each Association?	Yes/No
1-17	If #14 is yes, does the contract cover the marketing of your product?	Yes/No
1-18	If #14 is yes, does the contract cover the collection of dues and fees?	Yes/No
1-19	If #14 is yes, does the contract cover commissions?	Yes/No
1-20	If #14 is yes, what other operational areas are covered in the contract?	Comment
1-21	Does the company issue STLDI products through trusts?	Yes/No
1-22	If #21 is yes, how many?	Comment
1-23	Does the company issue STLDI products through administrators?	Yes/No
1-24	If #23 is yes, how many?	
1-25	Does the company contract with third-party administrators for administrative services related to STLDI products?	Comment
1-26	If yes, does your delegation structure include claims related to STLDI products?	Yes/No
1-27	If yes, does your delegation structure include claims related to STLDI products?	Yes/No
1-28	If yes, does your delegation structure include complaints related to STLDI products?	Yes/No
1-29	If yes, does your delegation structure include medical underwriting related to STLDI products?	Yes/No
1-30	If yes, does your delegation structure include pricing related to STLDI products?	Yes/No
1-31	If yes, does your delegation structure include producer appointments related to STLDI products?	Yes/No
1-32	If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLDI products?	Yes/No
1-33	Does your company audit Third parties to whom you have delegated responsibilities?	Yes/No
1-34	If # 33 is yes, please provide frequency of audits	Comment
1-35	Does the company offer renewals/reissues?	Yes/No
1-36	Are any renewals/reissues subject to optional or mandatory underwriting?	Yes/No
1-37	If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue	Comment
1-38	Are there limitations on the number renewals per individual?	Yes/No
1-39	Does your company offer renewal(s) without underwriting for an additional charge?	Yes/No
1-40	If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge	Comment
1-41	Are the limitations on renewals based on state, federal, or company rules?	Yes/No

Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

1-42	Does your company distribute its product through independent agents?	Yes/No
1-43	Does your company distribute its products through captive agents?	Yes/No
1-44	Does your company distribute its products through its employees?	Yes/No
1-45	What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)	Comment
1-46	Additional State Specific Comments (optional)	Comment

Products

Product Identifiers	Explanation of Product Identifiers
STLDI <=90	**Short-Term Limited Duration Insurance not sold through an Association with a term less than or equal to 90 days**
STLDI < 180	**Short-Term Limited Duration Insurance not sold through an Association with a term greater than 90 and less than or equal to 180 days**
STLDI 181 - 364	**Short-Term Limited Duration Insurance not sold through an Association with a term greater than 180 days and less than 364 days**
STLDI Not Sitused <=90	**Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term less than or equal to 90 days**
STLDI Not Sitused < 180	**Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 90 and less than or equal to 180 days**
STLDI Not Sitused 181 - 364	**Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 180 days and less than 364 days**
STLDI Sitused <=90	**Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term less than or equal to 90 days**
STLDI Sitused < 180	**Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 90 and less than or equal to 180 days**
STLDI Sitused >181 - 364	**Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 180 days and less than 364 days**

Short-Term Limited Duration Insurance Market Conduct Annual Statement
Data Call & Definitions

Schedule 2 – Policy/Certificate Administration

2-1	Net Written Premium
2-2	Earned premiums for Reporting Year
2-3	Number of Policies/Certificates in Force at the Beginning of the Period
2-4	Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period
2-5	Number of new policy/certificate applications received during the period
2-6	Number of new policy/certificates issued during the period
2-7	Number of new policies/certificates denied during the period
2-8	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-9	Member months for policies/certificates newly issued during the period
2-10	Number of policy/certificate renewal/reissue applications received during the period
2-11	Number of policies/certificates renewed/reissued during the period
2-12	Number of policies/certificates non-renewed or denied at the option of insurer during the period
2-13	Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period
2-14	Number of renewals/reissues allowed?
2-15	Member months for policies/certificates renewed/reissued during the period
2-16	Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting
2-17	Number of Member Months of on Other Than New Policies/Certificates or Renewal/Reissued Policies/Certificates During the Period
2-18	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificateholder
2-19	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Period
2-20	Number of policies/certificates cancelled during the free look period
2-21	Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period
2-22	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period
2-23	Number of policy/certificate terminations and cancellations due to non-payment of premium

2-24	Number of Lives on Policies/Certificates Cancelled Due to Non-Payment of Premium During the Period
2-25	Number of Policies/Certificates Cancelled by Insurer for Any Reason Other Than Non-Payment of Premium During the Period
2-26	Number of Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period
2-27	Number of Lives on Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period
2-28	Number of rescissions
2-29	Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificateholder
2-30	Number of insured lives impacted on terminations and cancellations due to nonpayment
2-31	Number of insured lives impacted by rescissions
2-32	Number of Policies/Certificates in Force at the End of the Period
2-33	Number of Covered Lives on Policies/Certificates in Force at the End of the Period

Schedule 3 – Prior Authorizations

3-1	Number of Prior Authorization Requests Pending at the Beginning of the Period
3-2	Number of prior authorizations requested during period
3-3	Number of prior authorizations approved during period
3-4	Number of prior authorizations denied during period
3-5	Number of claims where prior authorization penalties were assessed
3-6	Number of Prior Authorization Requests Pending at the End of the Period
3-7	Median Number of Days from Receipt of Prior Authorization Request to Decision
3-8	Average Number of Days from Receipt of Prior Authorization to Decision

Schedule 4 – Claims Administration (Including Pharmacy)

4-1	Number of Claims Pending at the Beginning of the Period
4-2	Number of claims received
4-3	Total number of claims denied, rejected or returned
4-4	Number of denied, rejected, or returned due to claims submission coding error(s)
4-5	Number of denied, rejected, or returned for lack of Prior Authorization

4-6	Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation
4-7	Number of denied, rejected, or returned as Not medically necessary
4-8	Number of denied, rejected, or returned as Subject to pre-existing condition exclusion
4-9	Number denied, rejected, or returned due to failure to provide adequate documentation
4-10	Number denied, rejected, or returned due to being within the waiting period
4-11	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
4-12	Number of denied, rejected, or returned for Out-of-Network provider
4-13	Number of Claims Pending at End of Period
4-14	Median Number of Days from Receipt of Claim to Decision for Denied Claims
4-15	Average Number of Days from Receipt of Claim to Decision for Denied Claims
4-16	Median Number of Days from Receipt of Claim to Decision for Approved Claims
4-17	Average Number of Days from Receipt of Claim to Decision for Approved Claims
4-18	Number of Claim Decisions Appeals Pending At Beginning of Period
4-19	Number of Claim Decision Appeals Received During the Period
4-20	Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period
4-21	Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period
4-22	Number of Claim Decision Appeals Rejected and Not Considered for Any Reason
4-23	Number of Claim Decision Appeals Pending at End of Period
4-24	Average Number of Days from Receipt of Appeal to Decision
4-25	Number of claims paid

Schedule 5 – Consumer Complaints and Lawsuits

5-1	Number of complaints received by Company (other than through the DOI)
5-2	Number of complaints received through DOI
5-3	Number of complaints resulting in claims reprocessing
5-4	Number of Lawsuits Open at Beginning of the Period
5-5	Number of Lawsuits Opened During the Period
5-6	Number of Lawsuits Closed During the Period
5-7	Number of Lawsuits Closed During the Period with Consideration for the Consumer

5-8	Number of Lawsuits Open at End of Period

Schedule 6 – Marketing and Sales

6-1	Number of Individual Applications Pending at the Beginning of the Period
6-2	Number of applications received
6-3	Number of Renewal/Reissue Individual Applications Received During the Period
6-4	Number of New Individual Applications Denied During the Period for Any Reason
6-5	Number of New Individual Applications Denied During the Period - Health Status or Condition
6-6	Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason
6-7	Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition
6-8	Number of New Individual Applications Approved During the Period
6-9	Number of Renewal/Reissue Individual Applications Approved During the Period
6-10	Number of Individual Applications Pending at the End of the Period
6-11	Number of applications initiated via phone
6-12	Number of applications completed via phone
6-13	Number of applications initiated face-to-face
6-14	Number of applications completed face-to-face
6-15	Number of applications initiated online (Electronically)
6-16	Number of applications completed online (Electronically)
6-17	Number of New Individual Applications initiated by Mail During the Period
6-18	Number of New Individual Applications completed by Mail During the Period
6-19	Number of New Individual Applications initiated by Any Other Method During the Period
6-20	Number of New Individual Applications completed by Any Other Method During the Period
6-21	Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period)
6-22	Unearned Commissions returned to company on policies/certificates sold during the period?
6-23	Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period)

Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

Participation Requirements: All companies licensed and reporting at least $50,000 of Short-Term Limited Duration Insurance (STLDI) premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

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

Short-Term Limited Duration Insurance Market Conduct Annual Statement Data Call & Definitions

General Definitions:

Short-Term Limited-Duration Insurance - Health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract. (state and federal government guidelines may have renewal duration limitations)

Association – For purposes of this MCAS blank, a non-employer group that secures benefits for its members.

Individual STLDI Product – Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance. An individual STLDI policy is **not** issued to a trust, association, or administrator.

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

New Policies/Certificates Issued - STLDI policy/certificate issued to an individual or family for whom no prior short-term coverage has been placed with the same insurer within the previous 63 days

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

Policyholder / Certificateholder – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association). Policyholder is the individual when purchased in the individual market. Certificateholder is the individual when purchased through an Association, which is the policyholder.

Renewal / Reissue - STLDI policy/certificate issued to an individual or family for whom prior short-term coverage has been placed with the same insurer within 63 days of the prior coverage. If a policy is re-underwritten based on health factors or provides different benefits, it should be reported as a new policy/certificate issued.

<u>Schedule 2 Definitions (Policy/Certificate Administration):</u>

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

Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

Written Premium - Provide the total annual written premium for all policies and/or certificates issued to insureds residing in the state for which reporting is being completed

Earned Premium – Total premium earned from all policies/certificates written by the insurer during the specified period.

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

Member months– The *sum* of total number of lives insured on policies/certificates issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Schedule 3 and 4 Definitions (Prior Authorization and Claims Administration):

Prior Authorization – A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification, this includes any provision requiring the insured to notify the company prior to treatment.

Claim – For the purposes of this data call a claim means any individual line of service within a bill for services.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Claims are to be reported at the service line level.
- Capitated claims are to be reported if an Explanation of Benefits (EOB) is generated.
- Duplicate claims should not be reported.

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

Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

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

Clarification:

- The nine claim denial reporting categories are not exhaustive. Claim denials reported in the categories should be a subset of the reported total denials.

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

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

Schedules 5 Definitions (Consumer Requested Reviews/Grievance/Complaints):

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 Short-Term Limited Duration Insurance products:

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

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
Adopted by the MCAS Blanks (D) Working Group, May 26, 2021

Short-Term Limited Duration Insurance Market Conduct Annual Statement

Data Call & Definitions

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

Schedule 6 Definitions (Marketing and Sales)

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

Other Remuneration - Any monetary consideration provided by the insurer through the course of the insurance transaction. This is not commissions and are separate amounts paid for as a result of the insurance transaction.

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Draft: 5/26/21

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
Adopted by the MCAS Blanks (D) Working Group, May 26, 2021

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

Line of Business: Travel

Reporting Period: January 1, 2022 through December 31, 2022

Filing Deadline: April 30, 2023

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	Comment
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) 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	Number of Travel Retailers offering and disseminating Travel Insurance on behalf of the Company at the end of the reporting period.	Comment
1-14	Additional state specific Claims comments (optional)	Comment
1-15	Additional state specific Lawsuit and Complaints comments (optional)	Comment
1-16	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	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 31-90 days
2-25	Number of claims closed with payment beyond 90 days

2-26	Number of claims closed without payment within 0-30 days
2-27	Number of claims closed without payment within 31-90 days
2-28	Number of claims closed without payment beyond 90 days
2-29	Dollar amount of claims closed with payment

Schedule 3 – Lawsuits and Complaints

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

Schedule 4 – Underwriting

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

Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

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.)

Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

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.

Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

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: Coverage 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.

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 seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;

- 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:

	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.

	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.

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.

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Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
Adopted by the MCAS Blanks (D) Working Group, June 30, 2021

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Line of Business: Homeowners

Reporting Period: January 1, 20XX through December 31, 20XX

Filing Deadline: April 30, 20XX

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	Comment
1-01	Were there policies in-force during the reporting period that provided Dwelling coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Personal Property coverage?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Liability coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Loss of Use coverage?	Yes/No
1-06	Was the Company still actively writing policies in the state at year end?	Yes/No
1-07	Does the Company write in the non-standard market?	Yes/No
1-08	If yes, what percentage of your business is non-standard?	Comment
1-09	If yes, how is non-standard defined?	Comment
1-10	Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No	Yes/No
1-11	If yes, add additional comments	Comment
1-12	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
1-13	If yes, add additional comments	Comment
1-14	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
Adopted by the MCAS Blanks (D) Working Group, June 30, 2021

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

1-15	Does the company use Managing General Agents (MGAs)?	Yes/No
1-16	If yes, list the names of the MGAs.	Comment
1-17	Does the company use Third Party Administrators (TPAs)?	Yes/No
1-18	If yes, list the names of the TPAs.	Comment
1-19	Does the company use digital claim settlement?	Yes/No
1-20	If yes, list the vendors providing third-party data and algorithms used in the digital claim settlement process, and for each vendor identify the vendor's role in the digital claims process.	Comment
1-21	Claims Comments	Comment
1-22	Underwriting Comments	Comment

Coverages	**Reported also at the Digital Claim Handling Process Level of Detail ***
Dwelling (includes – Other Structures)	**X**
Personal Property	**X**
Liability	
Medical Payments	
Loss of Use	

*** Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)**

Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment.

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
Adopted by the MCAS Blanks (D) Working Group, June 30, 2021

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Schedule 2—Homeowners Claims Activity, Counts Reported by Claimant and by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two liability claimants, two medical payment claims, one dwelling claim for the insured, and one personal property claim for the insured, you would report as follows: Dwelling – 1; Personal Property – 1; Liability – 2; Medical Payments – 2. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

ID	Description
2-23	Number of claims open at the beginning of the period
2-24	Number of claims opened during the period
2-25	Number of claims closed during the period, with payment
2-26	Number of claims closed during the period, without payment
2-27	Number of claims open at the end of the period
2-28	Median days to final payment
2-29	Number of claims closed with payment within 0-30 days
2-30	Number of claims closed with payment within 31-60 days
2-31	Number of claims closed with payment within 61-90 days
2-32	Number of claims closed with payment within 91-180 days
2-33	Number of claims closed with payment within 181-365 days
2-34	Number of claims closed with payment beyond 365 days
2-35	Number of claims closed without payment within 0-30 days
2-36	Number of claims closed without payment within 31-60 days
2-36	Number of claims closed without payment within 61-90 days
2-37	Number of claims closed without payment within 91-180 days
2-38	Number of claims closed without payment within 181-365 days
2-39	Number of claims closed without payment beyond 365 days
2-40	Number of lawsuits open at beginning of the period
2-41	Number of lawsuits opened during the period
2-42	Number of lawsuits closed during the period
2-43	Number of lawsuits open at end of period
2-44	Number of lawsuits closed with consideration for the consumer.

Adopted by the Executive (EX) Committee and Plenary, XX, XX, 2021
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, XX, 2021
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Homeowner Data Call & Definitions

Schedule 3—Homeowners Underwriting Activity

ID	Description
3-46	Number of dwellings which have policies in-force at the end of the period
3-47	Number of dwelling fire policies in force at the end of the period.
3-48	Number of homeowner policies in force at the end of the period.
3-49	Number of tenant/renter/condo policies in force at the end of the period.
3-50	Number of all other residential property policies in force at the end of the period.
3-51	Number of new business policies written during the period
3-52	Dollar amount of direct premium written during the period
3-53	Number of Company-Initiated non-renewals during the period
3-54	Number of cancellations for non-pay or non-sufficient funds
3-55	Number of cancellations at the insured's request
3-56	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-57	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-58	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-59	Number Of Complaints Received Directly From Any Person or Entity Other than the DOI

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Homeowner Data Call & Definitions

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Exclude lender-placed or creditor-placed policies.

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 will be 0.

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium or non-sufficient funds.
    - These should be reported every time a policy cancels for the above reasons. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)
- Policies cancelled at the insured's request.
- Policies cancelled for underwriting reasons.

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

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Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

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

Include:

- Both first and third party claims.

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

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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.

Clarification:

- 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 closed 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 that supplemental payment from the time the request for supplemental payment was received to the date of 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 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.

Calculation Clarification:

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- For each coverage identifier, the sum of the claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period.

Complaint – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.
Include:

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

Coverage - Dwelling (includes – Other Structures) – Coverage for dwellings under Homeowners Policies and Dwelling Fire and Dwelling Liability Policies. It includes coverage for Other Structures.

Coverage - Loss of Use – Loss of Use provided under Homeowners Policies.

Coverage - Personal Property – Personal Property provided under Homeowners Policies.

Coverage - Liability – Liability insurance provided under Homeowners Policies.

Coverage - Medical Payments – Medical Payments provided under Homeowners Policies.

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 date was made during the reporting period regardless of the date of loss or when the claims 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.

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- 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 loss to either the company or insurance agent.

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Digital Claim Handling Process Level of Detail Breakdown:

Digital Claim – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the production of the initial loss settlement offer. Digital claims utilize only digital information to establish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property is conducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or data provided by in-vehicle or in-property sensors.

Hybrid C**laim** – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the use of human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

Non-Digital Claim – means any claim other than a Digital Claim or Hybrid Claim.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:

- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be

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made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

- A 2 or 3 family home covered under one policy would be considered 1 dwelling.

Dwelling Fire Policies – Coverage for dwellings and their contents. It may also provide liability coverage and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner's policy, or because of a requirement for the insured to select several different kinds of coverage and limits on this protection.

Include:

- Dwelling Fire and Dwelling Liability policies should be included ONLY IF the policies written under these programs are for personally occupied residential dwellings, not policies written under a commercial program and/or on a commercial lines policy form.

Homeowners Policies – Policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses.

Include:

- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
- Renters insurance, Policies covering log homes, land homes, and site built homes are included.
- Inland Marine or Personal Articles endorsements.
- Include policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms.

Exclude:

- Farmowners is not included as it is considered to be Commercial Lines for purposes of this project.
- Umbrella policies.
- Lender-placed or creditor-placed policies.

Inland Marine or Personal Articles Endorsements – Provides coverage via endorsement to a homeowners policy for direct physical loss to personal property as described in the endorsement.

Exclude:

- Stand-alone Inland Marine Policies.

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Note: Revisions to the 2021 data year Lawsuits definitions were adopted by the Market Regulation and Consumer Affairs (D) Committee and NAIC EX/Plenary during the 2020 NAIC Fall National Meeting.

Lawsuit – A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.

Exclude:

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, and declaratory judgment actions filed by an insurer.

Calculation Clarification:

- Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each / claimant / coverage combination, regardless of the number of actual suits filed.
- One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.
- One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage.
- Lawsuits should be reported in the state in which the claim was reported on this statement.
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission state the number of class action lawsuits included in the data and the general cause of the action.

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 claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Liability Insurance – Coverage for all sums that the insured becomes legally obligated to pay because of bodily injury or property damage, and sometimes other torts to which an insurance policy applies.

Loss Of Use – Coverage for additional living expenses incurred by the insured or fair rental value when the insured dwelling becomes uninhabitable as the result of an insured loss or when access to the dwelling is barred by civil authority.

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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.

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

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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.

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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.

Medical Payments Coverage – Provides coverage for medical expenses resulting from injuries sustained by a claimant regardless of liability.

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.

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- 'Re-written' policies unless there was a lapse in coverage.

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 nonrenewals should be reported on a policy basis regardless of the number of dwellings insured under the policy.

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Other Structures – Structures on the residence premises (1) separated from the dwelling by a clear space or (2) connect to the dwelling by a fence, wall, wire, or other form of connection but not otherwise attached.

Personal Property Damage Coverage – Provides coverage for damage to dwelling contents or other covered personal property caused by an insured peril.

Personally Occupied – A dwelling in which the person owning the policy personally occupies the dwelling and lives there.

Property Damage Coverage – Provides coverage for damage to the dwelling and/or other insured structures caused by an insured peril.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Tenant/Renters/Condo Policies – Policies that provide coverage for the personal property of tenants, renters, condominium and cooperative unit owners. Include policies typically written on the HO-4 and HO-6 policy forms.

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Private Passenger Auto Data Call & Definitions

Line of Business: Private Passenger Auto

Reporting Period: January 1, 20XX through December 31, 20XX

Filing Deadline: April 30, 20XX

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	Comments
1-01	Were there policies in-force during the reporting period that provided Collision coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Comprehensive/Other Than Collision coverage?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Bodily Injury coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Property Damage coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?	Yes/No
1-06	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?	Yes/No
1-07	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-08	Were there policies in-force during the reporting period that provided Combined Single Limits coverage?	Yes/No
1-09	Were there policies in-force during the reporting period that provided Personal Injury Protection coverage?	Yes/No
1-10	Was the Company still actively writing policies in the state at year end?	Yes/No
1-11	Does the Company write in the non-standard market?	Yes/No
1-12	If yes, what percentage of your business is non-	Percentage

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	standard?	
1-13	If yes, how is non-standard defined?	Comment
1-14	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-15	If yes, add additional comments	Comment
1-16	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
1-17	If yes, add additional comments	Comment
1-18	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment
1-19	Does the company use Managing General Agents (MGAs)?	Yes/No
1-20	If yes, list the names of the MGAs.	Comment
1-21	Does the company use Third Party Administrators (TPAs)?	Yes/No
1-22	If yes, list the names of the TPAs.	Comment
1-23	Does the company use telematics or usage-based data?	Yes/No
1-24	Does the company use digital claim settlement?	Yes/No
1-25	If yes, list the vendors providing third-party data and algorithms used in the digital claim settlement process, and for each vendor identify the vendor's role in the digital claims process.	Comment
1-26	Claims Comments	Comment
1-27	Underwriting Comments	Comment

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Private Passenger Auto Data Call & Definitions

Coverages	Reported also at the Digital Claim Handling Process Level of Detail *
Collision	X
Comprehensive/Other Than Collision	X
Bodily Injury	
Property Damage	X
Uninsured Motorists and Underinsured Motorists (UMBI)	
Uninsured Motorists and Underinsured Motorists (UMPD)	X
Medical Payments	
Combined Single Limits	
Personal Injury Protection	

*** Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)**

Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment.

Schedule 2—Private Passenger Auto Claims Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim. For example, if one claim results in a reserve/line/feature opened for two bodily injury claimants (one property damage claimant, one collision claim for the insured, and one medical payment claim for the insured), it would be reported as follows: Collision – 1, Bodily Injury – 2; Property Damage – 1; and Medical Payments – 1. The number of days to final payment (if payment is made) would be calculated separately for each claimant.

ID	Description
2-28	Number of claims open at the beginning of the period
2-29	Number of claims opened during the period
2-30	Number of claims closed during the period, with payment
2-31	Number of claims closed during the period, without payment.
2-32	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.

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Private Passenger Auto Data Call & Definitions

2-33	Number of claims remaining open at the end of the period
2-34	Median days to final payment
2-35	Number of claims closed with payment within 0-30 days
2-36	Number of claims closed with payment within 31-60 days
2-37	Number of claims closed with payment within 61-90 days
2-38	Number of claims closed with payment within 91-180 days
2-39	Number of claims closed with payment within 181-365 days
2-40	Number of claims closed with payment beyond 365 days
2-41	Number of claims closed without payment within 0-30 days
2-42	Number of claims closed without payment within 31-60 days
2-43	Number of claims closed without payment within 61-90 days
2-44	Number of claims closed without payment within 91-180 days
2-45	Number of claims closed without payment within 181-365 days
2-46	Number of claims closed without payment beyond 365 days
2-47	Number of lawsuits open at beginning of the period
2-48	Number of lawsuits opened during the period
2-49	Number of lawsuits closed during the period
2-50	Number of lawsuits open at end of period
2-51	Number of lawsuits closed with consideration for the consumer.

Schedule 3—Private Passenger Auto Underwriting

ID	Description
3-52	Number of autos which have policies in-force at the end of the period
3-53	Number of policies in-force at the end of the period
3-54	Number of new business policies written during the period
3-55	Dollar amount of direct premium written during the period
3-56	Number of Company-Initiated non-renewals during the period
3-57	Number of cancellations for non-pay or non-sufficient funds
3-58	Number of cancellations at the insured's request
3-59	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company

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3-60	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-61	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-62	Number of complaints received directly from any person or entity other than the DOI

Definitions:

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Exclude lender-placed or creditor-placed policies.

Data should be reported for both private passenger automobiles and motorcycles. Exclude antique vehicles and primarily off-road vehicles such as dune buggies or three-wheel ATVs.

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis regardless of the number of automobiles insured under the policy.

Report cancellations separately for:

- Policies cancelled for non-payment of premium or non-sufficient funds
    - These should be reported every time a policy cancels for the above reasons (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted).
- Policies cancelled at the insured's request
- Policies cancelled for underwriting reasons.

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

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- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

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

- Both first- and third-party claims.

Exclude:

- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.

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- 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 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.

Complaint – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.
Include:

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

Coverage - Collision Insurance – Coverage to provide protection against physical contact of an automobile with another inanimate object resulting in damage to the insured automobile.

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a collision claim should not be counted as separate claims.

Coverage - Comprehensive/Other than Collision Insurance – Coverage providing protection in the event of physical damage (other than collision), including theft of the insured automobile.

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a comprehensive/other than collision claim should not be counted as separate claims.

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Coverage - Bodily Injury – Physical damage to one's person. The purpose of liability (casualty) insurance is to cover bodily injury to a third party resulting from the negligent acts and omissions of an insured.

Coverage - Property Damage Liability Insurance – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another's property.

Include:

- 'Property Damage Rental' coverage (i.e. amounts paid for a third party claimant's rental car).

Coverage - UMBI – Includes both Uninsured Motorist Coverage and Underinsured Motorists Coverage for bodily injury claims.

- **Underinsured Motorist Coverage (UIM)** – Provides coverage for bodily injury sustained by an insured who is involved in an accident caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Coverage (UM)** – Provides coverage for bodily injury sustained by an insured involved in an accident caused by an at-fault driver who does not have liability insurance.

Coverage - UMPD – Includes both Uninsured Motorist Property Damage Coverage and Underinsured Motorist Property Damage Coverage.

- **Underinsured Motorist Property Damage Coverage –** Provides coverage for property damage to covered property caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have liability insurance.

Coverage - Medical Payments Coverage – First party coverage for injuries incurred in a motor vehicle accident.

Coverage - Combined Single Limit – Bodily injury liability and property damage liability expressed as a single sum of coverage.

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Coverage - Personal Injury Protection (PIP) – A first party benefit. coverage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry personal injury protection coverage to pay for basic medical needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

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 claims 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 loss to either the company or insurance agent.

Digital Claim Handling Process Level of Detail Breakdown:

> **Digital Claim** – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company

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in the loss appraisal process, settlement determination, and/or in the production of the initial loss settlement offer. Digital claims utilize only digital information to establish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property is conducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or data provided by in-vehicle or in-property sensors.

Hybrid Claim – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the use of human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

Non-Digital Claim – means any claim other than a Digital Claim or Hybrid Claim.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:

- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

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Note: Revisions to the 2021 data year Lawsuits definitions were adopted by the Market Regulation and Consumer Affairs (D) Committee and NAIC EX/Plenary during the 2020 NAIC Fall National Meeting.

Lawsuit – A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.

Exclude:

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, and declaratory judgment actions filed by an insurer.

Calculation Clarification:

- Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each claimant / coverage combination, regardless of the number of actual lawsuits filed.
- One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.
- One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage. If the lawsuit is seeking damages for bodily injury and property damage, one lawsuit should be reported for each of the two coverages.
- Lawsuits should be reported in the state in which the claim is reported on this statement.
- 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 claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

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

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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 should not be included.

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.

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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.

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.

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:

- Renewals or 're-written' policies unless there was a lapse in coverage.

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.

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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.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Private Passenger Auto Insurance – Those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household that are reported on lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement.

Include:

- This covers four-wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.
- Vehicles as defined above that are reported on Lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement which meet the definition of private passenger automobiles.
- Motorcycles
- Policies where the insured's vehicle is titled privately to the insured but is used by the insured for work should be included, unless the coverage is written on a commercial auto form.
- Policies written on a volunteer basis and those written through a residual market mechanism such as assigned risk pools should be included.
- Policies written on RV's and motor homes are included as they are licensed vehicles that fall under the various states' Motor Vehicle Responsibility laws.

Exclude:

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- Policies written on antiques, collectibles, all-terrain vehicles, snowmobiles, trailers, dune buggies.
- Miscellaneous vehicles written on Inland Marine policies.
- Other vehicles classified by ISO as miscellaneous that do not fall under the various states' Motor Vehicle Responsibility laws.
- 'Fleet' policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as 'private passenger auto' insurance on lines 19.1, 19.2 or 21.1 of the state page of the financial annual statement.
- Non-owned vehicle insurance policies.
- Lender-placed or creditor-placed policies.
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.

Telematics and Usage-Based Data – Data which is collected through devices installed in a vehicle, through mobile applications, or other method. These devices then transmit the data in real time back to insurers. Examples of usage-based data collected via telematics includes - but is not limited to - miles driven, time of day, where the vehicle is driven (Global Positioning System or GPS), rapid acceleration, hard braking, hard cornering and air bag deployment.

