Draft: 12/13/19

Market Regulation and Consumer Affairs (D) Committee
Austin, Texas
December 9, 2019

The Market Regulation and Consumer Affairs (D) Committee met in Austin, TX, Dec. 9, 2019. The following Committee members participated: Chlora Lindley-Myers, Chair (MO); Allen W. Kerr, Vice Chair, and Russ Galbraith (AR); Trinidad Navarro represented by Frank Pyle (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida represented by Paul Yuen (HI); Stephen W. Robertson represented by Holly Williams-Lambert (IN); Vicki Schmidt (KS); Anita G. Fox represented by Michele Riddering (MI); Mike Causey represented by Tracy Biehn (NC); Barbara D. Richardson (NV); Kent Sullivan and Ignatius Wheeler (TX); Todd E. Kiser (UT); and Mike Kreidler and John Haworth (WA). Also participating were: Maria Ailor (AZ); Cynthia Amann (MO); Timothy Schott (ME); Bruce R. Ramge (NE); Jessica Altman (PA) and Larry Deiter (SD).

1. Adopted its Oct. 1 Minutes

The Committee met Oct. 1 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) appointed the Privacy Protections (D) Working Group.

Commissioner Kerr made a motion, seconded by Mr. Haworth, to adopt the Committee's Oct. 1 minutes (Attachment One). The motion passed unanimously.

2. Adopted its 2020 Proposed Charges

Director Lindley-Myers said the Committee's 2020 proposed charges are similar to its 2019 charges, except for some revisions to the charges of the Market Conduct Annual Statement Blanks (D) Working Group. She said the first charge of Working Group was changed to reflect that the review of Market Conduct Annual Statement (MCAS) data elements should be for the lines of business in effect longer than three years, rather than for all lines. Additionally, the reference to completing work by June 1 was deleted to reflect that the Working Group's tasks are completed as necessary and appropriate.

Commissioner Kerr made a motion, seconded by Mr. Haworth, to adopt the Committee's 2020 proposed charges (*see NAIC Proceedings – Fall 2019, Executive (EX) Committee and Plenary, Attachment Two*). The motion passed unanimously.

3. Adopted the Workers' Compensation In-Force SDR and the Travel Insurance Examination Standards

Director Ramge said the Market Conduct Examination Standards (D) Working Group met Aug. 29 and adopted a new workers' compensation in-force standardized data request (SDR) that will be incorporated into the reference documents of the *Market Regulation Handbook.*

Director Ramge said the Working Group also met Oct. 9 and adopted new travel insurance examination standards (for inclusion in the *Market Regulation Handbook*. He said the examination standards were discussed during the Working Group's May 30, June 18, July 18, Aug. 29 and Oct. 9 conference calls. He said the Working Group's revisions to the exposure draft were drafted with input from the U.S. Travel Insurance Association (UStiA) and the American Property Casualty Insurance Association (APCIA).

Commissioner Richardson made a motion, seconded by Commissioner Schmidt, to adopt the workers' compensation in-force SDR (Attachment Two) and the travel insurance examination standards (Attachment Three). The motion passed unanimously.

4. Adopted Revisions to the *State Licensing Handbook* and the 2019 Continuing Education Reciprocity Agreement

Director Deiter said the Producer Licensing (D) Task Force met Dec. 7 and adopted revisions to the *State Licensing Handbook* (Handbook), which was revised to be consistent with established NAIC policy on producer licensing. He said the Producer Licensing Uniformity (D) Working Group began its review of the Handbook in April 2019. He said the Working Group met six times from August through October and adopted the proposed revisions to the Handbook during its Oct. 30 conference call. The Producer Licensing (D) Task Force subsequently adopted the proposed revisions to the Handbook during its Dec. 7 meeting at the Fall National Meeting.

Director Deiter said the more significant changes to the Handbook are as follows: 1) exact language from the *Producer Licensing Model Act* (#218) was added where appropriate; 2) the appendix to the Handbook will be removed from future hardcopy versions and will be posted as a separate electronic appendix on the NAIC website; 3) the Handbook was updated to provide a link to the NAIC web page where the most current information about the National Association of Registered Agents and Brokers (NARAB) is posted because of ongoing uncertainty about when NARAB will be formed; and 4) additional clarification was added to the licensing reciprocity examples in Chapter 4 of the Handbook.

Director Deiter said the Producer Licensing (D) Task Force also adopted the 2019 Continuing Education Reciprocity Agreement (CER Agreement) during its Dec. 7 meeting at the Fall National Meeting. He said the Uniform Education (D) Working Group drafted the CER Agreement throughout 2019 and adopted the agreement during its Oct. 31 conference call.

Director Deiter said the CER Agreement supports the use of the Uniform Continuing Education Reciprocity Course Filing Form (CER Form). He said continuing education (CE) providers may use the CER Form to streamline the course-approval process in multiple states. He noted that through the reciprocal approval process, the CE provider's home state conducts a substantive review of the CE course; therefore, non-resident states do not need to perform a similar review for a course previously approved by the home state.

Commissioner Schmidt made a motion, seconded by Commissioner Kerr, to adopt the proposed revisions to the *State Licensing Handbook* (Attachment Four) and the 2019 CER Agreement (Attachment Five). The motion passed unanimously.

5. Adopted its Task Force and Working Group Reports

Director Lindley-Myers said the reports of the Committee's task forces and working groups were circulated for this meeting. She said the Market Actions (D) Working Group met Dec. 7 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. She asked if any of the chairs of the task forces or working groups, committee members, or interested parties would like to make any comments on the reports.

a. Advisory Organization Examination Oversight (D) Working Group

Mr. Schott said the Advisory Organization Examination Oversight (D) Working Group issued a survey to collaborative action designees (CADs), market analysis chiefs (MACs) and market chief examiners (MCEs) concerning whether to add three new advisory organizations to be overseen by the Working Group for regularly scheduled examinations. The Working Group meets in regulator-to-regulator session pursuant to paragraph 3 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. He encouraged any state that has not yet responded to do so.

b. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met Dec. 8 and adopted its Nov. 21 minutes. He said that during the Nov. 21 conference call, the Working Group: 1) agreed to not include fraternals in the MCAS until a formal proposal is received for their inclusion; 2) adopted "other health" as a line of business in the MCAS; and 3) discussed a uniform process for addressing MCAS extension requests.

Mr. Haworth said that during the Working Group's Dec. 8 meeting, it continued its discussion of adding "other health" to the MCAS and assured all interested parties that the development of the blank will be done by the Market Conduct Annual Statement Blanks (D) Working Group, and it will include state insurance regulators, carriers and consumer representatives. The goal, as always, will be to develop a blank with all the parameters and data elements fully and clearly defined.

Mr. Haworth said the Working Group also heard an update on the short-term limited duration (STLD) data call. He said a reminder letter was sent to all companies Dec. 5 reminding them of the Dec. 13 due date. He said only one filing has been received as of Dec. 7. He said the Working Group encouraged companies to complete their filings or notify NAIC staff that they do not write STLD.

Mr. Haworth said the Working Group also began work revising the MCAS Best Practices Guide and other MCAS materials in order to build consistency in how the states handle extension and waiver requests.

Finally, Mr. Haworth said the Working Group discussed its plans for meeting its 2020 proposed charges.

Samantha Burns (America's Health Insurance Plans—AHIP) said the development of the "other health" MCAS blank will be a significant undertaking. She said AHIP has concerns about the scope of the blank and the definitions. She said even though the Market Conduct Annual Statement Blanks (D) Working Group is charged with developing the blank, it is the purview of the Market Analysis Procedures (D) Working Group to adopt the line of business before it is created. She said the Working Group should better define what is expected to be included as "other health." By not being specific, the Working Group is setting a bad precedent.

Ms. Burns said the discussion about the other health line of business was tabled in 2018 and the Working Group focused on STLD. When discussions were renewed in November, the line of business was adopted without any discussion about what products are included in "other health." Ms. Burns noted that packaged indemnity products were mentioned as being included in other health, but they are not packaged or sold at the carrier level. She said the MCAS would not be the best avenue for obtaining data on packaged indemnity plans. Ms. Burns said more discussion is needed, and she asked the Committee to not adopt other health as the next line of business and instruct the Working Group to continue its discussions about what is included in the line of business.

Chuck Piacentini (American Council of Life Insurers—ACLI) agreed with Ms. Burns. He said "other health" is not a common term, and if the intent is to obtain information on plans other than major medical plans, the Working Group should be more specific. There may be better methods for getting data for different types of products.

Birny Birnbaum (Center for Economic Justice—CEJ) said there was an extended discussion during the Working Group's Dec. 8 meeting about the process for developing an MCAS blank. He said the Market Analysis Procedures (D) Working Group is charged with identifying the need for a new MCAS line of business. The Working Group did that. He said the Market Conduct Annual Statement Blanks (D) Working Group will then consider the coverages and data that will be collected in the MCAS blank. He said if the Market Conduct Annual Statement Blanks (D) Working Group decides that packaged indemnity products should not be collected in an MCAS blank, it can decide not to include them. As an example, he said the Market Conduct Annual Statement Blanks (D) Working Group eliminated coverages from both the flood insurance and lender-placed insurance MCAS blanks. He said the industry is encouraged to take part in the development of the MCAS blanks.

Commissioner Kerr agreed with Mr. Birnbaum. He said state insurance regulators need to know what is being sold in the marketplace.

Commissioner Altman also agreed and said the Working Groups should move forward with the creation of the "other health" MCAS blank.

Commissioner Richardson made a motion, seconded by Commissioner Kerr, to adopt the report of the Market Analysis Procedures (D) Working Group (Attachment Six), including the adoption of "other health" as the next line of business in the MCAS. The motion passed unanimously.

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

Ms. Ailor said the Market Conduct Annual Statement Blanks (D) Working Group did not meet at the Fall National Meeting. She said the Working Group met Oct. 23 and Nov. 21 via conference call.

Ms. Ailor said that during its Oct. 23 conference call, the Working Group heard an update on the Life and Annuity MCAS Data Element Review Project, and it decided to issue a survey to the states to determine if any data elements need to be added, deleted or revised for the homeowners and auto lines of business in the MCAS.

Ms. Ailor said that during its Nov. 21 conference call, the Working Group made two changes to due dates. She said the first change involves situations where the MCAS due date occurs on a weekend or federal holiday. She said that in that instance, the Working Group agreed that the due date will be moved to the next business day.

Ms. Ailor said the second change is to the due date for the health MCAS. She said the Working Group extended the health MCAS filing due date to June 30 for data to be reported in 2020, 2021 and 2022. She said that after three years, the due date will automatically revert to April 30 unless health companies request a re-evaluation. She said that because this is an extension of the April 30 due date, the Working Group received assurances from industry that companies would not request extensions beyond the June 30 due date except for extraordinary circumstances.

Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) thanked Ms. Ailor, Ms. Dingus and the Working Group for overseeing a collaborative process to address issues raised by the health insurance industry regarding its MCAS filings.

d. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group met Dec. 8. She said the Working Group was appointed Oct. 1, noting that she is chair Ron Kreiter (OK) is vice chair. She said the Working Group is in the process of building the membership, as well as the distribution lists for interested state insurance regulators and interested parties. She the Working Group will work closely with the other working groups in this arena, such as the Artificial Intelligence (EX) Working Group and the Accelerated Underwriting (A) Working Group. She noted that each of these working groups has its unique set of issues that, nevertheless, require coordination.

Ms. Amann said that during its Dec. 8 meeting, the Working Group discussed its proposed workplan to meet every six weeks via conference call to keep on track so it can accomplish its charges by the deadline established. She said the Working Group also heard a presentation by Jennifer McAdam (NAIC) in which she reviewed: 1) the *NAIC Insurance Information and Privacy Protection Model Act* (#670); 2) the *Privacy of Consumer Financial and Health Information Regulation* (#672); 3) the European Union's General Data Protection Regulation (GDPR); 4) the California Consumer Privacy Act (CCPA); and 5) the states' data privacy legislation.

Ms. Amann said the Working Group also received an update from Kendall Cotton (MT) on current legislative activities in Montana. Additionally, the Working Group discussed comments received from the CEJ, the National Association of Mutual Insurance Companies (NAMIC) and the APCIA.

David Snyder (APCIA) said the Antifraud (D) Task Force summary report in the Committee materials references a *Buzzfeed* article bringing awareness to a potential threat claiming that an alliance between insurers and law enforcement is working against innocent consumers. He said the report says the Task Force decided to review and provide an additional update at the 2020 Spring National Meeting. He said the APCIA challenges the validity of the article and asked to participate in the review of the allegations in the article. He noted that the insurer antifraud efforts and law enforcement have cooperated to effectively protect consumers, not harm them.

Mr. Pyle said he is a member of the Antifraud (D) Task Force, and although he cannot speak for the chair, he is certain the APCIA's participation would be welcomed by the Task Force.

Mr. Birnbaum said the CEJ is responsible for forwarding the article to the Task Force and the Market Regulation and Consumer Affairs (D) Committee chairs to illustrate the need to review the algorithms being used in antifraud efforts to be sure that they are not biased in some way. He said it was not meant to cast any aspersion of the work of antifraud entities.

Commissioner Kerr made a motion, seconded by Commissioner Kreidler, to adopt the reports of the Committee's task forces and working groups: the Antifraud (D) Task Force, the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Advisory Organization Examination Oversight (D) Working Group; the Market Actions (D) Working Group; the Market Analysis Procedures (D) Working Group; the Market Conduct Annual Statement Blanks (D) Working Group (Attachment Seven); the Market Conduct Examination Standards (D) Working Group (Attachment Eight); the Market Regulation Certification (D) Working Group (Attachment Nine); and the Privacy Protections (D) Working Group (Attachment Ten). The motion passed unanimously.

6. Discussed Updates to *Best Practices and Guidelines for Consumer Information Disclosures*

Director Lindley-Myers said the review of the *Best Practices and Guidelines for Consumer Information Disclosures* is in response to a request from the NAIC funded consumer representatives for the NAIC membership to consider best practices for consumer information disclosures. She said that in response to requests for comments prior to the Summer National Meeting and again in October, the Committee received extensive, suggested revisions from the NAIC funded consumer representatives. She said no state insurance regulators or other interested parties submitted comments.

Mr. Birnbaum said the consumer representatives provided proposed revisions to the *Best Practices and Guidelines for Consumer Information Disclosures* to incorporate new information on how consumers learn to make consumers disclosures more effective. He said it also highlights the work of state insurance regulators to get consumer engagement, notably Commissioner Sullivan and the Texas Department of Insurance. He said the consumer representative asks that the proposed revisions be exposed for another comment period to add additional information.

7. Heard a Presentation on Mental Health Parity Examinations

Joel Ario (Manatt Health), Daniel Blaney-Koen (American Medical Association—AMA) and Tim Clement (American Psychiatric Association—APA) gave a presentation to the Committee on the urgency of the state insurance departments to use their mental health and substance use disorder (MH/SUD) parity oversight authority to address the opioid epidemic in the U.S.

Mr. Blaney-Koen provided recommendations including: 1) removing prior authorization regulations for medication-assisted treatment (MAT); 2) increased oversight and enforcement of MH/SUD parity laws; 3) ensuring network adequacy for those needing treatment for opioid use disorder; 4) enhancing access to comprehensive, multi-disciplinary multimodal pain care; 5) expanding access to naloxone; and 6) evaluating the results to identify what is working, and building on the most successful efforts.

Mr. Clement said when conducting a market conduct examination regarding MH/SUD parity, examiners should not assume that a company is necessarily complying with the easiest parts of the federal Mental Health Parity and Addiction Equity Act (MHPAEA), such as defining MH/SUD, classifying benefits, or using quantitative treatment limitations and financial requirements. He said many carriers are setting non-quantitative treatment limitations, such as requiring prior authorizations on all formulations of naloxone, all inpatient MH/SUD benefits, and blanket exclusions on benefits. He also said examiners should look to see if the carrier has more stringent written processes, evidentiary standards, and triggers for utilization review. Finally, he encouraged examiners to look closely at claims to see if the company's utilization review approvals for MH/SUD are more limited, whether MH/SUD requests are more often sent for peer review, and whether the peer reviewers are adhering to medical necessity criteria and level of care guidelines.

Commissioner Kreidler asked whether the use of blanket prior authorizations is more of an issue when a consumer changes carriers or plans, rather than when a consumer has a continuity of coverage.

Mr. Blaney-Koen said it is more common when switching plans, but it occurs in both instances.

Commissioner Kreidler also recommended that a review of the thorough study being conducted by the Washington State Office of the Insurance Commissioner to evaluate consumer access to services for MH/SUD in state-regulated individual, small group, and large group health insurance plans.

Commissioner Sullivan asked if there are tools available to consumers to help them inquire of a company about their MH/SUD parity and compare companies.

Mr. Clement said there are some resources, but they are written at too high a level. He asked Commissioner Sullivan and other members of the Committee to contact him for more information on consumer tools that are available.

Mr. Ario said some of the state insurance department websites contain useful consumer assistance.

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

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CLAIMS STANDARDIZED DATA REQUEST
Property & Casualty Line of Business
Farmowners

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of Farmowners claims within the scope of the examination.

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted;
- Cross-reference with the company's in force data file to ensure completeness of exam data submitted; and
- Cross-reference to state (s) licensing information to ensure proper adjuster licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix (**Blank if NONE**)
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix (**Blank if NONE**)
ClmNo	32	15	A		Claim number
ClmPre	47	3	A		Claim number prefix (**Blank if NONE**)
ClmSuf	50	3	A		Claim number suffix (**Blank if NONE**)
Cov	53	5	A		Coverage under which claim was submitted (Coverage A, B, C, etc.)
CovClCod	58	3	A		Description of item for which claim was submitted (e.g. barns, silos, tractors, livestock) **Please provide a list to explain any codes used**
CATCode	61	6	A		Catastrophe (CAT) loss code, if applicable (**Blank if NONE**)
COL	67	20	A		Cause of loss (water, hail, medical, theft, fire, etc.)
DedDesc	87	20	A		Description of deductible applied (e.g. standard, wind/hail/earthquake)
Ded Type	107	15	A		Describe if the deductible is reflected as dollars or as a percentage
DedAmt	122	11	N	2	Deductible amount (Dollar amount or percentage amount)
Endorse	133	20	A		List endorsements applicable to this claim transaction (if any) **Please provide a list to explain any codes used**
InsFirst	153	15	A		First name of insured
InsMid	168	15	A		Middle name of insured
InsLast	183	20	A		Last name of insured
InsAddr	203	100	A		Insured street address (residence premises)

Field Name	Start	Length	Type	Decimals	Description
InsCity	303	20	A		Insured city (residence premises)
InsSt	323	2	A		Insured resident state (residence premises)
InsZip	325	5	A		Insured ZIP code (residence premises)
CmtFirst	330	15	A		First name of claimant
CmtMid	345	15	A		Middle name of claimant
CmtLast	360	20	A		Last name of claimant (Entity filing proof of loss, e.g. business, etc.)
CmtAddr	380	100	A		Claimant street address
CmtCity	480	20	A		Claimant city
CmtSt	500	2	A		Claimant state
CmtZip	502	5	A		Claimant ZIP code
ClmStat	507	1	A		Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded
Litig	508	1	A		Y/N - Is claim currently in litigation?
AdjCode	509	9	A		Internal adjuster identification code **Please provide a list to explain any codes used**
NPN	518	6	A		National (adjuster) number
LossDt	524	10	D		Date loss occurred [MM/DD/YYYY]
RcvdDt	534	10	D		First notice of loss [MM/DD/YYYY]
ClmAckDt	544	10	D		Date company or its producer acknowledged the claim [MM/DD/YYYY]
DtClmFrm	554	10	D		Date claim forms sent to claimant [MM/DD/YYYY]
AppDt	564	10	D		Date of company appraisal [MM/DD/YYYY
NtcInvDt	574	10	D		Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]
DepTkn	584	1	A		Was depreciation taken? (Y/N)
DepAmt	585	11	N	2	Amount of depreciation taken
DepPdAmt	596	11	N	2	Amount of recoverable depreciation paid
DepPdDt	607	10	D		Date recoverable depreciation paid [MM/DD/YYYY]
PdClmAmt	617	11	N	2	Total amount of claim paid
ClmPay	628	50	A		Claim payee
ClmPdDt	678	10	D		Claim paid date [MM/DD/YYYY]
IntPdAmt	688	11	N	2	Amount of interest paid, if applicable
IntPdDt	699	10	D		Date interest paid [MM/DD/YYYY]
ClmDnyDt	709	10	D		Date claim was denied [MM/DD/YYYY]
ClmDenRsn	719	100	A		Reason for claim denial **Please provide a list to explain any codes used**
Subro	819	1	A		Indicate whether claim was subrogated (Y/N)
SubRecdDt	820	10	D		Date company received subrogation refund [MM/DD/YYYY]
SubAmt	830	11	N	2	Subrogation received amount

Field Name	Start	Length	Type	Decimals	Description
AmtDedRm	841	11	N	2	Amount of deductible reimbursed to insured
SubRefDt	852	10	D		Date deductible refunded to insured [MM/DD/YYYY]
EndRec	862	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

POLICY IN FORCE STANDARDIZED DATA REQUEST
Property & Casualty Line of Business
Farmowners

Contents: This file should be downloaded from company system(s) and contain one record for each property insured under a Farmowners policy issued in [applicable state] which was in force at any time during the examination period.

For multiple dwellings, non-dwelling structures, and scheduled farm property, please repeat records as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of Farmowners policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state (s) licensing information to ensure proper producer licensure.

Field Name	Start	Length	Type	Decimals	Description
CoCode	1	5	A		NAIC company code
PolPre	6	3	A		Policy prefix (**Blank if NONE**)
PolNo	9	20	A		Policy number
PolSuf	29	3	A		Policy suffix (**Blank if NONE**)
PolStTyp	32	3	A		Policy status type for the record (i.e., new or renewal) **Please provide a list to explain any codes used**
PolTyp	35	5	A		Type of policy (i.e., FO-1, FO-2, etc.) **Please provide a list to explain any codes used**
PolForm	40	10	A		Policy form number as filed with the insurance department
FormTyp	50	10	A		Basic, Broad, Specified
PrCode	60	6	A		Company internal producer, CSR, or business entity producer identification code **Please provide a list to explain any codes used**
NPN	66	6	A		National producer number
InsFirst	72	15	A		First name of the first named insured
InsMid	87	15	A		Middle name of the first named insured
InsLast	102	20	A		Last name of the first named insured
CovLmtA	122	11	N	0	Coverage A limit (Dwelling)
CovPremA	133	11	N	2	Coverage A premium amount (Dwelling)
CovLmtB	144	11	N	0	Coverage B limit (Personal property, if coverage allocated by Dwelling)
CovPremB	155	11	N	2	Coverage B premium amount (Personal property)
InsAddr	166	25	A		Dwelling street address (location)
InsCity	191	20	A		Dwelling city (location)
InsSt	211	2	A		Dwelling state (location)

Field Name	Start	Length	Type	Decimals	Description
InsZip	213	5	A		Dwelling ZIP code (location)
StrYr	218	4	A		Year the structure was built
StrTyp	222	15	A		Type of structure (i.e. frame, masonry, etc.) **Please provide a list to explain any codes used.**
StrSqFt	237	4	A		Structure square footage
ProtCl	241	3	A		Protection class (if protection class is utilized)
CovLmtC	244	11	N	0	Coverage C limit (Loss of use)
CovPremC	255	11	N	2	Coverage C premium amount (Loss of use)
CovLmtD	266	11	N	0	Coverage D limit (Other Farm Structures) (Barns, Farm Buildings, Silos)
CovPremD	277	11	N	2	Coverage D premium amount (Other Farm Structures) (Barns, Farm Buildings, Silos)
SchStr	288	64	A		List all scheduled structures not Dwellings (on separate line)
CovLmtE	352	11	N	0	Coverage E limit (Blanket Farm Personal Property)
CovPremE	363	11	N	2	Coverage E premium amount Blanket Farm Personal Property)
CovLmtF	374	11	N	0	Coverage F limit (Scheduled Farm Personal Property)
CovPremF	385	11	N	2	Coverage F premium amount (Scheduled Farm Personal Property)
SchProp	396	64	A		List all scheduled property not Dwellings or Structures (on separate line)
CovLmtG	460	11	N	0	Coverage G limit (Farm Personal Liability)
CovPremG	471	11	N	2	Coverage G premium amount (Farm Personal Liability)
RemLoc	482	64	A		List all secondary locations with no structures (on separate line)
CovLmtH	546	11	N	0	Coverage H limit (Medical payments)
CovPremH	557	11	N	2	Coverage H premium amount (Medical payments)
PolDisc	568	20	A		Policy discounts (i.e. alarm, multi policy) **If codes are used, provide a list of codes along with their meanings**
SurTyp	588	15	A		Surcharge type, if applicable **Please provide a list to explain any codes used**
SurAmt	603	11	N	2	Surcharge amount (Do not use commas or dollar signs)
PolPrem	614	11	N	2	Total policy premium amount (sum of all premium for the policy, involving all premium, fees, etc.)
EndorLst	625	20	A		List endorsements attached to the policy **Please provide a list to explain any codes used**
RateTerr	645	5	A		Code specifying rating territory (please provide list of codes)
DedTyp	650	10	A		Deductible type **If codes are used, provide a list of codes along with their meanings**
DedAmt	660	11	N	0	Deductible amount or percentage, if any
UWTier	671	25	A		Underwriting tier, if tier rating is utilized **Please provide a list to explain any codes used**
InsVal	696	11	N	2	Insurance to value amount
InsValDt	707	10	D		Date of last insurance to value completed [MM/DD/YYYY]
FeeTyp	717	20	A		Type of fees applied, if applicable **Please provide a list to explain any codes used**
FeeAmt	737	11	N	2	Amount of fee applied **Repeat field for each fee applied**

Field Name	Start	Length	Type	Decimals	Description
AppRecDt	748	10	D		Date application received [MM/DD/YYYY]
AppProDt	758	10	D		Date application processed [MM/DD/YYYY]
InceptDt	768	10	D		Inception date of the policy [MM/DD/YYYY]
EffDt	778	10	D		Policy effective date [MM/DD/YYYY]
ExpDt	788	10	D		Policy expiration date [MM/DD/YYYY]
PdDt	798	10	D		Date policy was paid to before cancellation [MM/DD/YYYY]
CanTerDt	808	10	D		Date policy cancelled/terminated [MM/DD/YYYY]
CanReqDt	818	10	D		Date cancellation requested, if applicable [MM/DD/YYYY]
CanTer	828	1	A		Who cancelled the coverage **C=Consumer or I=Insurer**
CanTerRs	829	64	A		Reason for cancellation/termination of coverage (i.e.,) **If codes are used, provide a list of codes along with their meanings**
CanTerNt	893	10	D		Date the cancellation/termination notice was mailed [MM/DD/YYYY]
PremRef	903	11	N	2	Amount of premium refunded to the insured
RfndDt	914	10	D		Date premium refund mailed [MM/DD/YYYY]
RefMthd	924	25	A		Refund method (i.e., 90%, pro rata, etc.) **If codes are used, provide a list of codes along with their meanings**
EndRec	949	1	A		End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

MCAS Blanks (D) Working Group Approved
Changes May27 and May 28, 2020 and Additional Clarifications June 24, 2020

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Line of Business: Homeowners

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

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
1-15	Does the company use Managing General Agents (MGAs)?	Yes/No
1-16	If yes, list the names of the MGAs.	Comment

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

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	Claims Comments	Comment
1-20	Underwriting Comments	Comment

Coverages

Dwelling (includes – Other Structures)
Personal Property
Liability
Medical Payments
Loss of Use

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
2-21	Number of claims open at the beginning of the period
2-22	Number of claims opened during the period
2-23	Number of claims closed during the period, with payment
2-24	Number of claims closed during the period, without payment
2-25	Number of claims open at the end of the period
2-26	Median days to final payment
2-27	Number of claims closed with payment within 0-30 days
2-28	Number of claims closed with payment within 31-60 days
2-29	Number of claims closed with payment within 61-90 days
2-30	Number of claims closed with payment within 91-180 days
2-31	Number of claims closed with payment within 181-365 days
2-32	Number of claims closed with payment beyond 365 days
2-33	Number of claims closed without payment within 0-30 days
2-34	Number of claims closed without payment within 31-60 days

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

2-35	Number of claims closed without payment within 61-90 days
2-36	Number of claims closed without payment within 91-180 days
2-37	Number of claims closed without payment within 181-365 days
2-38	Number of claims closed without payment beyond 365 days
2-39	Number of lawsuits open at beginning of the period
2-40	Number of lawsuits opened during the period
2-41	Number of lawsuits closed during the period
2-42	Number of lawsuits open at end of period
2-43	Number of lawsuits closed with consideration for the consumer.

Schedule 3––Homeowners Underwriting Activity

ID	Description
3-44	Number of dwellings which have policies in-force at the end of the period
	~~Number of policies in-force at the end of the period~~
3-45	Number of dwelling fire policies in force at the end of the period.
3-46	Number of homeowner policies in force at the end of the period.
3-47	Number of tenant/renter/condo policies in force at the end of the period.
3-48	Number of all other residential property policies in force at the end of the period.
3-49	Number of new business policies written during the period
3-50	Dollar amount of direct premium written during the period
3-51	Number of Company-Initiated non-renewals during the period
3-52	Number of cancellations for non-pay or non-sufficient funds
3-53	Number of cancellations at the insured's request
3-54	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-55	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-56	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-57	Number Of Complaints Received Directly From Any Person or Entity Other than the DOI

Property & Casualty Market Conduct Annual Statement

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.

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.

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.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

- 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 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.

Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

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:
- 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:

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

- 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.
    - 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.

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.

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

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

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Dwelling Fire ~~and Dwelling Liability~~ 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.

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 Homeowners products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

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

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.

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.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

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.

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.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

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.

MCAS Blanks (D) Working Group Approved Changes May28, 2020

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

Lines of Business: Lender-Placed Auto and Lender-Placed Homeowners

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

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 Attestors	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 provided single-interest lender-placed auto coverage?	Yes/No
1-02	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were single-interest lender-placed auto.	Comment
1-03	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed auto coverage?	Yes/No
1-04	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were dual-interest lender-placed auto.	Comment
1-05	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners hazard coverage?	Yes/No
1-06	If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were single-interest lender-placed homeowners hazard.	Percentage
1-07	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners hazard coverage?	Yes/No
1-08	If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were dual-interest lender-placed homeowners hazard.	Percentage

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

1-09	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners flood coverage?	Yes/No
1-10	If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were single-interest lender-placed homeowners flood.	Percentage
1-11	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners flood coverage?	Yes/No
1-12	If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were dual-interest lender-placed homeowners flood.	Percentage
1-13	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners wind-only coverage?	Yes/No
1-14	If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were single-interest lender-placed homeowners wind-only.	Percentage
1-15	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners wind-only coverage?	Yes/No
1-16	If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were dual-interest lender-placed homeowners wind-only.	Percentage
1-17	Were there policies-in-force during the reporting period that provided blanket vendor single interest auto (vehicle) coverage?	Yes/No
1-18	If Yes, enter the percentage of all lender-placed blanket vendor single interest auto (vehicle) coverage.	Percentage
1-19	Were there policies-in-force during the reporting period that provided blanket vendor single interest home (residential property) coverage?	Yes/No
1-20	If Yes, enter the percentage of all lender-placed blanket vendor single interest home (residential property) coverage.	Percentage

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

1-21	Was the company still actively writing policies/certificates in the state at year end?	Yes/No
1-22	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-23	If yes, add additional comments	Comment
1-24	Has this block of business or part of this block of business been sold, closed or moved to another company during the year?	Yes/No
1-25	If yes, add additional comments	Comment
1-26	How does the company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? For example: Re-open original claim/open new claim	Comment
1-27	Does the company require third parties it contracts with to forward insurance-related complaints to the company so the company may report the complaints in its complaints logs?	Yes/No
1-28	Add additional comment if desired	Comment
1-29	Does the company monitor third parties it contracts with to ensure insurance complaints are forwarded to the company?	Yes/No
1-30	Add additional comment if desired	Comment
1-31	Claims Comments	Comment (if necessary)
1-32	Underwriting Comments	Comment (if necessary)

Coverages

Single-Interest Lender-Placed Auto
Dual-Interest Lender-Placed Auto
Single-Interest Lender-Placed Homeowners Hazard
Dual-Interest Lender-Placed Homeowners Hazard
Single-Interest Lender-Placed Homeowners Flood
Dual-Interest Lender-Placed Homeowners Flood
Single-Interest Lender-Placed Homeowners Wind-Only
Dual-Interest Lender-Placed Homeowners Wind-Only
Blanket Vendor Single-Interest Auto (Vehicle)
Blanket Vendor Single-Interest Home (Residential Property)

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

Schedule 2––Lender-Placed Auto and Homeowners and Lender-Placed Blanket Vendor Single-Interest Auto and Home Claims Activity, Counts Reported by Claimant, by Coverage

Report the number of reserves/lines/features opened for each coverage part per claim.

ID	Description
2-33	Number of claims open at the beginning of the period
2-34	Number of claims opened during the period
2-35	Number of claims closed during the period, with payment
2-36	Number of claims closed during the period, without payment
2-37	Number of claims remaining open at the end of the period
2-38	Number of claims closed with payment within 0-30 days
2-39	Number of claims closed with payment within 31-60 days
2-40	Number of claims closed with payment within 61-90 days
2-41	Number of claims closed with payment within 91-180 days
2-42	Number of claims closed with payment within 181-365 days
2-43	Number of claims closed with payment beyond 365 days
2-44	Number of claims closed without payment within 0-30 days
2-45	Number of claims closed without payment within 31-60 days
2-46	Number of claims closed without payment within 61-90 days
2-47	Number of claims closed without payment within 91-180 days
2-48	Number of claims closed without payment within 181-365 days
2-49	Number of claims closed without payment beyond 365 days
2-50	Median days to final payment
2-51	Number of suits open at beginning of the period
2-52	Number of suits opened during the period
2-53	Number of suits closed during the period
2-54	Number of suits closed during the period with consideration for the borrower
2-55	Number of suits open at end of the period

Schedule 3––Lender-Placed Auto and Home Underwriting Elements

ID	Description
3-56	Number of master policies in-force at beginning of the period
3-57	Number of master policies added during the period

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

3-58	Number of master policies canceled for any reason during the period
3-59	Number of master policies in-force at the end of the period
3-60	Number of certificates in-force at the beginning of the period
3-61	Number of certificates written during the period
3-62	Number of certificates in-force at the end of the period
3-63	Number of certificates flat-cancelled during the period
3-64	Number of certificates cancelled for reasons other than flat cancellations during the
3-65	Number of flat cancellations on certificates within 45 days of placement
3-66	Number of flat cancellations on certificates within 45-90 days of placement
3-67	Number of flat cancellations on certificates after 90 days from placement
3-68	Number of individual policies in-force at the beginning of the period
3-69	Number of individual policies written during the period
3-70	Number of individual policies in-force at the end of the period
3-71	Number of individual policies cancelled for reasons other than flat cancellations during
3-72	Number of individual policies flat-cancelled during the period
3-73	Number of flat cancellations on individual policies within 45 days of placement
3-74	Number of flat cancellations on individual policies within 45-90 days of placement
3-75	Number of flat cancellations on individual policies after 90 days from placement
3-76	Average gross placement rate during period
3-77	Dollar amount of gross written premium during the period
3-78	Dollar amount of net written premium during the period
3-79	Net written premium during period for policies/certificates for which no separate
3-80	Dollar amount of premium earned during the period
3-81	Dollars of claims paid during the period
3-82	Dollars of claims incurred during the period
3-83	Number of complaints received directly from the DOI
3-84	Number of complaints received directly from any person or entity other than the DOI

Schedule 3––Blanket Vendor Single-Interest Auto and Home Underwriting Elements

ID	Description
3-54	Number of master policies in-force at beginning of the period
3-55	Number of master policies added during the period

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

3-56	Number of master policies canceled for any reason during the period
3-57	Number of master policies in-force at the end of the period
3-75	Dollar amount of gross written premium during the period
3-76	Dollar amount of net written premium during the period
3-77	Net written premium during period for policies/certificates for which no separate charge is made to the borrower
3-78	Dollar amount of premium earned during the period
3-79	Dollar of claims paid during the period
3-80	Dollars of claims incurred during the period
3-81	Number of complaints received directly from the DOI
3-82	Number of complaints received directly from any person or entity other than the DOI

Participation Requirements: All companies licensed and reporting at least $50,000 of lender-placed auto, $50,000 of lender-placed homeowners (hazard, wind-only, and flood collectively), or $50,000 of blanket vendor single-interest auto and home gross premium within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Definitions:

Lender-placed insurance has the same meaning as "Creditor-placed insurance" to be reported in the Credit Insurance Experience Exhibit (CIEE) of the Statutory Annual Statement. Lender-placed insurance means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to the property as a result of fire, theft, collision or other risk of loss that would either impair a creditor's interest or adversely affect the value of collateral.

Except for data element "Net premium written during period for policies/certificates for which no separate charge is made to the borrower," report experience for lender-placed insurance products for which a separate charge is made to the borrower regardless of whether the charge to the borrower is made at loan origination, periodically while the loan is outstanding or following issuance of coverage under the master policy.

Lender-placed auto has the same meaning as "creditor-placed auto" to be reported in the CIEE. Lender-placed auto means lender-placed insurance on autos, boats or other vehicles.

Lender-placed homeowners has the same means as "creditor-placed homeowners" to be reported in the CIEE. Lender-placed homeowners means lender-placed insurance on homes, mobile homes and other real estate.

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 CIEE. 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.

Lender-placed homeowners hazard means that portion of lender-placed homeowners required to be reported in the CIEE covering perils other than flood or wind-only (in those states in which insurers may exclude wind coverage).

Lender-placed homeowners flood means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of flood only.

Lender-placed wind-only means that portion of lender-placed homeowners required to be reported in the CIEE covering the peril of wind only.

Lender-placed blanket vendor means that portion of lender-placed

Single-interest means insurance that protects only the creditor's interest in the collateral securing the debtor's credit.

Dual-interest means insurance that protects the creditor's and the debtor's interest in the collateral securing the debtor's credit transaction. Dual-interest includes insurance commonly referred to as limited dual-interest.

Blanket Vendor Single-Interest (VSI), for purposes of reporting experience in this Lender-Placed MCAS, means coverage issued to a lender or servicer to protect a lender's interest and which:

- Is provided through a blanket policy covering eligible collateral securing loans in the lender/servicer's portfolio
- Premium charges to the lender/servicer are based on aggregate exposures insured as opposed to any characteristics specific to any individual vehicle or property;
- No individual certificates or policies are issued to borrowers
- Has no ongoing tracking of insurance on borrower's loans; and
- If there is a charge to the borrower at loan origination, the same charge is made for all borrowers with eligible collateral regardless of insurance status.

Blanket VSI Auto experience and Blanket VSI Home experience is reported separately from Single-Interest Auto, Dual-Interest Auto, Single-Interest Home, and Dual-Interest Home.

Average Gross Placement Rate – The total number of coverages placed before cancellations during the reporting period divided by the average number of exposures during the reporting period. Average number of exposures means the average number of vehicles covered by Lender Placed Auto policies or average number of properties covered by Lender Placed Home policies during the reporting period.

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. *See also Flat Cancellation*

Certificate – Lender-placed insurance issued under a master policy for an individual vehicle or property, respectively.

Example:

- If the insurer issues 300 certificates under a lender-placed master policy or policies, report 300.

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.

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 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.

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 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, including, but not limited to, lenders or servicers

Complaints Received Directly from the Department of Insurance – All complaints:

- As identified by the DOI as a complaint.
- Related to LPI or insurance tracking.
- 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.

Dollars of Claims Incurred During Period – The total dollars incurred for claims for the particular type of lender-placed insurance during the period. Include incurred claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

Dollars of Claims Paid During Period – The total dollars paid for claims for the particular type of lender-placed insurance during the period. Include paid claim dollars only for lender-placed insurance for which a separate charge is made to the borrower.

Flat Cancellation – The coverage was cancelled effective the date of coverage with 100% refund of premium.

Gross Premium Written During Period – The total premium written before any reductions for refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

In-force – A master policy, individual policy, or certificate in effect during the reporting period.

Individual Policy – Lender-placed insurance issued for an individual vehicle or property, respectively.

Example:

- If the insurer issues 300 lender-placed policies for individual vehicles or properties (as opposed to issuing master policies to lenders or servicers), report 300.

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

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 MCAS blank:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, 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 state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

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

Master Policy – A group policy providing coverage for the vehicles or property serving as collateral for a portfolio of loans. Individual coverage, typically in the form of a certificate, is issued from the Master Policy at the direction of the lender/servicer or automatically at the point in time when the borrower's required voluntary insurance ceases to be in-force.

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

Calculation for claims with one final payment date during the reporting period:

- Date the claim was reported to the company to the date of final payment.

Calculation for claims with multiple final payment dates during the reporting period:

- Date the request for supplemental payment was received to the date of final payment (for each different final payment date.)

Exclude:

- Subrogation payments.

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

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 claim 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

Property & Casualty Market Conduct Annual Statement

Lender-Placed Data Call & Definitions

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.

Net Premium Written During Period – Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

Net Premium Written During Period for Policies/Certificates for Which No Separate Charge is Made to the Borrower – Gross premium written less refunds for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which no separate charge is made to the borrower.

Premiums Earned During Period – Earned premiums for the particular type of lender-placed insurance during the reporting period. Include premium only for lender-placed insurance for which a separate charge is made to the borrower.

MCAS Blanks (D) Working Group Approved
Changes May20 and May 21, 2020 and Additional Clarifications June 24, 2020

Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

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

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

Contact Information

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

Life and Annuity Product Types

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

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Schedule 1A––Life Interrogatories

ID	Description	Comments
1A-01	Individual Life Cash Value – Does the company have data to report for this product type?	Yes/No
1A-02	Individual Life Non-Cash Value – Does the company have data to report for this product type?	Yes/No
1A-03	Is there a reason that the reported Individual Life Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
1A-04	If yes, add additional comments	Comment
1A-05	Is there a reason that the reported Individual Life Non-Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
1A-06	If yes, add additional comments	Comment
1A-07	Does the company use third party administrators (TPAs) for purposes of supporting the individual life business being reported?	Yes/No
1A-08	If yes, provide the names and functions of each TPA.	Comment
1A-09	Individual Life Cash Value comments	Comment
1A-10	Individual Life Non-Cash Value comments	Comment

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

ID	Description
1B-11	Number of New Replacement Policies Issued During the Period (Include only the number of replacement insurance policies issued)
1B-12	Number of Internal Replacements Issued During the Period
	~~Number of External Replacements Issued During the Period~~
1B-13	Number of External Replacements of Unaffiliated Company Policies Issued During the Period.
1B-14	Number of External Replacements of Affiliated Company Policies Issued During the Period.
1B-15	Number of Policies Replaced Where Age of Insured at Replacement was <65 (Only applies to ICVP)

Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

1B-16	Number of Policies Replaced Where Age of Insured at Replacement was Age 65 and Over (Only applies to ICVP)
1B-17	Number of Policies Surrendered Under 2 Years from Policy Issue (Only applies to ICVP)
1B-18	Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue (Only applies to ICVP)
1B-19	Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue (Only applies to ICVP)
1B-20	Number of Policies Surrendered More Than 10 Years from Policy Issue (Only applies to ICVP)
1B-21	Total Number of Policies Surrendered During the Period (Only applies to ICVP)
1B-22	Number of Policies Surrendered with a Surrender Fee (Only applies to ICVP)
1B-23	Number of Policies Issued During the Period where age of insured at issue was <65 (Only applies to ICVP)
1B-24	Number of Policies Issued During the Period where age of insured at issue was Age 65 and over (Only applies to ICVP)
1B-25	Total Number of New Policies Issued by the Company During the Period
1B-26	Number of Policies Applied for During the Period
1B-27	Number of Free Looks During the Period
1B-28	Number of Policies In-Force at the End of the Period (The number of active policies that the company has outstanding at the end of the reporting period)
1B-29	Dollar Amount of Direct Premium During the Period
1B-30	Dollar Amount of Insurance Issued During the Period (Face Amount)
1B-31	Dollar Amount of Insurance In-Force at the End of the Period (Face Amount)
1B-32	Number of Complaints Received Directly from Any Person or Entity Other than the DOI
1B-33	Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the claim was received)
1B-34	Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the claim was received)
1B-35	Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the claim was received)
1B-36	Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the date of due proof of loss occurred)
1B-37	Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date of Due Proof of Loss (Include claims where the final decision was

Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

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

Schedule 2A--Annuity Interrogatories

ID	Description	Comments
	~~Individual Fixed Annuities – Does the company have data to report for this product type?~~	~~Yes/No~~
2A-01	Individual Indexed Fixed Annuities – Does the company have data to report for this product type?	Yes/No
2A-02	Individual Other Fixed Annuities – Does the company have data to report for this product type?	Yes/No
	~~Individual Variable Annuities – Does the company have data to report for this product type?~~	~~Yes/No~~
2A-03	Individual Indexed Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-04	Individual Other Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-05	Is there a reason that the reported Individual (Indexed or Other) Fixed Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)	Yes/No
2A-06	If yes, add additional comments	Comment

Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

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

Schedule 2B––~~Individual Fixed Annuity (IFA) and Individual Variable Annuity (IVA) Products~~ Individual Indexed Fixed Annuities (IIFA), Individual Other Fixed Annuities (IOFA), Individual Indexed Variable Annuities (IIVA), and Individual Other Variable Annuities (IOVA)

ID	Description
2B-13	Number of New Replacement Contracts Issued During the Period (Include only the number of replacement annuity contracts issued)
2B-14	Number of Internal Replacement Contracts Issued During the Period
	~~Number of External Replacement Contracts Issued During the Period~~
2B-15	Number of External Replacements of Unaffiliated Company Contracts Issued During the Period.
2B-16	Number of External Replacements of Affiliated Company Contracts Issued During the Period.
2B-17	Number of Contracts Replaced Where Age of Annuitant at Replacement was < 65
2B-18	Number of Contracts Replaced Where Age of Annuitant at Replacement was 65 to 80
2B-19	Number of Contracts Replaced Where Age of Annuitant at Replacement was > 80
2B-20	Number of New Immediate Contracts Issued During the Period
2B-21	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was < 65
2B-22	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
2B-23	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
2B-24	Total Number of New Deferred Contracts Issued By the Company During the Period
2B-25	Number of Contracts Surrendered Under 2 Years from Issuance
2B-26	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
2B-27	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance

Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

2B-28	Number of Contracts Surrendered Over 10 Years from Issuance
2B-29	Total Number of Contracts Surrendered During the Period
2B-30	Total Number of Contracts Surrendered with a Surrender Fee
2B-31	Number of Contracts Applied for During the Period
2B-32	Number of Free Looks During the Period
2B-33	Number of Contracts In-Force at the End of the Period (The number of active contracts that the company has outstanding at the end of the reporting period)
2B-34	Dollar Amount of Annuity Considerations During the Period
2B-35	Number of Complaints Received Directly From Any Person or Entity Other than the DOI
2B-36	Number of Lawsuits Open At the Beginning of the Period
2B-37	Number of Lawsuits Opened During the Period
2B-38	Number of Lawsuits Closed During the Period
2B-39	Number of Lawsuits Closed During the Period with Consideration for the Customer
2B-40	Number of Lawsuits Open at the End of the Period

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

Definitions:

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

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

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

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

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

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

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

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

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

Contestability Period – The period of time before a policy's incontestability clause becomes effective. During this period, a company may contest a claim based upon material misrepresentation or concealment during the policy application process. The contestability period is usually 2 years.
- Do not report claims on guaranteed issue life policies
- Do not report claims that are contested after the incontestability clause is in effect.

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

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

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

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

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

Direct Written Premium – The actual amount of direct premiums written during the reporting period and should be determined in the same manner used for the financial annual statement. Data for subject business reported by the company on the financial annual

statement should be reported for the purposes of this project regardless of any 1) reinsurance agreements or 2) arrangements to administer the business that may exist with another insurer. (See also: "Life Insurance Premium" and "Annuity Considerations")

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

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

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

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

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

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

Immediate Annuity – An annuity (either fixed or variable) that begins its payment stream to the policyholder within 12 months after a single premium is paid. Immediate annuities are included within the scope of this statement and should be reported as a new immediate contract issued when issued during the reporting period. In addition, immediate annuities still in force at the end of the period should be included as well.

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

Individual Indexed Variable Annuity – A variable annuity whose accumulation or policy value is, in whole or in part, linked to an index or indices and may offer some principal

protection. Variable indexed annuities include buffer annuities or registered index-linked annuity that offer some principal protection but do not provide a guaranty against loss of principal.

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

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

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

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

For purposes of reporting lawsuits for Life & Annuities products:

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

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

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

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

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which file a Financial Annual Statement with the NAIC.

NAIC Group Code – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of an insurance holding company.

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

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

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

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

Do not include:

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

Resisted Claim – A claim is considered resisted when it is in dispute and not resolved on the financial statement date for the reporting period. Where the company is holding up payment for sufficient evidence or where a beneficiary has made a claim and then withdraws it, such items should be considered as in the course of settlement.

Surrendered Policy/Contract – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the

withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as "surrenders" for this statement.

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

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

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

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

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

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

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

MCAS Blanks (D) Working Group Approved
Changes May27 and May 28, 2020 and Additional Clarifications June 24, 2020

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Line of Business: Private Passenger Auto

Reporting Period: January 1, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

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-standard?	Percentage

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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	Claims Comments	Comment
1-25	Underwriting Comments	Comment

Coverages

Collision
Comprehensive/Other Than Collision
Bodily Injury
Property Damage
Uninsured Motorists and Underinsured Motorists (UMBI)
Uninsured Motorists and Underinsured Motorists (UMPD)
Medical Payments
Combined Single Limits
Personal Injury Protection

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

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

(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
2-26	Number of claims open at the beginning of the period
2-27	Number of claims opened during the period
2-28	Number of claims closed during the period, with payment
2-29	Number of claims closed during the period, without payment.
2-30	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.
2-31	Number of claims remaining open at the end of the period
2-32	Median days to final payment
2-33	Number of claims closed with payment within 0-30 days
2-34	Number of claims closed with payment within 31-60 days
2-35	Number of claims closed with payment within 61-90 days
2-36	Number of claims closed with payment within 91-180 days
2-37	Number of claims closed with payment within 181-365 days
2-38	Number of claims closed with payment beyond 365 days
2-39	Number of claims closed without payment within 0-30 days
2-40	Number of claims closed without payment within 31-60 days
2-41	Number of claims closed without payment within 61-90 days
2-42	Number of claims closed without payment within 91-180 days
2-43	Number of claims closed without payment within 181-365 days
2-44	Number of claims closed without payment beyond 365 days
2-45	Number of lawsuits open at beginning of the period
2-46	Number of lawsuits opened during the period
2-47	Number of lawsuits closed during the period
2-48	Number of lawsuits open at end of period
2-49	Number of lawsuits closed with consideration for the consumer.

Schedule 3––Private Passenger Auto Underwriting

ID	Description

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

3-50	Number of autos which have policies in-force at the end of the period
3-51	Number of policies in-force at the end of the period
3-52	Number of new business policies written during the period
3-53	Dollar amount of direct premium written during the period
3-54	Number of Company-Initiated non-renewals during the period
3-55	Number of cancellations for non-pay or non-sufficient funds
3-56	Number of cancellations at the insured's request
3-57	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-58	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-59	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-60	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.

Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

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.

- 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.

Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

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 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.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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.

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.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

- **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.

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.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Date the Claim was Reported – The date an insured or claimant first reported his or her loss to either the company or insurance agent.

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.

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 Private Passenger Auto products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants,

report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;

- Report a lawsuit in the jurisdiction in which the policy or contract was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

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

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 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:

	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.

Property & Casualty Market Conduct Annual Statement
Private Passenger Auto Data Call & Definitions

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.

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:

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

- 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:

- 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.

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