NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 4/22/22

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Thursday, April 28, 2022
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

Erica Weyhenmeyer, Chair	Illinois	Martin Swanson	Nebraska
Rebecca Rebholz, Vice Chair	Wisconsin	Hermoliva Abejar	Nevada
Maria Ailor	Arizona	Leatrice Geckler	New Mexico
Crystal Phelps/Teri Ann Mecca	Arkansas	Guy Self	Ohio
Scott Woods	Florida	Gary Jones/August Hall/	Pennsylvania
Scott Sanders/Elizabeth Nunes	Georgia	Jeffrey Arnold	
October Nickel	Idaho	Michael Bailes/Rachel Moore	South Carolina
Tate Flott	Kansas	Larry D. Deiter/Candy Holbrook	South Dakota
Lori Cunningham	Kentucky	Shelli Isiminger	Tennessee
Dawna Kokosinski	Maryland	Shelley Wiseman	Utah
Mary Lou Moran	Massachusetts	Melissa Gerachis/Will Felvey	Virginia
Jill Huisken	Michigan	John Haworth/Jason Carr	Washington
Paul Hanson	Minnesota	Letha Tate	West Virginia
Jennifer Hopper/Teresa Kroll	Missouri		

NAIC Support Staff: Teresa Cooper/Beth Bentley

AGENDA

1. Consider Adoption of its March 17 Minutes—*Erica Weyhenmeyer (IL)* — Attachment 1

2. Receive an Update on the Draft Life Market Conduct Annual Statement (MCAS) Edits on Accelerated Underwriting (AU)—*Erica Weyhenmeyer (IL)*

3. Receive an Overview of the Other Health Draft to be Considered by the Working Group—*Randy Helder (NAIC)* — Attachment 2

4. Discuss Possible Edits to the Lawsuit Definition for all MCAS Lines of Business that Contain Lawsuit Reporting—*Erica Weyhenmeyer (IL)*

5. Consider a Proposal on Lawsuit Definitions and the Placement of the Lawsuit Data Elements for the Homeowners and Private Passenger Auto (PPA) MCAS Lines of Business—*Erica Weyhenmeyer (IL)* — Attachment 3

6. Discuss Any Other Matters Brought Before the Working Group
   —*Erica Weyhenmeyer (IL)*

7. Adjournment

Draft Pending Adoption

Draft: 4/2/22

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
March 17, 2022

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 17, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Chair, Vice Chair (WI); Maria Ailor and Cheryl Hawley (AZ); Scott Woods (FL); Paula Shamburger (GA); Brenda Johnson (KS); Lori Cunningham (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Jill Huisken (MI); Teresa Kroll and Jo LeDuc (MO); Martin Swanson (NE); Guy Self (OH); Jeff Arnold (PA); Michael Bailes (SC); Tony Dorschner (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); and Jason Carr (WA).

1. Adopted its Nov. 22, 2021, Minutes

The Working Group met Nov. 22, 2021, and took the following action: 1) adopted its July 28, 2021, minutes; 2) received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU); 3) received an update on the Other Health Drafting Group; 4) received a proposal from the subject matter expert (SME) group on lawsuit definitions and placement of the lawsuit data elements for the homeowners and private passenger auto (PPA) MCAS; and 5) received a proposal from the SME group on reporting of the digital claims interrogatory question.

Ms. Rebholz made a motion, seconded by Ms. Moran, to adopt the Working Group's Nov. 22, 2021, minutes (*see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Eight*). The motion passed unanimously.

2. Received an Update on the Life MCAS Draft Edits for AU

Ms. Weyhenmeyer stated that the March 4 draft of AU in the life insurance educational paper, which was drafted by the Accelerated Underwriting (A) Working Group, was exposed for a two-week public comment period ending March 18. The draft can be found on the Accelerated Underwriting (A) Working Group's web page for anyone who would like to review it.

Ms. Weyhenmeyer stated the Accelerated Underwriting (A) Working Group is meeting March 24 in lieu of the Spring National Meeting to: 1) discuss comments received; and 2) consider adoption of the educational paper. Upon adoption, the Working Group plans forward it to the Life Insurance and Annuities (A) Committee for consideration of adoption at the Spring National Meeting. She stated if the draft paper is adopted on March 24, the Market Conduct Annual Statement Blanks (D) Working Group will be reconvening the AU SME group that worked on the life MCAS updates related to AU. The SME group will be tasked with reviewing the definition of AU adopted by the Accelerated Underwriting (A) Working Group to determine if it is appropriate for use with MCAS reporting of AU. She stated if these things happen and are completed before the Market Conduct Annual Statement Blanks (D) Working Group's meeting in April, then the AU edits will again be exposed to the Working Group along with an updated definition. Then the Working Group can consider the edits during its May meeting.

3. Received an Update on the Other Health Draft Group

Randy Helder (NAIC) stated the Other Health Drafting Group is being led by Mary Kay Rodriguez (WI) and that meetings have been taking place weekly for the last few months, with about 20 people in attendance, including state insurance regulators, consumer representatives, and industry members. He stated drafts are being posted

regularly on the Market Conduct Annual Statement Blanks (D) Working Group web page for review and that any questions can be forwarded to him.

Mr. Helder stated that the Drafting Group began its work by identifying the other health lines to be included in the blank. The other health lines agreed upon are: 1) Health - Accident Only; 2) Health - Accidental Death and Dismemberment; 3) Health - Specified Disease - Limited Benefit; 4) Health – Hospital/Other Indemnity; and 5) Health – Hospital/Surgical/Medical Expense. He stated each of these are divided into individual policies that are sold through associations and policies that are sold through employer groups. The drafting group used the adopted short-term, limited-duration (STLD) MCAS blank as a starting point for developing the data elements and definitions. It eliminated the non-relevant data points and added some data elements that are more appropriate for the other health products. He stated the data elements are divided into five sections: 1) interrogatories; 2) policy/certificate administration; 3) claims administration; 4) consumer complaints and lawsuits; and 5) marketing and sales.

Mr. Helder stated the data elements are close to conclusion and that another meeting will take place for a review of some additional definitions. The goal is for this to be completed by the end of April for the Working Group's review.

4. Adopted the Proposal for Digital Claims Interrogatories for the Homeowner and PPA MCAS Lines of Business

Ms. Weyhenmeyer stated the proposal for digital claims interrogatories for the homeowner and PPA MCAS lines of business is included in attachment two of the meeting materials. She stated this proposal was first presented to the Working Group last November, and that during last year's June 30, 2021, Working Group meeting, the Working Group voted to include an interrogatory within the home and auto MCAS blanks to capture third-party vendors providing third-party data and algorithms used in the digital claims process. The wording approved during the June 30 meeting included "and for each vendor, identify the vendor's specific role in the digital claim process." The SME group was tasked with reviewing this interrogatory and to make recommendations of how third-party vendor data should be reported.

Ms. Weyhenmeyer stated the proposal shows the requirement to identify vendor roles is removed, allowing single-element capture of names of third-party vendors, similar to the capture of names of managing general agents (MGAs) and third-party administrators (TPAs). A public comment period was allowed for review of this proposal, and no comments were received.

Ms. Rebholz made a motion, seconded by Ms. Gerachis, to adopt the proposal for the auto and home digital claims Interrogatories that will be included in the 2023 MCAS reporting, to be collected in 2024 (Attachment xx). The motion passed unanimously.

5. Discussed the Proposed Lawsuit Definitions and Placement of Lawsuit Data Elements for the Homeowners and Auto MCAS

Ms. Weyhenmeyer stated the proposal for lawsuit definitions and placement of lawsuit data elements for the homeowners and auto MCAS is included in the meeting materials. She stated this was first presented to the Working Group in November 2021 and that the materials include a description and redline version, followed by a clean version of the proposal. Ms. Weyhenmeyer stated the proposal simplifies the lawsuit reporting and its definition as much as possible. The SME group proposes the following for the home and PPA MCAS lawsuit reporting: 1) removal of the lawsuit data elements from the claims reporting section; 2) creation of a new reporting section for the lawsuit data elements; 3) reporting the lawsuit data elements by claims coverage type as has been done in the past; 4) adding reporting for "non-claim related lawsuits"; and 5) updating the definition of lawsuits to accommodate the new reporting structure

Ms. Weyhenmeyer stated the proposed definition is similar to the definition used for other MCAS lines of business, which was done for consistency. She stated a few of the simplifications to the definition could be made to the definition in other lines of business if the Working Group finds that it would be useful. In November, the SME group also proposed the addition of an interrogatory to capture comments for the newly added lawsuit section.

Lisa Brown (American Property Casualty Insurance Association—APCIA) submitted comments for review, which were also part of the meeting materials. Ms. Brown stated she participated in the SME group for this. She stated the proposed definition says: "include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer or its agent as a defendant." She stated that "agent" should be defined if it is going to be used as a term in the definition because it was unclear to many of their members if that is referring to an agent as an insurance producer or a third-party that has an agency relationship based on the definition of agency. Ms. Brown stated the definition also states: "If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits." She stated there needs to be clarification on how these should be reported as there may be multiple policies issued by multiple insurers. Ms. Brown stated they support the language proposed for arbitration, mediation, and appraisal, but ask that it be amended to exclude appraisal matters filed in a court of law and interpleader actions filed by a company. She stated that in Michigan, there seems to be a lot of suits brought by a medical provider for payment under personal injury protection (PIP) and asked if those suits would be counted since medical provider may not fall into the category of policyholder, applicant, or claimant. She also asked if a Pennsylvania writ of summons would be considered a lawsuit under this definition.

Ms. Brown stated the APCIA recognizes the need to expand collection of lawsuit data for both claims-related and non-claims related lawsuits but asks that the coverage breakout for claims-related lawsuit data be deleted and the reasons for this request. Ms. Huisken stated Michigan is not ready to decide on proposed language with the way it is written now. Ms. Brown stated their request would be that under what to exclude in the definition explanation, to exclude lawsuits brought directly by medical providers.

Mr. Arnold stated he did some research on the question raised regarding Pennsylvania and explained that a writ of summons allows someone to start a lawsuit without actually filing the complaint that would include the grounds on which the lawsuit is being filed, including specific allegations. He stated that the writ of summons just identifies the parties and that the details come later. He said he thinks waiting to include this as a lawsuit would be more appropriate when the actual complaint is filed and the details of the lawsuit are included.

Ms. LeDuc stated companies are already reporting lawsuits based on coverage type in the claims-related area and that there was a request to add all of the other types of non-claims related lawsuits. She stated companies would continue to report what they have been for lawsuits and then just add a single number for any non-claim related lawsuits, which would be the lawsuit total minus the claims related lawsuits. Ms. Brown stated companies would appreciate more time to get the programming in place to report this additional data element and that she will get more information from companies as to why more time is needed before this is collected. Ms. LeDuc and Ms. Huisken stated they believe more time is needed before the proposal on lawsuit definitions and the placement of lawsuit data elements for the homeowners and PPA MCAS is considered. Ms. Weyhenmeyer agreed and stated the SME group will reconvene. Ms. Huisken asked that information be shared regarding Michigan concerns, and Ms. Brown stated they would do that.

6. Received Guidance Regarding the New "Number of Lawsuits Closed with Consideration for the Consumer" Data Element for the Homeowner and PPA MCAS Lines of Business

Ms. Weyhenmeyer stated that the meeting materials include guidance for some of the questions that have been presented on the data element for "number of lawsuits closed with consideration for the consumer" data element

for the homeowners and PPA MCAS lines of business . She stated this is being provided to let meeting attendees know that these will be added to the MCAS frequently asked questions (FAQ) document posted on the MCAS web page. No questions or concerns were presented.

7. Discussed Other Matters

Ms. Weyhenmeyer stated the next Working Group meeting is scheduled for April 21, 2022. She stated during that meeting, a draft for the AU proposal may be exposed, which would include a new definition and a draft for the other health MCAS reporting data call and definitions. She advised that if these items are exposed, the Working Group will consider them during its May meeting.

Having no further business, the MCAS Blanks (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Spring National Meeting/Committee Meetings/Market Regulation and Consumer Affairs (D) Committee/MCAS WG/0317 Meeting

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

Line of Business: Other Health Insurance

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

Filing Deadline: month dd, 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	Are you currently marketing these products in this jurisdiction?	Yes/No
1-02	Do the products you are reporting on in response to this blank include closed or frozen blocks of business?	Yes/No
1-03	If yes, list the closed or frozen blocks of business?	Comment
1-04	Number of Other Health products offered to residents in this state	Number
1-05	For products reported to this MCAS jurisdiction, list the states where your Other Health products are filed (provide SERFF tracking 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
1-06	For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?	Yes/No
1-07	If yes, list the associations	Comment
1-08	If yes, do you have a contractual relationship with any association?	Comment
1-09	If yes, please identify which associations	Comment
1-10	If yes, does the contract allow any association to market the product?	Yes/No
1-11	If yes, please identify which associations	
1-12	If yes, does the contract allow any association to collect policy or contract premiums?	Yes/No
1-13	If yes, does the contract allow any association to collect and pay commissions?	Yes/No
1-14	If yes, please identify which associations	Comment
1-15	If yes, does the contract allow any association to handle claims?	Yes/No
1-16	if yes, please identify which associations	Comment

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

1-17	Has the company filed the associations by-laws and articles of incorporation in their state of domicile?	Yes/No
1-18	Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?	Yes/No
1-19	If yes please provide the state, and the SERFF tracking number, if applicable	Comment
1-20	Has the company filed the association by-laws and articles of incorporation in the filing state?	Yes/No
1-21	Has the company filed the certificate of insurance in the filing state, if applicable?	Yes/No
1-22	Does the company contract with third-party administrators for administrative services related to Other Health products?	Yes/No
1-23	If yes, does the company issue Other Health products through administrators/TPAs?	Yes/No
1-24	If yes, how many administrators/TPAs?	Number
1-25	List the TPAs with their respective National Producer Number (NPN)	Comment
1-26	If yes, does your company contract claims services related to Other Health products?	Yes/No
1-27	If yes, does your company contract complaints-related services related to Other Health products?	Yes/No
1-28	If yes, does your company contract medical underwriting services related to Other Health products?	Yes/No
1-29	If yes, does your company contract pricing services related to Other Health products?	Yes/No
1-30	If yes, does your company contract producer appointment services related to Other Health products?	Yes/No
1-31	If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?	Yes/No
1-32	If yes, does your company contract policyholder services related to Other Health products?	Yes/No
1-33	If yes, does your company contract premium collection services related to Other Health products?	Yes/No
1-34	Does your company audit third parties to whom you have delegated responsibilities?	Yes/No
1-35	If yes, please provide frequency of audits	Comment
1-36	Does your company distribute its product through independent agents?	Yes/No
1-37	Does your company distribute its products through captive agents?	Yes/No
1-38	Does your company distribute its products through its employees?	Yes/No
1-39	Does the company use pre-existing condition exclusions?	Yes/No
1-40	If yes, identify which products	Comment
1-41	Does the company contract with agents to collect premium or bind coverage on behalf of the company?	Yes/No

1-42	For fees that are included in reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.	
1-43	For fees not included in the reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.	
1-44	Additional state specific comments (optional)	Comment

Products

Product Identifiers	Explanation of Product Identifiers
Individual H-AO	**Accident Only. Purchased by an individual**
Individual ADD	**Accidental Death and Dismemberment. Purchased by an individual**
Individual SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased by an individual**
Individual H-H/OI	**Hospital/Other Indemnity. Purchased by an individual**
Individual H-HSME	**Hospital/Surgical/Medical Expense. Purchased by an individual**
Association H-AO	**Accident Only. Purchased through an association**
Association ADD	**Accidental Death and Dismemberment. Purchased through an association**
Association SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased through an association**
Association H-H/OI	**Hospital/Other Indemnity. Purchased through an association**
Association H-HSME	**Hospital/Surgical/Medical Expense. Purchased through an association**
Employer Group H-AO	**Accident Only. Purchased through an employer group**
Employer Group ADD	**Accidental Death and Dismemberment. Purchased through an employer group**
Employer Group SD	**Specified Disease-Limited Benefit/Critical Illness. Purchased through an employer group**
Employer Group H-H/OI	**Hospital/Other Indemnity. Purchased through an employer group**
Employer Group H-HSME	**Hospital/Surgical/Medical Expense. Purchased through an employer group**

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

Schedule 2 – Policy/Certificate Administration

2-1	Net written premium
2-2	Earned premiums for reporting year
2-3	Number of policies/certificates in force at the beginning of the period
2-4	Number of covered lives on policies/certificates in force at the beginning of the period
2-5	Number of new policy/certificate applications received during the period
2-6	Number of new policy/certificates issued during the period
2-7	Number of new policies/certificates denied during the period
2-8	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-9	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder
2-10	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the period
2-11	Number of policies/certificates cancelled during the free look period
2-12	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-13	Number of policy/certificate terminations and cancellations due to non-payment of premium
2-14	Number of covered lives on policies/certificates cancelled due to non-payment of premium during the period
2-15	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
2-16	Number of covered lives on policies/certificates cancelled by the company due to non-payment of premium during the period
2-17	Number of rescissions
2-18	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder (only answer for individual products)
2-19	Number of covered lives impacted on terminations and cancellations due to non-payment (only answer for individual products)
2-20	Number of covered lives impacted by rescissions (only answer for individual products)
2-21	Number of policies/certificates in force at the end of the period
2-22	Number of covered lives on policies/certificates in force at the end of the period

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

Schedule 3 – Claims Administration (Including Pharmacy)

3-1	Number of claims pending at the beginning of the period
3-2	Number of claims received (include non-clean claims)
3-3	Total number of claims denied, rejected or returned
3-4	Number of denied, rejected, or returned as non-covered or beyond benefit limitation
3-5	Number of denied, rejected, or returned as subject to pre-existing condition exclusion
3-6	Number denied, rejected, or returned due to failure to provide adequate documentation
3-7	Number denied, rejected, or returned due to being within the waiting period (do not answer for ADD products)
3-8	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
3-9	Number of claims pending at end of the period
3-10	Median number of days from receipt of claim to decision for denied claims
3-11	Average number of days from receipt of claim to decision for denied claims
3-12	Median number of days from receipt of claim to decision for approved claims
3-13	Average number of days from receipt of claim to decision for approved claims
3-14	Number of claims paid
3-15	Aggregate dollar amount of paid claims during the period
3-16	Number of claims where the claims payment was reduced by premium owed
3-17	Dollar amount of claims payments applied to unpaid premiums.

Schedule 4 – Consumer Complaints and Lawsuits

4-1	Number of complaints received by Company (other than through the DOI)
4-2	Number of complaints received through DOI
4-3	Number of complaints resulting in claims reprocessing
4-4	Number of lawsuits open at beginning of the period
4-5	Number of lawsuits opened during the period
4-6	Number of lawsuits closed during the period
4-7	Number of lawsuits closed during the period with consideration for the consumer
4-8	Number of lawsuits open at end of the period

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

Schedule 5 – Marketing and Sales

5-1	Number of individual applications pending at the beginning of the period
5-3	Number of applications received during the period
5-4	Number of individual applications/enrollments denied during the period for any reason
5-5	Number of individual applications/enrollments denied during the period - health status or condition
5-6	Number of individual applications/enrollments approved during the period
5-7	Number of individual applications pending at the end of the period
5-8	Number of applications received via phone (audio only) (only answer for individual products)
5-9	Number of applications received in person or via video application (e.g., Zoom, WebEx) (only answer for individual products)
5-10	Number of applications received online (electronically) (only answer for individual products)
5-11	Number of applications received by mail during the period (only answer for individual products)
5-12	Number of applications received by any other method during the period (only answer for individual products)
5-13	Commissions paid during reporting period (dollar amount of commissions incurred during the period)
5-14	Unearned commissions returned to company on policies/certificates sold during the period

Participation Requirements: All companies licensed and reporting at least $50,000 of other health insurance 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 Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group m/dd/yyyy)

General Definitions:

Other Health - Health insurance forms that are not subject to the Affordable Care Act (ACA). For this MCAS blank, they are Health-Accident Only; Health - Accidental Death and Dismemberment; Health-Specified Disease-Limited Benefit/Critical Illness; Health - Hospital/Other Indemnity; and Health - Hospital/Surgical/Medical Expense

Health-Accident Only - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability (not disability income), or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident

Health-Accidental Death and Dismemberment - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

Health-Specified Disease-Limited Benefit/Critical Illness - An insurance contract that pays benefits for the diagnosis and/or treatment of a specifically named disease, diseases, or critical illness. Benefits can be paid as expense incurred, per diem, or a principle sum.

Health-Hospital/Other Indemnity - An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred.

Health-Hospital/Surgical/Medical Expense - An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.

Association/Trust – For purposes of this MCAS blank, a non-employer group that offers benefits to its members.

Individual 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.

Group Product / Coverage - Policies issued to a trust, association, employer, or administrator for the purpose of marketing, selling, and issuing certificates to eligible members or employees, 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, employer, or administrator is situsted.

National Producer Number (NPN) - This is a specific number provided by National Insurance Producers Registry (NIPR) to individuals and most business entities that are listed in the NIPR's Producer Database (PDB).

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

Policyholder/Certificate holder – Refers to the individual or member who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association)

Policyholder Service - A company's activities relating to servicing its policyholders which incudes, but is not limited to, notice/billing, disclosures, premium refunds and coverage questions.

Schedule 2 Definitions (Policy/Certificate Administration):

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

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.

Schedule 3 Definitions (Claims Administration):

Claim – 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.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Duplicate claims should not be reported.

For the purposes of this Market Conduct Annual Statement, a "Claim" includes any such request or demand, even those with incomplete or inadequate documentation and those made by an individual not eligible or covered under the policy against which the claim is made.

Communications with an insurer that are not explicit claims as per the definition above should not be reported on this MCAS. Such communications could include general queries regarding policy provisions, potential coverage, events reported for "information only", or other communications for which a clear request or demand for payment has not been made.

If a claim is reopened, treat the reopened claim as a new and distinct claim apart from the original claim. For reopened claims, the claim determination time period is measured from the date the claim was re-opened to the date a benefit determination is made.

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

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

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

Schedules 4 Definitions (Consumer Complaints and Lawsuits):

Complaint - any written communication that expresses dissatisfaction with a specific person or entity. 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. A complaint should be reported to the state where the policyholder resides.

Include:

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

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 Other Health Insurance products:

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

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

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

Schedule 5 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. Do not include any fees or other compensation paid for outsourced services.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Draft: April 2022 - Redline

The Subject Matter Expert group proposes the following for the Home and Private Passenger Auto MCAS Lawsuit reporting:

- **Remove the Lawsuit data elements from the claims reporting section**
- **Create a new reporting section for the Lawsuit data elements**
- **Report the Lawsuit data elements by claims coverage type and add reporting for "Non-claim Related Lawsuits"**
- **Update the definition of Lawsuits to accommodate the new reporting structure**
- **Remove "or its agent" from the first bullet under "For purposes of reporting lawsuit for Homeowner / Private Passenger Auto products"**
- **Exclude interpleader actions in the second exclusion bullet**

Below for your review, you'll find:

- **A redline version of showing the Homeowner line of business Data Call and Definitions updates**
- **A clean version of the proposed updates**

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

ID	Description
~~2-39~~	~~Number of lawsuits open at beginning of the period~~
~~2-40~~	~~Number of lawsuits opened during the period~~
~~2-41~~	~~Number of lawsuits closed during the period~~
~~2-42~~	~~Number of lawsuits open at end of period~~
~~2-43~~	~~Number of lawsuits closed with consideration for the consumer.~~

Schedule 4 – Lawsuit Activity

Reporting Breakdown

Dwelling (includes – Other Structures)	Claim related lawsuits
Personal Property	
Liability	
Medical Payments	
Loss of Use	
Non-claim Related Lawsuits	Non-claim related lawsuits

Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions
Draft: April 2022 - Redline

ID	Description
4-53	Number of lawsuits open at beginning of the period
4-54	Number of lawsuits opened during the period
4-55	Number of lawsuits closed during the period
4-56	Number of lawsuits open at end of period
4-57	Number of lawsuits closed with consideration for the consumer

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.

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

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, interpleader actions, and declaratory judgment actions filed or brought by an insurer.
- Arbitrations, mediation, appraisal, or any other form of dispute resolution not brought in a court of law.

For purposes of reporting lawsuit for Homeowner / Private Passenger Auto products:
- Include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer ~~or its agent~~ as a defendant.
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- 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.
- With the exception of class action lawsuits, report a lawsuit with two or more complainants as one lawsuit.
- With the exception of class action lawsuits, report a lawsuit in the jurisdiction in which the policy was issued.
- Report claim related lawsuits broken out by coverage as outlined in the schedule.
- Report non-claim related lawsuits in aggregate as outlined in the schedule.

~~Calculation Clarification:~~
- ~~Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each / claimant / coverage combination, regardless of the number of actual suits filed.~~

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Draft: April 2022 - Redline

- ~~One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.~~
- ~~One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage.~~
- ~~Lawsuits should be reported in the state in which the claim was reported on this statement.~~
-

Treatment of ~~class action lawsuits~~Class Action Lawsuits:

- Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission state the number of class action lawsuits included in the data and the general cause of the action.

Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions
(Draft: April 2022)

Schedule 4 – Lawsuit Activity

Reporting Breakdown

Dwelling (includes – Other Structures)	Claim related lawsuits
Personal Property	
Liability	
Medical Payments	
Loss of Use	
Non-claim Related Lawsuits	Non-claim related lawsuits

ID	Description
4-53	Number of lawsuits open at beginning of the period
4-54	Number of lawsuits opened during the period
4-55	Number of lawsuits closed during the period
4-56	Number of lawsuits open at end of period
4-57	Number of lawsuits closed with consideration for the consumer

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.

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.

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, interpleader actions, and declaratory judgment actions filed or brought by an insurer.
- Arbitrations, mediation, appraisal, or any other form of dispute resolution not brought in a court of law.

For purposes of reporting lawsuit for Homeowner / Private Passenger Auto products:
- Include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer as a defendant.
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- 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.

Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions
Draft: April 2022

- With the exception of class action lawsuits, report a lawsuit with two or more complainants as one lawsuit.
- With the exception of class action lawsuits, report a lawsuit in the jurisdiction in which the policy was issued.
- Report claim related lawsuits broken out by coverage as outlined in the schedule.
- Report non-claim related lawsuits in aggregate as outlined in the schedule.

Treatment of Class Action Lawsuits:

- Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides.
- Include an explanatory note with your submission state the number of class action lawsuits included in the data and the general cause of the action.