NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 5/25/21

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Wednesday, May 26, 2021
2:00 – 3:00 p.m. ET / 1:00 – 2:00 p.m. CT / 12:00 – 1:00 p.m. MT / 11:00 a.m. – 12:00 p.m. PT
Thursday May 27, 2021
2:00 – 3:00 p.m. ET / 1:00 – 2:00 p.m. CT / 12:00 – 1:00 p.m. MT / 11:00 a.m. – 12:00 p.m. PT

ROLL CALL

Rebecca Rebholz, Chair	Wisconsin	Teresa Kroll	Missouri
Tate Flott, Vice Chair	Kansas	Martin Swanson	Nebraska
Maria Ailor	Arizona	Hermoliva Abejar	Nevada
Jimmy Harris/Crystal Phelps	Arkansas	Leatrice Geckler	New Mexico
Scott Woods	Florida	Guy Self	Ohio
Sarah Crittenden	Georgia	Katie Dzurec	Pennsylvania
October Nickel	Idaho	Michael Bailes/Rachel Moore	South Carolina
Erica Weyhenmeyer	Illinois	Maggie Dell	South Dakota
Lori Cunningham	Kentucky	Shelli Isiminger	Tennessee
Erica Bailey	Maryland	Shelley Wiseman	Utah
Mary Lou Moran	Massachusetts	Ned Gaines/John Haworth	Washington
Jill Huisken	Michigan	Letha Tate	West Virginia
Paul Hanson	Minnesota		

NAIC Support Staff: Teresa Cooper/Angela Hamilton

AGENDA

1.	Consider Adoption of its April 28 Minutes—*Rebecca Rebholz (WI)*	Attachment 1
2.	Consider the Draft Travel Market Conduct Annual Statement (MCAS) Data Call and Definitions—*Rebecca Rebholz (WI)*	Attachment 2
3.	Consider the Draft Short Term Limited Duration Health MCAS Data Call and Definitions —*Rebecca Rebholz (WI)*	Attachment 3
4.	Consider the Draft Homeowner and Private Passenger Auto MCAS Edits on Digital Claims—*Rebecca Rebholz (WI)*	Attachments 4 & 5
5.	Consider the Draft Life MCAS Edits for Accelerated Underwriting Reporting —*Rebecca Rebholz (WI)*	Attachment 6
6.	Consider Placement of the Lawsuit Data Elements for the Homeowner and Private Passenger Auto MCAS Lines of Business—*Rebecca Rebholz (WI)*	Attachment7
7.	Consider Edits to the Lawsuit Definition for the Following MCAS Lines of Business: Life, Annuity, Disability Income, Private Flood, Lender Placed Home and Auto, and Long-Term Care (LTC)—*Rebecca Rebholz (WI)*	Attachment 8

8. Consider the Lawsuit Definition for the Homeowner and Private Passenger Auto Lines of Business—*Rebecca Rebholz (WI)* — Attachment 9

9. Discuss Any Other Matters Brought Before the Working Group —*Rebecca Rebholz (WI)*

10. Adjournment

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Draft: 5/18/21

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 28, 2021

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 28, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Cheryl Hawley (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Dawna Kokosinski (MD); Jill Huisken (MI); Teresa Kroll (MO); Martin Swanson (NE); Leatrice Geckler (NM); Hermoliva Abejar (NV); Guy Self (OH); Katie Dzurec (PA); Rachel Moore (SC); Maggie Dell (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); Ned Gaines (WA); and Letha Tate (WV).

1. Adopted its March 23 Minutes

The Working Group met March 23 and took the following action: 1) adopted its Feb. 24 minutes; 2) heard an update on the Travel Market Conduct Annual Statement (MCAS); 3) heard an update on the Other Health MCAS; 4) heard an update on the Accelerated Underwriting and Digital Claims MCAS; 5) discussed the placement of complaint and lawsuit data elements within the Home and Auto MCAS reporting blanks; 6) discussed the MCAS lawsuit definitions; and 7) adopted a motion to add a note in the Disability Income blank clarifying that Schedule 3 is designed to only collect claims information about claims that have payment.

Mr. Flott made a motion, seconded by Ms. Kroll to adopt the Working Group's March 23 minutes (Attachment). The motion passed unanimously.

2. Heard an Update on the Travel MCAS

Ms. Rebholz noted that the Travel MCAS subject matter expert (SME) group met March 29, April 19, and April 27. She stated that the most recent draft of the data call and definitions has been sent to the SME group for a final review, with any comments to be provided by the end of this week. Depending on comments received, the draft will be approved to pass along to the Working Group, or additional discussion will take place if needed to finalize the draft.

3. Heard an Update on the Other Health MCAS

Ms. Dzurec stated that the Other Health SME group is meeting regularly, and it is close to having a draft for the Working Group to review. Currently, definitions are being finalized to ensure that they support the questions and interrogatories, then ratios will be reviewed. Ms. Dzurec stated that one of the ongoing discussions related to short-term limited-duration (STLD) is the relationship between insurers and associations. The SME group is trying to ensure that the data that will be requested is data the companies will have, since associations are their own incorporated entities. Currently, the group is on iteration 5.6, which is posted on the Working Group's web page in the "Current MCAS Blanks Discussions" if anyone wishes to review it. Ms. Dzurec stated that unlike the Health MCAS blank, cost sharing will not be in the Other Health blank.

4. Heard an Update on the Accelerated Underwriting and Digital Claims Discussions

Ms. Rebholz stated that the Accelerated Underwriting SME group met April 2, April 15, and April 20. Concerns with the definition of Accelerated Underwriting have been voiced by industry, and the SME group has had difficulty moving forward with the definition. Ms. Rebholz stated that to ensure coordination amongst committees and working groups, she met yesterday with the chair of the Market Regulation and Consumer Affairs (D) Committee and the chair of the Life Insurance and Annuities (A) Committee's Accelerated Underwriting (A) Working Group. They discussed the Working Group's need for a definition of Accelerated Underwriting for MCAS reporting purposes and also noted the June 1 deadline. Additional communication with the Accelerated Underwriting (A) Working Group will take place, and Ms. Rebholz hopes to have a definition available to review in time for the Market Conduct Annual Statement Blanks (D) Working Group to approve by the June 1 deadline.

Ms. Rebholz stated that the Digital Claims SME group met April 1, April 15, and April 21. Final drafts of the Home and Auto data call and definitions with the addition of the Digital Claims data element and definitions have been distributed to the SME group. Ms. Rebholz stated that some input was received, so the SME group is working to finalize the drafts and provide them to the Working Group for its approval in May.

5. Discussed the Placement of Complaint and Lawsuit Data Elements within the Home and Auto MCAS Reporting Blanks

Ms. Rebholz noted that attachment two in the meeting materials outlines the information for this agenda item. She stated that during its March meeting, the Working Group discussed the reporting of complaints within the Home and Auto MCAS submissions. Currently, complaints are reported within the Underwriting section of the blank, and they are reported in total only. No Working Group members have voiced interest in changing the complaint reporting for Home and Auto to report at the coverage level. Ms. Rebholz stated that the question for the Working Group is whether state insurance regulators need complaint data by coverage type to perform market analysis or are total complaint counts sufficient for analysis purposes. She stated that the options are: 1) no change, which means total Home and Auto complaint counts are sufficient for market analysis, and the complaints will continue to be reported in total within the Underwriting section of the blank; or 2) ask that Home and Auto complaints be reported by coverage, which means state insurance regulators need coverage level complaint data to perform market analysis. If option two is chosen, then the Home and Auto complaints data element will need to be moved to another section of the blank. Ms. Rebholz asked for input from Working Group members, other state insurance regulators, and interested parties, and there was no discussion. Teresa Cooper (NAIC) stated that if there was no discussion or motion on this topic, it is assumed that no change is needed. Ms. Rebholz confirmed that would be appropriate, and no change was made.

Ms. Rebholz stated that the next matter to discuss is lawsuit reporting for Home and Auto. Attachment two in the meeting materials outlined this discussion topic. Ms. Rebholz stated that the question to the Working Group is whether state insurance regulators need lawsuit counts that include non-claims-related lawsuits to perform market analysis for the Home and Auto lines of business or is it sufficient to collect only lawsuit counts that are claims-related. She outlined the options as: 1) no change, which means only claims-related lawsuit counts are needed for market analysis purposes, and Home and Auto lawsuits will continue to be reported by coverage type within the Claims section of the blank and capture lawsuit data for claims-related suits only; or 2) include non-claims-related suits, which means lawsuit counts would include non-claims-related lawsuits for market analysis purposes. She stated that option two aligns with reporting used in other MCAS lines.

Mr. Gaines stated that he supports option two because if someone is suing for an underwriting or policy cancellation issue, he would like to know about those types of lawsuits. Ms. Crittenden stated that she also supports option two. Richards L. Bates (State Farm Insurance) expressed concern about how this change would affect the lawsuit ratios. Ms. Rebholz stated that the ratios would have to be reviewed to ensure that they would still apply as intended. She stated that Home and Auto lawsuit reporting would also have to be removed from the Claims section, where it is currently located, and a determination would need to be made on whether expanded reporting would be in total or broken out by coverage type.

Mr. Gaines made a motion, seconded by Ms. Crittenden, to include non-claims-related lawsuit data in the Home and Auto MCAS blanks reporting. The motion passed unanimously.

6. Discussed the MCAS Lawsuit Definitions

Ms. Rebholz stated that there are comments in attachment three of the meeting materials for the Working Group to discuss. Each bullet under the lawsuit definition for the lines of business of Life and Annuity, Disability Income, Private Flood, Lender-Placed Home and Auto, and Long-Term Care (LTC) was reviewed. The issue raised for the first bullet was whether producers should be excluded, or clarification be added for the term "agent" and whether the term "agent" refers to a conservator or power of attorney. Ms. Rebholz stated that concern was raised that some companies may not track lawsuits against agents, so asking for that kind of reporting may not be helpful. Ms. Crittenden asked if the term "representative" would be a better term instead of "agent." Mr. Gaines stated that "representative" may be a better term. Mr. Birnbaum stated that he has concern with using the term "representative" since it is an undefined term and changing "agent" to "producer" might be better since "producer" is the broader term. He stated that if a lawsuit was filed against a company's employee, then it would be a lawsuit against the company also, so capturing that information is covered. Ms. Rebholz noted that there were comments received suggesting that another option would be to keep the definition and just add clarification to the terms in the definition. She stated that a decision on this will be considered at a later date.

Ms. Rebholz stated that the next item to review is whether the second bullet should be removed, because comments were received stating that it becomes unclear when it is combined with the first bullet. A decision on this will be reviewed at a later date, as there was no discussion suggesting the need for a change here. Ms. Rebholz stated that the third bullet question to consider is whether there should be separate reporting for arbitrations. A decision on this will be reviewed at a later date, as there was no discussion suggesting the need for a change here. Ms. Rebholz clarified that absent feedback on these bullet points, the wording will stay the same. She encouraged anyone that feels changes need to be made to share their thoughts verbally, in the chat or even after the call, if preferred.

The next bullet discussed was regarding the use of the term "complainant." The question is whether the intent was for this to refer to plaintiffs in a lawsuit rather than complainants. Mr. Gaines stated that he believes "plaintiff" would be clearer than "complainant." Ms. Kroll stated that she agrees that "plaintiff" is clearer than "complainant" regarding lawsuits. The last bullet discussed was regarding whether clarification needed to be added for what a general cause of action is. Mr. Bates stated that he has concerns with this bullet because having to basically restate a complaint in an explanatory note regarding class action lawsuits could be problematic. Ms. Rebholz stated that this is the current definition, and she was not aware of any concerns or issues companies were having in listing a general cause of action; but she noted her interest in hearing from industry representatives if there have been issues with earlier reporting in providing this information. She stated that a decision does not need to be made right now, and comments will be included for future discussion as to whether state insurance regulators find this information useful.

Ms. Cooper stated that she reviewed previous call minutes, and the comment raised on the issue regarding the first bullet was that it states, "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." The second bullet states, "include all lawsuits whether or not a hearing a proceeding before the court occurred." The comment stated that these bullets together seem unclear. Ms. Weyhenmeyer suggested removing "or its agent" from the first bullet and then making bullet two a sub-bullet to the first as a clarification. Mr. Birnbaum suggested removing the second bullet and leaving the first bullet as it currently reads. Mr. Bates stated that typically when a producer that acts on behalf of a company is sued, the company is also named in the lawsuit. He also stated that the lawsuit could be a human resources (HR) action against the producer and have nothing to do with the company, or it could be that the producer did not explain the policy terms as well as were needed, and the company may or may not be included on lawsuits like that. Ms. Nickel stated that she believes it is important to focus on what the company is involved in rather than the agent, since that could encompass a broad range of different relationships. Mr. Birnbaum stated that he believes the HR example is misplaced since an applicant for insurance, policyholder or beneficiary is unlikely to bring an action against an HR policy of an agent. He stated that if a lawsuit is brought against an agent, the company is going to know since it would have to be reported to the company. Michael Byrne (McDermott Will & Emery LLP) stated that he does not believe that was always the case under every contract of an agent to report all lawsuits against the agent if it has nothing to do with the product being sold on behalf of the insurer. Ms. Rebholz stated that after hearing the comments on this topic, some proposed draft language options will be created to review and consider on a future call. She asked that Working Group members think about what data they would like to capture here and whether or not capturing lawsuits naming agents as a defendant is necessary in the context of this reporting.

Ms. Rebholz stated that the next topic to discuss is the Lender-Placed Home and Auto MCAS lawsuit definition and reporting. The question is whether the Lender-Placed insurance should use the same reporting approved in the last agenda for Home and Auto. The issue with Lender-Placed insurance is that the approved definition aligns with the Life, Annuity, Disability Income, Private Flood and LTC definition instead of aligning with the Home and Auto definition. Ms. Rebholz stated that this does not need to be decided on today, and she asked that this question be given some thought so a decision can be made in May.

7. Discussed Other Matters

Ms. Rebholz stated that in May, the Working Group will have two meetings to allow for ample time to consider all proposals before the June 1 deadline. She stated that drafts will be posted and/or distributed for review prior to the May meetings.

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

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Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

Line of Business: Travel

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

Filing Deadline: April 30, 2023

Contact Information

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

Schedule 1 – Interrogatories

ID	Description	Comment
1-01	Were there policies/certificates in force during the reporting period that provide travel insurance coverage?	Yes/No
1-02	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-03	If yes, add additional comments	Comment
1-04	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-05	If yes, add additional comments	Comment
1-06	How does the company treat subsequent supplemental or additional payments on previously closed claims?	Comment
1-07	Additional state-specific underwriting comments (optional)	Comment
1-08	Additional state-specific claims comments (optional)	Comment
1-09	Does the company use third party administrators (TPAs) for purposes of supporting the travel insurance business being reported?	Yes/No
1-10	If yes, provide the names and functions of each TPA.	Comment
1-11	Does the company use managing general agents (MGAs) for purposes of supporting the travel insurance business being reported?	Yes/No
1-12	If yes, provide the names and functions of each MGA.	Comment
1-13	Does the company use travel administrators for purposes of supporting the travel insurance business being reported?	Yes/No
1-14	If yes, provide the names and functions of each travel administrator.	Comment
1-15	Number of Travel Retailers offering and disseminating Travel Insurance on behalf of the Company at the end of the reporting period.	Comment

Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

Coverages

Trip Cancellation
Trip Interruption
Trip Delay
Baggage Loss/Delay
Emergency Medical/Dental
Emergency Transportation/Repatriation
Other

Other Breakouts:

1) **Each coverage listed is also broken out by Domestic vs. International coverage**
2) **Emergency Medical/Dental coverage is also broken out by Primary vs. Excess/Secondary coverage**

Schedule 2—Travel Claims Activity, Counts Reported by Claimant, by Coverage

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

ID	Description
2-16	Number of claims open at the beginning of the period
2-17	Number of claims opened during the period
2-18	Number of claims closed during the period, with payment
2-19	Number of claims closed during the period, without payment
2-20	Number of claims open at the end of the period
2-21	Median days to final payment
2-22	Number of claims closed with payment within 0-30 days
2-23	Number of claims closed with payment within 31-90 days
2-24	Number of claims closed with payment beyond 90 days
2-25	Number of claims closed without payment within 0-30 days
2-26	Number of claims closed without payment within 31-90 days
2-27	Number of claims closed without payment beyond 90 days
2-28	Dollar amount of claims closed with payment

Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

Schedule 3 – Lawsuits and Complaints

ID	Description
3-29	Number of lawsuits open at the beginning of the period
3-30	Number of lawsuits opened during the period
3-31	Number of lawsuits closed during the period
3-32	Number of lawsuits open at the end of the period
3-33	Number of lawsuits closed with consideration for the consumer
3-34	Number of complaints received directly from the DOI
3-35	Number of complaints received directly from any person or entity other than the DOI

Schedule 4 – Underwriting

ID	Description
4-36	Number of individual policies in force at the beginning of the period
4-37	Number of group policies (other than blanket policies) in force at the beginning of the period
4-38	Number of blanket policies in force at the beginning of the period
4-39	Number of individuals insured under all policies at the beginning of the period
4-40	Number of individual policies and certificates from group policies cancelled by the consumer during the period
4-41	Number of individual policies and certificates from group policies expired during the period
4-42	Number of individual policies and certificates from group policies in force at end of the period
4-43	Dollar amount of direct premium written during the period for individual policies
4-44	Dollar amount of direct premium written during the period for group policies (other than blanket)
4-45	Dollar amount of direct premium written during the period for blanket policies

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. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Participation Requirements: All companies licensed and reporting any travel insurance within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Property & Casualty Market Conduct Annual Statement

Travel Insurance Data Call & Definitions

Definitions:

Travel Insurance means insurance coverage for personal risks incident to planned travel.

Include:

- Interruption or cancellation of trip or event;
- Loss of baggage or personal effects;
- Damages to accommodations or rental vehicles;
- Sickness, accident, disability or death occurring during travel;
- Emergency evacuation;
- Repatriation of remains; or
- Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Exclude:

- major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months, including for example, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

Blanket Travel Insurance means a policy of Travel Insurance issued to any Eligible Group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the Eligible Group without a separate charge to individual members of the Eligible Group.

Coverages

For the following terms, the NAIC asks that the insurer use definitions that meet industry standards. To the extent the insurer's definitions differ from industry standards, the NAIC asks that the insurer provide those definitions.

Trip Cancellation
Trip Interruption
Trip Delay
Baggage Loss/Delay
Emergency Medical / Dental
Emergency Transportation/Repatriation
Primary Coverage
Excess/Secondary Coverage

Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage.

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

Exclude:

- An event reported for "information only".
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

Claims Closed With Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. *See also "Date of Final Payment".*

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarifications:

- If a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.
- For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:

- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

Claims Closed Without Payment – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also "Date of Final Payment".

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was

made for company loss adjustment expenses.

- A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured's deductible.
- Claims closed because primary coverage was available elsewhere.

Complaints Received Directly from any Person or Entity Other than the Department of Insurance – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the 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

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

- As identified by the DOI as a complaint.
- Sent or otherwise forwarded by the DOI to the reporting company.

Date of Final Payment – The date final payment was issued to the insured/claimant.
Calculation Clarification:

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.
    - The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

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

Domestic Coverage: Coverage for travel originating and contained within the United States

including travel directly to and from mainland United States to Hawaii, Alaska and United States territories.

Group Travel Insurance means Travel Insurance issued to any Eligible Group as defined by state law.

International Coverage: Coverage for any travel other than Domestic.

Premium Written During Period – The total premium written before any reductions for refunds for travel insurance during the reporting period.

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

Lawsuit – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.
For purposes of reporting lawsuits in the MCAS blank:

- Include only lawsuits brought by an applicant for insurance or a policyholder as a plaintiff against the reporting insurer or its representative 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 plaintiffs, report the number of plaintiffs as the number of lawsuits. For example, if one lawsuit has two plaintiffs, 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 or policyholder in an amount greater than offered by the reporting company before the lawsuit was brought.

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

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

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

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

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

Exclude:

- Subrogation payments.

Calculation Clarification / Example:

- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

Median - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

	Nbr 1	**Nbr 2**	**Nbr 3**	**Nbr 4**	**Nbr 5**	**Nbr 6**	**Nbr 7**
Days to Settle	2	4	4	5	6	8	20

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

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

Median Days to Final Payment = (5 + 6)/2 = 5.5

The median should be consistent with the paid claim counts reported in the closing time intervals.

Example: A carrier reports the following closing times for paid claims.

Closing Time	**# of Claims**
< 30	22
31-60	13
61-90	18

91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the 46th claim. This claim falls into the closing time interval "61-90 days." Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

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

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

Travel Retailer means a business entity that makes, arranges or offers planned travel and may offer and disseminate Travel Insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.

Other Health (STLDI) Market Conduct Annual Statement
Data Call & Definitions

Line of Business: Other Health – Short-Term Limited Duration Insurance

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

Filing Deadline: June 30, yyyy

Contact Information

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

Schedule 1 - Interrogatories

1-01	List the states where your STLDI products are marketed	Comment
1-02	Does the company offer STLDI policies/certificates with up to a 90-day duration?	Yes/No
1-03	Does the company offer STLDI policies/certificates with 91- to 180-day duration?	Yes/No
1-04	Does the company offer STLDI policies/certificates with 181- to 364-day duration?	Yes/No
1-05	Number of STLDI forms offered to residents in this state	Comment
1-06	Number of STLDI forms offered in all states	Comment
1-07	Number of STLDI forms filed to in this state	Comment
1-08	Number of STLDI forms filed in all states	Comment
1-09	List the states where your STLDI products are filed (provide SERFF tracking number and form number, if applicable) If a company issues the product in a state that does not require a filing, please identify the product and describe the basis for not filing	Comment
1-10	How many policy forms have waiting periods that apply to the entire policy/certificate?	Number
1-11	How many policy forms have waiting periods that apply per specific benefits?	Number
1-12	Do any waiting periods exceed the policy/certificate term?	Y/N
1-13	If the answer to #12 is yes, please explain	Comment
1-14	Does the company issue STLDI products through associations? If yes, list the associations	Yes/No
1-15	If #14 is yes, list the associations	Comment
1-16	If #14 is yes, do you have a contractual relationship with each Association?	Yes/No
1-17	If #14 is yes, does the contract cover the marketing of your product?	Yes/No
1-18	If #14 is yes, does the contract cover the collection of dues and fees?	Yes/No
1-19	If #14 is yes, does the contract cover commissions?	Yes/No

Other Health (STLDI) Market Conduct Annual Statement

Data Call & Definitions

1-20	If #14 is yes, what other operational areas are covered in the contract?	Comment
1-21	Does the company issue STLDI products through trusts?	Yes/No
1-22	If #21 is yes, how many?	Comment
1-23	Does the company issue STLDI products through administrators?	Yes/No
1-24	If #23 is yes, how many?	
1-25	Does the company contract with third-party administrators for administrative services related to STLDI products?	Comment
1-26	If yes, does your delegation structure include claims related to STLDI products?	Yes/No
1-27	If yes, does your delegation structure include claims related to STLDI products?	Yes/No
1-28	If yes, does your delegation structure include complaints related to STLDI products?	Yes/No
1-29	If yes, does your delegation structure include medical underwriting related to STLDI products?	Yes/No
1-30	If yes, does your delegation structure include pricing related to STLDI products?	Yes/No
1-31	If yes, does your delegation structure include producer appointments related to STLDI products?	Yes/No
1-32	If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLDI products?	Yes/No
1-33	Does your company audit Third parties to whom you have delegated responsibilities?	Yes/No
1-34	If # 33 is yes, please provide frequency of audits	Comment
1-35	Does the company offer renewals/reissues?	Yes/No
1-36	Are any renewals/reissues subject to optional or mandatory underwriting?	Yes/No
1-37	If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue	Comment
1-38	Are there limitations on the number renewals per individual?	Yes/No
1-39	Does your company offer renewal(s) without underwriting for an additional charge?	Yes/No
1-40	If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge	Comment
1-41	Are the limitations on renewals based on state, federal, or company rules?	Yes/No
1-42	Does your company distribute its product through independent agents?	Yes/No
1-43	Does your company distribute its products through captive agents?	Yes/No
1-44	Does your company distribute its products through its employees?	Yes/No
1-45	What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)	Comment

Other Health (STLDI) Market Conduct Annual Statement
Data Call & Definitions

Products

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

Schedule 2 – Policy/Certificate Administration

2-1	Net Written Premium
2-2	Earned premiums for Reporting Year
2-3	Number of Policies/Certificates in Force at the Beginning of the Period
2-4	Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period
2-5	Number of new policy/certificate applications received during the period
2-6	Number of new policy/certificates issued during the period
2-7	Number of new policies/certificates denied during the period
2-8	Number of Covered Lives on New Policies/Certificates Issued During the Period

Other Health (STLDI) Market Conduct Annual Statement

Data Call & Definitions

2-9	Member months for policies/certificates newly issued during the period
2-10	Number of policy/certificate renewal/reissue applications received during the period
2-11	Number of policies/certificates renewed/reissued during the period
2-12	Number of policies/certificates non-renewed or denied at the option of insurer during the period
2-13	Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period
2-14	Number of renewals/reissues allowed?
2-15	Member months for policies/certificates renewed/reissued during the period
2-16	Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting
2-17	Number of Member Months of on Other Than New Policies/Certificates or Renewal/Reissued Policies/Certificates During the Period
2-18	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificateholder
2-19	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Period
2-20	Number of policies/certificates cancelled during the free look period
2-21	Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period
2-22	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period
2-23	Number of policy/certificate terminations and cancellations due to non-payment of premium
2-24	Number of Lives on Policies/Certificates Cancelled Due to Non-Payment of Premium During the Period
2-25	Number of Policies/Certificates Cancelled by Insurer for Any Reason Other Than Non-Payment of Premium During the Period
2-26	Number of Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period
2-27	Number of Lives on Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period
2-28	Number of rescissions
2-29	Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificateholder
2-30	Number of insured lives impacted on terminations and cancellations due to nonpayment
2-31	Number of insured lives impacted by rescissions
2-32	Number of Policies/Certificates in Force at the End of the Period
2-33	Number of Covered Lives on Policies/Certificates in Force at the End of the Period

Other Health (STLDI) Market Conduct Annual Statement
Data Call & Definitions

Schedule 3 – Prior Authorizations

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

Schedule 4 – Claims Administration (Including Pharmacy)

4-1	Number of Claims Pending at the Beginning of the Period
4-2	Number of claims received
4-3	Total number of claims denied, rejected or returned
4-4	Number of denied, rejected, or returned due to claims submission coding error(s)
4-5	Number of denied, rejected, or returned for lack of Prior Authorization
4-6	Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation
4-7	Number of denied, rejected, or returned as Not medically necessary
4-8	Number of denied, rejected, or returned as Subject to pre-existing condition exclusion
4-9	Number denied, rejected, or returned due to failure to provide adequate documentation
4-10	Number denied, rejected, or returned due to being within the waiting period
4-11	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
4-12	Number of denied, rejected, or returned for Out-of-Network provider
4-13	Number of Claims Pending at End of Period
4-14	Median Number of Days from Receipt of Claim to Decision for Denied Claims
4-15	Average Number of Days from Receipt of Claim to Decision for Denied Claims
4-16	Median Number of Days from Receipt of Claim to Decision for Approved Claims
4-17	Average Number of Days from Receipt of Claim to Decision for Approved Claims
4-18	Number of Claim Decisions Appeals Pending At Beginning of Period
4-19	Number of Claim Decision Appeals Received During the Period
4-20	Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period
4-21	Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period

4-22	Number of Claim Decision Appeals Rejected and Not Considered for Any Reason
4-23	Number of Claim Decision Appeals Pending at End of Period
4-24	Average Number of Days from Receipt of Appeal to Decision
4-25	Number of claims paid

Schedule 5 – Consumer Complaints and Lawsuits

5-1	Number of complaints received by Company (other than through the DOI)
5-2	Number of complaints received through DOI
5-3	Number of complaints resulting in claims reprocessing
5-4	Number of Lawsuits Open at Beginning of the Period
5-5	Number of Lawsuits Opened During the Period
5-6	Number of Lawsuits Closed During the Period
5-7	Number of Lawsuits Closed During the Period with Consideration for the Consumer
5-8	Number of Lawsuits Open at End of Period

Schedule 6 – Marketing and Sales

6-1	Number of Individual Applications Pending at the Beginning of the Period
6-2	Number of applications received
6-3	Number of Renewal/Reissue Individual Applications Received During the Period
6-4	Number of New Individual Applications Denied During the Period for Any Reason
6-5	Number of New Individual Applications Denied During the Period - Health Status or Condition
6-6	Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason
6-7	Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition
6-8	Number of New Individual Applications Approved During the Period
6-9	Number of Renewal/Reissue Individual Applications Approved During the Period
6-10	Number of Individual Applications Pending at the End of the Period
6-11	Number of applications initiated via phone
6-12	Number of applications completed via phone
6-13	Number of applications initiated face-to-face
6-14	Number of applications completed face-to-face
6-15	Number of applications initiated online (Electronically)
6-16	Number of applications completed online (Electronically)
6-17	Number of New Individual Applications initiated by Mail During the Period

Other Health (STLDI) Market Conduct Annual Statement

Data Call & Definitions

6-18	Number of New Individual Applications completed by Mail During the Period
6-19	Number of New Individual Applications initiated by Any Other Method During the Period
6-20	Number of New Individual Applications completed by Any Other Method During the Period
6-21	Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period)
6-22	Unearned Commissions returned to company on policies/certificates sold during the period?
6-23	Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period)

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

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

Other Health (STLDI) Market Conduct Annual Statement
Data Call & Definitions

General Definitions:

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

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

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

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

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

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

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

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

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

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

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

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

Other Health (STLDI) Market Conduct Annual Statement
Data Call & Definitions

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

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

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

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

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

Claim Clarifications:

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

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

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

Clarification:

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

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

Other Health (STLDI) Market Conduct Annual Statement
Data Call & Definitions

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

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

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

- 1st bullet options:
  - Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/ as a plaintiff against the reporting insurer or its producer as a defendant;
  - Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant as a plaintiff against the reporting insurer or its representative as a defendant;
  - Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant as a plaintiff against the reporting insurer as a defendant;
- Include 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 plaintiffs, report the number of plaintiffs as the number of lawsuits. For example, if one lawsuit has two plaintiffs, 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.

Schedule 6 Definitions (Marketing and Sales)

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

Other Health (STLDI) Market Conduct Annual Statement
Data Call & Definitions

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

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

Line of Business: Private Passenger Auto

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

Filing Deadline: April 30, 2023

Contact Information

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

Schedule 1—Interrogatories

ID	Description	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
1-13	If yes, how is non-standard defined?	Comment

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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

Other Breakouts:

The Collision, Comprehensive/Other Than Collision, Property Damage and Uninsured Motorists and Underinsured Motorists (UMPD) coverages are also broken out to identify Digital Claims, Digital/Traditional Hybrid Claims and Traditional/Other than Digital Claims (This applies only to claims related data elements and not to lawsuit data elements.)

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

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

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

ID	Description
2-26	Number of claims open at the beginning of the period
2-29	Number of claims opened during the period
2-30	Number of claims closed during the period, with payment
2-31	Number of claims closed during the period, without payment.
2-32	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.
2-33	Number of claims remaining open at the end of the period
2-34	Median days to final payment
2-35	Number of claims closed with payment within 0-30 days
2-36	Number of claims closed with payment within 31-60 days
2-37	Number of claims closed with payment within 61-90 days
2-38	Number of claims closed with payment within 91-180 days
2-39	Number of claims closed with payment within 181-365 days
2-40	Number of claims closed with payment beyond 365 days
2-41	Number of claims closed without payment within 0-30 days
2-42	Number of claims closed without payment within 31-60 days
2-43	Number of claims closed without payment within 61-90 days
2-44	Number of claims closed without payment within 91-180 days
2-45	Number of claims closed without payment within 181-365 days
2-46	Number of claims closed without payment beyond 365 days
2-47	Number of lawsuits open at beginning of the period
2-48	Number of lawsuits opened during the period
2-49	Number of lawsuits closed during the period
2-50	Number of lawsuits open at end of period
2-51	Number of lawsuits closed with consideration for the consumer.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Schedule 3—Private Passenger Auto Underwriting

ID	Description
3-52	Number of autos which have policies in-force at the end of the period
3-53	Number of policies in-force at the end of the period
3-54	Number of new business policies written during the period
3-55	Dollar amount of direct premium written during the period
3-56	Number of Company-Initiated non-renewals during the period
3-57	Number of cancellations for non-pay or non-sufficient funds
3-58	Number of cancellations at the insured's request
3-59	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-60	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-61	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-62	Number of complaints received directly from any person or entity other than the DOI

Definitions:

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

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

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

Report cancellations separately for:

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

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital Claims Reporting Definitions:

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

Includes the following scenarios:

- Insured has vehicle damage resulting from an insured event, takes photos of the vehicle, send photos to insurer. Insurer applies one or more automated loss settlement algorithms to photo data with no human visual inspection of the vehicle, offers the algorithm-developed value to the insured as the loss settlement and the insured accepts.
- Insured has vehicle damage resulting from an insured event, brings vehicle to auto repair shop, auto repair personnel take photos of the vehicle and send photos and no other information to insurer at request of the insured. Insurer applies one or more automated loss settlement algorithm to photo data with no human visual inspection of the vehicle, offers the algorithm-developed value to the insured as the loss settlement and the insured accepts.

Digital/Traditional Hybrid claim settlement – A claim involving loss appraisal and initial claim settlement offer utilizing digital information only with subsequent human on-site visual inspection or appraisal by the insurance company body shop, independent adjuster or any other person relied upon by the insurance company.

Includes the following scenario:

- Insured has vehicle damage resulting from an insured event, brings vehicle to auto repair shop, auto repair personnel take photos of the vehicle and send photos and no other information to insurer at request of the insured. Insurer applies loss settlement algorithm to photo data with no human visual inspection, offers the algorithm-developed value to the insured as the loss settlement. Insured does not accept the offer and

requests a revised offer. Insurer then performs a visual inspection of the vehicle to either confirm or revise the loss settlement offer.

Traditional/Other Than Digital Claims Settlement – means any claim other than a Digital Claim Settlement claim or a Hybrid claim settlement.

Includes the following scenario:

- Insured has vehicle damage resulting from an insured event, brings vehicle to auto repair shop, auto repair personnel take photos of the vehicle and send photos and no other information to insurer at request of the insured. Insurer receives the photos and asks the repair shop for cost estimate before providing a loss settlement offer.

Additional Digital Claims Settlement Guidance:

	Digital Claim Settlement	Hybrid Claim Settlement	Other Than Digital Claim Settlement
Initial Loss Settlement Offer or Claim Denial Involves No Human Inspection	YES	YES	NO
Initial Loss Settlement Offer Accepted	YES	NO	N/A
Two or More Loss Settlement Offers	NO	YES	N/A

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.

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

Line of Business: Homeowners

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

Filing Deadline: April 30, 2023

Contact Information

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

Schedule 1—Interrogatories

ID	Description	Comment
1-01	Were there policies 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
1-17	Does the company use Third Party Administrators (TPAs)?	Yes/No

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

1-18	If yes, list the names of the TPAs.	Comment
1-19	Does the company use digital claim settlement?	Yes/No
1-20	If yes, list the vendors providing third-party data and algorithms used in the digital claim settlement process.	Comment
1-21	Claims Comments	Comment
1-22	Underwriting Comments	Comment

Coverages

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

Other Breakouts:

The Dwelling and Personal Property coverages are also broken out to identify Digital Claims, Digital/Traditional Hybrid Claims and Traditional/Other than Digital Claims (This applies only to claims related data elements and not to lawsuit data elements.)

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

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

ID	Description
2-23	Number of claims open at the beginning of the period
2-24	Number of claims opened during the period
2-25	Number of claims closed during the period, with payment
2-26	Number of claims closed during the period, without payment
2-27	Number of claims open at the end of the period
2-28	Median days to final payment
2-29	Number of claims closed with payment within 0-30 days
2-30	Number of claims closed with payment within 31-60 days
2-31	Number of claims closed with payment within 61-90 days

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

2-32	Number of claims closed with payment within 91-180 days
2-33	Number of claims closed with payment within 181-365 days
2-34	Number of claims closed with payment beyond 365 days
2-35	Number of claims closed without payment within 0-30 days
2-36	Number of claims closed without payment within 31-60 days
2-36	Number of claims closed without payment within 61-90 days
2-37	Number of claims closed without payment within 91-180 days
2-38	Number of claims closed without payment within 181-365 days
2-39	Number of claims closed without payment beyond 365 days
2-40	Number of lawsuits open at beginning of the period
2-41	Number of lawsuits opened during the period
2-42	Number of lawsuits closed during the period
2-43	Number of lawsuits open at end of period
2-44	Number of lawsuits closed with consideration for the consumer.

Schedule 3—Homeowners Underwriting Activity

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

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

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

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

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

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

Coverage - Liability – Liability insurance provided under Homeowners Policies.

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

Date of Final Payment – The date final payment was issued to the insured/claimant.

Calculation Clarification:
- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment date was made during the reporting period regardless of the date of loss or when the claims was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:
- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.
    - The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

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

Digital Claims Reporting Definitions:

Digital Claim Settlement – A claim involving a loss appraisal and claim settlement utilizing digital information only with no human on-site visual inspection or appraisal of the vehicle or property by the insurance company, body shop, independent adjuster or

any other person relied upon by the insurance company. Examples of digital claim settlement include, but are not limited to, claim settlements based on photos taken by a claimant or insured, photos taken by a plane or drone, or data provided by in-vehicle or in-property sensors with no in-person inspection or appraisal by the insurance company, body shop, independent adjuster or any other person relied upon by the insurance company.

Includes the following scenario:

- Insured suffers roof damage and notifies the insurer. Insurer utilizes aerial photographs, applies one or more loss settlement algorithms to photo data with no human inspection of the roof, offers the algorithm-developed value to the insured as the loss settlement and the insured accepts the offer.

Digital/Traditional Hybrid claim settlement – A claim involving loss appraisal and initial claim settlement offer utilizing digital information only with subsequent human on-site visual inspection or appraisal by the insurance company body shop, independent adjuster or any other person relied upon by the insurance company.

Includes the following scenario:

- Insured suffers roof damage and notifies the insurer. Insurer utilizes aerial photographs, applies one or more loss settlement algorithms to photo data with no human inspection of the roof, offers the algorithm-developed value to the insured as the loss settlement. Insured does not accept, hires an engineering firm to assess the damage, forwards the information to the insurer with a request for a revised loss settlement offer.

Traditional/Other Than Digital Claims Settlement – means any claim other than a Digital Claim Settlement claim or a Hybrid claim settlement.

Includes the following scenario:

- Insured suffers roof damage, hires an engineering firm to assess the damage, includes the engineering firm's report when filing the claim with the insurer and insurer considers the engineering firm's report when developing the loss settlement offer.

Additional Digital Claims Settlement Guidance:

	Digital Claim Settlement	Hybrid Claim Settlement	Other Than Digital Claim Settlement
Initial Loss Settlement Offer or Claim Denial Involves No Human Inspection	YES	YES	NO
Initial Loss Settlement Offer Accepted	YES	NO	N/A

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Two or More Loss Settlement Offers	NO	YES	N/A

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.

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

Include:

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

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

Include:

- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

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

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

Filing Deadline: April 30, 2023

Contact Information

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

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)
IIFA	Individual Indexed Fixed Annuities
IOFA	Individual Other Fixed Annuities
IIVA	Individual Indexed Variable Annuities
IOVA	Individual Other Variable Annuities

In addition, some data elements are broken out by Accelerated Underwriting vs. Other than Accelerated Underwriting.

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Schedule 1A—Life Interrogatories

ID	Description	Comments
Interrogatories General		
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	Did the company use accelerated underwriting during the reporting period? If yes, complete the Accelerated Underwriting interrogatories.	Yes/No
Interrogatories Accelerated Underwriting		
1A-10	Did the company use accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, or 3-Both Cash Value and Non-Cash Value products	1/2/3
1A-11	Did the company utilize Application Data in its accelerated underwriting?	Yes/No
1A-12	If yes, list the data categories and sources of data associated with Application Data	Comment
1A-13	Did the company utilize Medical Data in its accelerated underwriting?	Yes/No
1A-14	If yes, list the data categories and sources of data associated with Medical Data	Comment
1A-15	Did the company utilize FCRA compliant non-medical third-party data in its accelerated underwriting?	Yes/No
1A-16	If yes, list the data categories and sources of data associated with FCRA compliant non-medical third-party data	Comment
1A-17	Did the company utilize other non-medical third-party data in its accelerated underwriting?	Yes/No

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

1A-18	If yes, list the data categories and sources of data associated with other non-medical third-party data	Comment

Interrogatories Comments

1A-19	Individual Life Cash Value comments	Comment
1A-20	Individual Life Non-Cash Value comments	Comment

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

ID	Description
1B-21	Number of New Replacement Policies Issued During the Period (Include only the number of replacement insurance policies issued)
1B-22	Number of Internal Replacements Issued During the Period
1B-23	Number of External Replacements of Unaffiliated Company Policies Issued During the Period.
1B-24	Number of External Replacements of Affiliated Company Policies Issued During the Period.
1B-25	Number of Policies Replaced Where Age of Insured at Replacement was <65 (Only applies to ICVP)
1B-26	Number of Policies Replaced Where Age of Insured at Replacement was Age 65 and Over (Only applies to ICVP)
1B-27	Number of Policies Surrendered Under 2 Years from Policy Issue (Only applies to ICVP)
1B-28	Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue (Only applies to ICVP)
1B-29	Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue (Only applies to ICVP)
1B-30	Number of Policies Surrendered More Than 10 Years from Policy Issue (Only applies to ICVP)
1B-31	Total Number of Policies Surrendered During the Period (Only applies to ICVP)
1B-32	Number of Policies Surrendered with a Surrender Fee (Only applies to ICVP)
1B-33	Number of Policies Issued During the Period where age of insured at issue was <65 (Only applies to ICVP)
1B-34	Number of Policies Issued During the Period where age of insured at issue was Age 65 and over (Only applies to ICVP)
1B-35	Number of Complaints Received Directly from Any Person or Entity Other than the DOI
1B-36	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-37	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-38	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-39	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-40	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 payment in full, and full payment was made within 31-60 days from when the date of due proof of loss occurred)
1B-41	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-42	Number of Death Claims Denied, Resisted or Compromised During the Period
1B-43	Number of Death Claims Closed with Payment During the Period, which Occurred within the Contestability Period
1B-44	Number of Death Claims Denied During the Period, which Occurred within the Contestability Period
1B-45	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-46	Number of Lawsuits Open at the Beginning of the Period
1B-47	Number of Lawsuits Opened During the Period
1B-48	Number of Lawsuits Closed During the Period
1B-49	Number of Lawsuits Closed During the Period with Consideration for the Customer
1B-50	Number of Lawsuits Open at the End of the Period

Schedule 1C—Individual Life Cash Value (ICVP) and Non-Cash Value (INCVP) Products with Accelerated Underwriting vs. Other Than Accelerated Underwriting Breakout

1C-51	Total Number of New Policies Issued by the Company During the Period
1C-52	Number of Policies Applied for During the Period
1C-53	Number of Free Looks During the Period
1C-54	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)
1C-55	Dollar Amount of Direct Premium During the Period
1C-56	Dollar Amount of Insurance Issued During the Period (Face Amount)
1C-57	Dollar Amount of Insurance In-Force at the End of the Period (Face Amount)

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Definitions:

Accelerated Underwriting – For purposes of MCAS reporting, accelerated underwriting means applying predictive modeling in the underwriting or pricing of life insurance using (in whole or in part) non-medical data obtained other than consciously provided by the applicant or policyholder. **(This definition is for MCAS reporting. In an ongoing effort to collaborate two workstreams at the NAIC, the definition will be reviewed and may be amended, as needed, upon the Accelerated Underwriting (A) Working Group's adoption of a definition of Accelerated Underwriting.)**

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.)

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

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

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.

Data utilized in accelerated underwriting algorithms:

- **Application data**: Information provided by or on behalf of the consumer in response to questions on the application for insurance, including any supplemental application forms, including medical information provided on the application. For application data, provide only the categories of data since the source of the information will be the application.
- **Medical data**: Medical information related to the consumer and collected from third parties with the authorization of the consumer, such as but not limited to health records and prescription records.
- **FCRA Compliant non-medical third-party data**: Non-medical data related to the consumer that is provided by a consumer reporting agency in a consumer report that is subject to the Fair Credit Reporting Act requirements and protections. Examples – 1) category of data is a motor vehicle report, and the source of the data is a state department of motor vehicles or a third-party vendor, 2) category of data is consumer credit information and the source of the data is Experian or TransUnion.
- **Other non-medical third-party data**: Any non-medical data not reported in the first three categories. Examples – 1) category of non-medical third-party data is social media and the source of those data is Facebook or Carpe Data, 2) category is facial analytics and the source is a video interview application used by insurer.

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.

Consider the Placement of Lawsuit Data Elements for the Homeowner and Private Passenger Auto Lines of Business:

During the MCAS Blanks Working Group April meeting it was decided to expand the definition of Lawsuits for Home and Private Passenger Auto to include non-claim related suits.

Next Step - Determine level of granularity for reporting

- Option 1 – Report all lawsuits at the coverage level *(This option seems problematic – non-claims related lawsuits do not fit well into the separate coverage types.)*
  - Leave data elements in the Claims reporting section
  - OR move data elements to a new section with reporting at the coverage level
- Option 2 – Report lawsuits in total
  - Move data elements to the underwriting reporting section
  - OR move data elements to a new section
- Option 3 – Report Claims related lawsuits in Claims section and all other lawsuits in Underwriting section
  - Leave data elements in the Claims reporting section
  - AND add data elements to the Underwriting reporting section

Consider edits for the lawsuits definition currently used for the following lines of business:
Life and Annuity, Disability Income, Private Flood, Lender Placed Home and Auto, and Long-Term Care

The edits shown below in redline reflect discussions during the April MCAS Blanks Working Group meeting and NAIC staff input.

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 (MCAS Line of Business) products:

- 1st bullet options:
  - Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its ~~agent~~ producer as a defendant;
  - Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/ beneficiary as a plaintiff against the reporting insurer or its ~~agent~~ representative as a defendant;
  - Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/ beneficiary as a plaintiff against the reporting insurer ~~or its representative/producer~~ 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~~ plaintiffs, report the number of ~~complainants~~ plaintiffs as the number of lawsuits. For example, if one lawsuit has two ~~complainants~~ plaintiffs, 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.

Consider the Lawsuit Definition for the Homeowner and Private Passenger Auto Lines of Business:

If Option 1 is selected – Additional work will need to be done to create a working definition
If Option 2 is selected – Consider using the definition approved for other MCAS lines of business.
If Option 3 is selected – Two definitions may be needed

- Reporting of Lawsuits in the Claims section – Consider using the current (2021 data year) definition of lawsuit
- Reporting of Lawsuits in the Underwriting section – Consider using the definition approved for other MCAS lines of business

The below definition is taken from the 2021 data year data call and definitions for the Homeowner and Private Passenger Auto MCAS

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

Exclude:

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

Calculation Clarification:

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

Note: Once decisions are finalized, the standard ratios will need to be reviewed by the Market Analysis Procedures (D) Working Group for relevance.