NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: 6/21/21

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Wednesday, June 30, 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	Gary Jones/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/Beth Bentley

AGENDA

1. Consider Adoption of its May 27 and May 26 Minutes — Attachment 1, Attachment 2
   —*Rebecca Rebholz (WI)*

2. Receive an Update on the Draft Life Market Conduct Annual Statement (MCAS) Edits on Accelerated Underwriting—*Rebecca Rebholz (WI)*

3. Consider the Draft Homeowner and Private Passenger Auto MCAS Edits on Digital Claims—*Rebecca Rebholz (WI*) — Attachment 3, Attachment 4

4. Consider the Lawsuit Definitions and Placement of the Lawsuit Data Elements for the Homeowner and Private Passenger Auto MCAS Lines of Business — Attachment 5
   —*Rebecca Rebholz (WI)*

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

6. Adjournment

W:\National Meetings\2021\Summer\Cmte\D\MCAS WG\0630 Meeting\MCAS Blanks WG Agenda 0630.Docx

Draft: 6/10/21

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 27, 2021

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 27, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Maria Ailor (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Jill Huisken and Randall Gregg (MI); Paul Hanson (MN); Cynthia Amann, Jo LeDuc and Teresa Kroll (MO); Laura Arp (NE); Hermoliva Abejar (NV); Todd Oberholtzer (OH); Gary Jones and Katie Dzurec (PA); Michael Bailes and Rachel Moore (SC); Maggie Dell (SD); Bill Huddleston and Shelli Isiminger (TN); Tanji J. Northrup and Tracy Klausmeier (UT); and John Haworth and Ned Gaines (WA). Also participating was: Kim Cross (IA).

1. Discussed Digital Claims Edits to the Homeowners and Private Passenger Auto MCAS Lines of Business

Ms. Rebholz stated that the meeting materials include the pages of the data call and definitions that contain edits for review. She stated that questions were received from Missouri state insurance regulators, and those questions and answers were posted for review on the Working Group's web page. She asked if there were any follow up questions.

Ms. LeDuc asked for clarification on how the median days to pay would be calculated. She stated that the response was that they could estimate what the calculation is for median days to pay so there could be consistency in looking at how that played out from prior years, or they could request that the aggregate median be reported. Birny Birnbaum (Center for Economic Justice—CEJ) stated that companies could be directed to report the median days not only for the individual breakouts, but also for the total. Ms. LeDuc stated that this would mean a change to the proposal would need to be made. Mr. Birnbaum stated that this is correct, and he explained that a proposal could be made to amend the blank to include reporting for the median days not only for the breakouts by digital, but also for the total. Mr. Hanson asked how important it is to have the three categories for digital claims plus a separate column for the total, other than for transitional purposes. Ms. Abejar stated that she believes there would be value in having all four columns to identify trends for analysis purposes. Ms. Rebholz stated that one of the solutions would be to have columns for the three separate digital claims categories and then a fourth column for the total. Mr. Birnbaum stated that there was previous discussion about using the term "total" or the term "all," and the term "all" was settled on because in some cases, the total is not needed, but rather the aggregate, so the term "all" for that fourth column would be recommended. Mr. Haworth clarified that his understanding of the four categories being discussed here are: digital claims, digital/traditional hybrid claims, traditional/other than digital claims, and all.

Ms. Ailor made a motion, seconded by Mr. Hanson, to add a total column for median days. The motion passed unanimously.

Ms. LeDuc asked for clarification on why the time frames were chosen of 0–30 days, 31–60 days and 61–90 days for claims closed with payment. Mr. Birnbaum stated that the primary reason for the time frames is consistency that companies are familiar with, and it would not require a new data element that would require programming change. He also explained that settling within 0–30 days is acceptable. He then stated that by breaking out the digital claims time frames this way, the data is more relevant and useful for the hybrid and traditional claims because they are going to be populating the other date ranges in a more accurate fashion, and the aggregate would not be skewed by digital claims.

Ms. LeDuc stated that she asked if digital claims applied to both first- and third-party claims, and the answer was yes. She asked if references to the term "insured" used in the Digital Claims Market Conduct Annual Statement (MCAS) blank should be changed to "insured/claimant" to be consistent with other MCAS lines of business.

Mr. Haworth made a motion, seconded by Ms. Nickel, to add "insured/claimant" in the Digital Claims MCAS example language. The motion passed unanimously.

Ms. LeDuc stated that the way the digital claims definition is currently written does not outline the requirement to have an algorithm applied for it to qualify as a digital claim. She believes the definition needs to stand on its own without having to provide examples. Ms. Abejar and Mr. Haworth agreed with this. Ms. Rebholz suggested adding "run through an algorithm" to the definition after "utilizing digital information." Mr. Birnbaum suggested adding "through an algorithm" after "utilizing digital information only."

Mr. Haworth made a motion, seconded by Mr. Flott, to add "through an algorithm" after "utilizing digital information only" to the digital claim settlement definition, which is also to be added to the definition of digital/traditional hybrid claim settlement. The motion passed unanimously.

Ms. LeDuc asked for clarification on a digital/traditional hybrid claim. She stated that her understanding is that the hybrid claim would be something that started off as a digital claim, then if human intervention later happened in the claim, it would be a hybrid claim. Ms. Rebholz confirmed that this was correct. Ms. Le Duc stated that she believes some clarity needs to be provided in this definition because an adjuster may look at a file without doing an in-person inspection or in-person appraisal; it does not sound like human intervention would be restricted to inspection or appraisal, but it becomes human intervention in the adjudication of the claim. Mr. Hanson stated that where it says the insurer then performs a visual inspection of the vehicle, it is unclear if that could mean a review done electronically by looking at photos or if it means in-person inspection needs to be completed. After some additional discussion among the Working Group about the three categories of digital claims, digital/traditional hybrid claims, and traditional/other than digital claims settlements, Ms. LeDuc stated that she believes more time is needed for everyone to review the draft and provide any additional comments, especially given that some revisions were made today. Mr. Birnbaum stated that the CEJ would strongly object to that, as it would mean the Digital Claims MCAS blank would not be implemented for 2022 reporting and would be pushed off for another year. He stated that these definitions were distributed two weeks ago or more for review and for people to raise any questions. Several state insurance regulators expressed interest in having more time to review the Digital Claims MCAS blank, including Ms. Cross, Ms. Moran, Ms. Arp, Ms. Abejar, Ms. Dell and Mr. Gregg; as such, the Digital Claims MCAS blank was not adopted at this time.

2. Discussed the Draft Edits to the Life MCAS to Include Reporting for Accelerated Underwriting

Ms. Rebholz stated that the draft for edits to the Life MCAS to include reporting for accelerated underwriting is included in the meeting materials. She stated the accelerated underwriting draft is being brought before the Working Group with objection from industry to the definition of accelerated underwriting. She provided background that last year, the CEJ proposed that accelerated underwriting breakout reporting be added to the Life MCAS, and in September of last year, the Working Group voted to move forward with reviewing the proposed definitions with the intent to implement accelerated underwriting reporting. This was done to provide state insurance regulators with data related to life insurers' use of non-traditional data sources, such as facial analytics, credit scores and social media for underwriting purposes, along with algorithms for faster underwriting turnaround. Ms. Rebholz stated that this data was intended to assist state insurance regulators with understanding the use of accelerated underwriting and monitoring the growth of the use of accelerated underwriting.

Ms. Rebholz stated that the Life Insurance and Annuities (A) Committee has a working group devoted to accelerated underwriting. This Accelerated Underwriting (A) Working Group is working on a definition of accelerated underwriting for the purposes of its white paper, but it is still in draft form. The subject matter expert (SME) group tried to wait for a definition of accelerated underwriting from the Accelerated Underwriting (A) Working Group; however, the SME group was unable to adopt a definition in time for the Market Conduct Annual Statement Blanks (D) Working Group to consider it prior to the June 1 deadline. Ms. Rebholz stated that with guidance from commissioners, it was agreed that the Accelerate Underwriting (A) Working Group would move forward with a definition, and a note was added to the definition stating the following, "[t]his 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." She stated that if the accelerated underwriting edits and definitions are adopted today, that definition is subject to edits upon receipt of the Accelerated Underwriting (A) Working Group's final definition. She stated that the SME group did not reach consensus on a definition, and the edits and most recent definition posted has been moved to the Accelerated Underwriting (A) Working Group for further discussion.

Ms. Rebholz noted that since posting the final SME group draft, proposed draft definitions were received from the American Council of Life Insurers (ACLI) and Nevada. She stated that the Accelerated Underwriting (A) Working Group also has a draft definition that they are working on, and a document was posted showing all four of the draft definitions in one document for easier review.

Ms. Rebholz stated that new interrogatories were added to indicate that whether accelerated underwriting is used by the company, and if so, to provide a listing of data categories and sources used for accelerated underwriting. She stated that no new data elements are added to the draft; instead, in addition to the existing breakouts for cash value and non-cash value products, breakouts were added for accelerated underwriting and other than accelerated underwriting for those data elements where it was deemed appropriate. The data elements that include an accelerated underwriting breakout are: 1) total number of new policies issued by the company during the period; 2) number of policies applied for during the period; 3) number of free looks

during the period; 4) number of policies in-force at the end of the period; 5) dollar amount of direct premium during the period; 6) face amount of insurance issued during the period; and 7) face amount of insurance in-force at the end of the period.

Mr. Birnbaum stated that when the proposals for digital claims and accelerated underwriting were made, the motivation was consumer concerns and the work being done by the NAIC on big data and artificial intelligence (AI), specifically related to insurers' use of new data sources and algorithms to speed up or replace traditional methods of pricing, claim settlement and antifraud. He stated that the industry term for the application of big data and AI for auto and home insurance claims is digital claims or virtual claim settlement. He noted that it is not referred to as accelerated underwriting, even though as with any consumer-facing big data application, the goals are to speed up the process and improve the consumer experience, lower insurance costs, and improve profitability. He explained that accelerated underwriting is simply life insurers' application of big data and AI to underwriting to speed up the application process, improve customer experience, lower costs, and sell more products. He stated that the SME group's definition for both digital claims and accelerated underwriting have always focused on the key consumer protection aspects of any big data and AI application and the consumer outcomes resulting from the use of new data sources and the new AI technology, not the benefits the insurer hopes to achieve. He stated that for those reasons, he does not believe the other definitions proposed are suitable for the purpose of MCAS reporting, as they seek to explain accelerated underwriting from the perspective of insurers marketing their practices to state insurance regulators and the public as something new the life insurance industry has invented. He stated that the reasons insurers use accelerated underwriting is not relevant, and the definition from the SME group provides very clear guidance on which criteria determine whether something is an accelerated underwriting transaction.

Ms. Abejar stated that the definition should support solving issues regarding the consumer risk that is associated with accelerated underwriting. She asked why data sets were not included for the use of medical data provided by an applicant, the use of non-medical data provided by an applicant, and the use of medical data that is not provided by an applicant. She stated that these data sets can still be misused when there is an algorithm that is faulty or problematic. She stated that not including those data sets limits the definition. She stated that the second concern is that there is no question asking what methods, tools or systems companies are using to accelerate underwriting, because each step of the process carries a different consumer risk and probably a different regulatory approach. Mr. Birnbaum stated that the thrust of the accelerated underwriting is to focus on new data types used by insurers, and they are using those new types of data, not simply algorithms that speed up the analysis of traditional data. He provided an analogy of a property/casualty (P/C) insurance company that previously accepted accident records from a consumer in an application, now using a third-party data provider to get those reports and accident history, which speeds up a traditional underwriting process but is not introducing new types of data. He stated that regarding the second concern, the interrogatory asks for a list of vendors that provide the data or the algorithms that addresses the tools and methods used.

Ms. Rebholz stated that the SME group did not reach consensus on the definition for accelerated underwriting, and if the Market Conduct Annual Statement Blanks (D) Working Group feels there needs to be more time devoted to this with input from more state insurance regulators, it can be pushed back another year if needed. Mr. Flott stated that he believes the SME group should reconvene on this with more representatives from industry and state insurance regulators. Mr. Hanson stated his agreement with Ms. Abejar, and he believes additional time should be spent on the definition because there is a lot of information that can be obtained from the consumer and used in a manner that leads to accelerated underwriting. Mr. Huddleston, Ms. Crittenden, Ms. LeDuc, Ms. Weyhenmeyer, Mr. Gregg, Ms. Huisken, Mr. Bailes, Ms. Moran and Ms. Cross agreed that more time is needed. Ms. Cross stated that the Market Conduct Annual Statement Blanks (D) Working Group should refer to the Accelerated Underwriting (A) Working Group for a definition and not make this determination. Ms. Moran stated that she believes the Accelerated Underwriting (A) Working Group would seem to be the more appropriate working group to develop the definition.

Brendan Bridgeland (Center for Insurance Research—CIR) stated that he strongly supports Mr. Birnbaum's recommendation, and he urged adoption of the proposed accelerated underwriting definition.

3. Adopted the Definition of Lawsuit

Ms. Rebholz stated that the decision was made by the Market Conduct Annual Statement Blanks (D) Working Group in April to expand the definition of lawsuits for home and auto to include non-claim related lawsuits. She stated that there are three options to consider in determining the level of granularity for reporting. She stated that the first option is to report all lawsuits at the coverage level, and it has been noted that this could be problematic since non-claims related lawsuits do not fit well into the separate coverage types. She stated that the data elements could be left in the claims reporting section, or they could be moved to a new section with reporting at that coverage level. The second option is to report lawsuits in total, either in the

underwriting section or in a new section. The third option is to report claims related lawsuits in the claims section and all other lawsuits in the underwriting section.

Ms. Rebholz asked if it would be an issue for the lawsuit language to go back to what it had been. Teresa Cooper (NAIC) stated that since the Working Group voted to expand the reporting to include non-claims related lawsuits, waiting could be an issue. She stated that it is critical to determine a lawsuit definition for the Travel and Short-Term Limited-Duration (STLD) lines of business that were recently adopted to move forward. Mr. Birnbaum suggested using the current definitions that were most recently developed for the other MCAS lines of business (Life and Annuity, Disability Income, Private Flood, Lender-Placed, Home and Auto, and Long-Term Care [LTC]), as they were vetted and straightforward. Ms. Cooper asked if Mr. Birnbaum is referring to the lawsuit definition on page 45 of the meeting materials. Mr. Birnbaum confirmed that he is and stated that the difference between agent or producer is editorial in nature, and clarification changes could be made if needed, since they would not be substantive between now and when the Market Regulation and Consumer Affairs (D) Committee considers this. Ms. Rebholz stated that if the current language is accepted, making an edit where it was previously suggested for "claimant/beneficiary" may be warranted. Ms. Crittenden asked if this is regarding option two. Ms. Cooper explained that the conversation switched from discussing Home and Auto to discussing Travel and STLD, and the question now is whether the lawsuit definition outlined on page 45 of the meeting materials, with the minor edit for "claimant/beneficiary," should be accepted for the Travel and STLD MCAS lines of business.

Ms. Crittenden made a motion, seconded by Ms. Phelps, to adopt the definition for lawsuit as outlined on page 45 of the meeting materials, with the "claimant/beneficiary" language to be added. The motion passed unanimously.

Ms. Rebholz stated that this adopted definition of lawsuit will apply to the recently adopted Travel and STLD MCAS blanks.

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

W:\National Meetings\2021\Summer\Cmte\D\MCAS WG\0527 Meeting.docx

Draft: 6/2/21

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 26, 2021

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 26, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Cheryl Hawley and Maria Ailor (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Chris Gleason (MI); Cynthia Amann, Jo LeDuc and Teresa Kroll (MO); Martin Swanson (NE); Leatrice Geckler (NM); Hermoliva Abejar (NV); Guy Self and Todd Oberholtzer (OH); Jeffrey Arnold (PA); Glynda Daniels (SC); Maggie Dell (SD); Shelli Isiminger (TN); Tanji J. Northrup (UT); John Haworth and Ned Gaines (WA). Also participating was: Kim Cross (IA).

1. Adopted its April 28 Minutes

The Working Group met April 28 and took the following action: 1) adopted its March 23 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) and discussed the MCAS lawsuit definitions.

Mr. Flott made a motion, seconded by Mr. Gaines, to adopt the Working Group's April 28 minutes (Attachment). The motion passed unanimously.

2. Adopted the Travel MCAS Draft

Ms. Rebholz stated that the Travel MCAS draft was provided for review in the meeting materials. She noted that the Travel MCAS subject matter expert (SME) group has identified Trip Cancellation, Trip Interruption, Trip Delay, Baggage Loss or Delay, Emergency Medical and Dental, Emergency Transportation and Repatriation, and Other as the coverage breakouts, with additional breakouts for Domestic versus International coverages. In addition, Emergency Medical is broken out by Primary versus Excess coverage. Ms. Rebholz stated that the Claims, Underwriting, Lawsuit and Complaint data elements are similar to other MCAS lines of business; and where possible, definitions from the *Travel Insurance Model Act* (#632) were used for consistency purposes. Since travel insurance is represented by a small number of companies and the policies are generally small in amount, it was decided by the SME group to require reporting for all companies licensed and reporting for any travel insurance within any of the participating MCAS jurisdictions. Ms. Rebholz stated that the SME group requested input from the Working Group regarding the definition of "lawsuit" for the Travel MCAS. She stated that lawsuit definitions will be discussed later in the meeting, the Travel MCAS draft could be adopted now, and the definition of "suits" could be amended, as needed.

Birny Birnbaum (Center for Economic Justice—CEJ) provided two proposed additions to the Travel MCAS draft. He stated that the first suggestion is to add a coverage breakout for cancel for any reason (CFAR) coverage, and the second is to add a data element for free-look cancellations. He stated that as a result of the pandemic, travel insurers have significantly increased the inclusion of CFAR coverage, and this breakout could provide relevant information about this new and growing benefit. He explained that CFAR coverage increases the cost dramatically for a travel insurance policy, and there are a number of features associated with it that could be confusing to a consumer. He stated that the CEJ is asking that CFAR coverage be broken out for Domestic versus International, but not by Primary versus Excess. Ms. Ailor asked if the definition for "cancel by the consumer" would need to be modified to exclude those CFAR if an addition were made for CFAR coverage. Mr. Birnbaum explained that cancel for any benefit is a coverage that allows the cancellation of a trip, but it is not the same as canceling a policy; it is using your policy to get a benefit. He explained that CFAR coverage is a different coverage that allows the cancellation of the policy for any reason, and the data element in the underwriting section is about cancelling a policy.

Mr. Birnbaum stated that the second suggestion is to add a data element in the underwriting table for free-look cancellations. This suggestion is made because the current data element does not break free-look cancellations out from other consumer-initiated cancellations and free-looks are included in travel insurance policies. He stated that this greatly limits the analytic value of the cancellation data since that element would likely include many free-look cancellations, and it is important to break them out not only to track free-look outcomes, but also to improve the value of the general cancellation data element. He pointed out that other MCAS lines of business that feature free-look periods include a free-look cancellation data element, including life insurance and long-term care insurance (LTCI) lines. The CEJ suggestion includes adding the data element for

free-look cancellations during the period and the definition for "free-look" as used in the other MCAS blanks. Ms. Nickel stated that she supports the addition of the free-look cancellation data element. Michael Byrne (US Travel Insurance Association—UStiA) stated that he believes there was a vote in the SME group on this, and he asked what the result of that vote was. Ms. Rebholz stated that it was a very close vote, and she believes there was only a one vote difference that tipped the vote toward not including this data element, with three for adding it and four for not adding it.

Ms. LeDuc stated that since this is a new blank, she believes now would be a good time to consider changing the word "states" to "jurisdictions" to be more inclusive of U.S. territories that may want to participate. She also noticed that the Travel MCAS blank has three schedules related to providing data—schedules two through four—and schedule one for interrogatories does not provide a specific line option for lawsuits and complaints where the insurance company reporting could provide additional comments related to the numbers they are reporting. She believes it would be helpful since the lawsuits and complaints are not attached to something else, and not having that separate line might not spur companies to provide information that could be helpful to analysts. She also asked why the number of complaints received directly from the department of insurance (DOI) was being asked for when that data is already available elsewhere. Ms. Nickel stated that the complaints reported by the carrier and the ones received by the DOI never seem to match up, so she believes it is helpful to have this data to be able to review and compare their information. Mr. Gaines agreed and said he sees discrepancies in this area as well, and it can be a red flag regarding data integrity.

Mr. Byrne stated that the UStiA objects to adding any new items, and it supports the template as presented by the SME group. He also stated that if additional elements are going to be added, the industry would like the opportunity to comment on them. Mr. Birnbaum stated that these issues were discussed in the SME group, and there was not consensus, which is why the request to make these additions is being asked of the Working Group. Lisa Brown (American Property Casualty Insurance Association—APCIA) stated that she would like more time to get feedback from companies, and she does not support adding the free look period, which her vote reflected in the SME group. Mr. Oberholtzer stated that Mr. Birnbaum has indicated that the majority of all cancellations are during free-look periods, so that information is already known. He stated if there were a high number of cancellations that state insurance regulators were curious about, they could ask the companies to provide additional information, as needed. Mr. Oberholtzer stated that Ohio does not support breaking out additional cancellation information. He stated that he supports the Travel MCAS blank as it was presented by the SME group, and that he wants to voice the position of state insurance regulators that voted not to add the additional data element. Ms. Nickel stated that while she believes it is important to have the additional data element, and a full premium return is important to differentiate in analysis, she would defer to Mr. Oberholtzer and his recommendation given his knowledge and expertise on this subject matter. Ms. Rebholz asked for a motion regarding Ms. LeDuc's recommendations to change the term in the Travel MCAS draft from "states" to "jurisdictions" and to add the two interrogatory lines for any comments that companies might choose to add about lawsuits or complaints for the schedules to align.

Ms. Nickel made a motion, seconded by Ms. Isiminger, to edit the Travel MCAS draft to change the term from "states" to "jurisdictions" and to add the interrogatory lines for any comments that companies might choose to add about lawsuits or complaints. The motion passed unanimously. Ms. Rebholz then asked if there was a motion to adopt the Travel MCAS blank, and she explained that the motion could also include whether it includes adoption of the CEJ proposals.

Mr. Oberholtzer made a motion, seconded by Ms. Kroll, to adopt the Travel MCAS draft without adding the CEJ proposals. The motion passed with Idaho abstaining.

3. Considered the Other Health MCAS Draft

Randy Helder (NAIC) stated that the Other Health SME group has been meeting regularly and has focused on short-term limited-duration (STLD). The final draft of the Other Health STLD MCAS blank was provided in the meeting materials. This is the product of a large group of state insurance regulators, industry, and consumer representatives who put in many hours of work. He stated that when work on the Other Health MCAS blank began, the drafting group's intention was to develop a blank to cover all the other health products that were not currently part of the Health MCAS blank. It was quickly realized that to meet the June 1 deadline for adoption, the group would have to concentrate on only one product, which was STLD insurance. If this blank is adopted by the Working Group, work on the remaining other health products will take place.

Mr. Helder stated the 2019 STLD insurance data call was used as the jumping off point, but it was significantly expanded. The blank is divided into six sections: 1) interrogatories; 2) policy/certificate administration; 3) prior authorizations; 4) claims administration; 5) consumer complaints and lawsuits, and 6) marketing and sales. Mr. Helder stated that the data will be reported in nine categories: STLD insurance products sold through associations used in the state; STLD insurance products

sold through associations not used in the state; and STLD insurance products not sold through an association. Each of these categories are divided into products with a term of less than or equal to 90 days, less than or equal to 180 days, and 181–364 days. In the interrogatories, information is requested on where the products are filed and marketed; waiting periods; triggers for pre-existing exclusions; renewals/reissues and re-underwriting upon renewal; associations and fees; the use of third-party administrators (TPAs); and other distribution channels, such as independent and captive agents or employees. The policy, claims, prior authorization, and complaints sections ask the typical questions found in the other MCAS blanks, such as: policies in-force; policies/certificates issued and renewed; covered lives and member months; cancellations by reason; claims received; claims paid; days to claims decisions; and claim denials or rejections by reason. The marketing and sales section asks for information on: applications received, approved and pending; the number of new applications denied by reason and renewal apps denied by reason; and how the applications were initiated and completed (whether by phone, face-to-face, mail or on-line); and information requested about commissions paid, unearned commissions returned to the company, and other fees charged to applicants and policyholders that the company collected. It is specified in the instructions that the threshold is $50,000 in premium within the jurisdiction, and the STLD insurance products should be reported by the residency of the individual insured. Mr. Helder stated that the drafting group left the definition of "lawsuit" unfinished. He stated that the intention is to have a definition of "lawsuit", since this blank does ask for lawsuit information. It was determined that it would be best to allow the Working Group to finish its work on the definitions first and to proceed with adoption of this blank, as the data elements for lawsuits will not change regardless of the definition. The drafting group believes the Other Health STLD Insurance MCAS blank is ready for adoption.

Mr. Birnbaum stated the data element of 2-20 is for the number of policies/certificates cancelled during the free-look period, and he asked why the SME group felt this was an important data element. Mr. Helder stated that he did not recall the exact discussion, but he believes it was kept in the blank, as it was not something they wanted to exclude from the data collection.

Ms. Nickel stated that when the SME group was initially meeting, the idea was that this blank would encompass other health products, but then the focus changed to just STLD insurance. She suggested just calling this blank the STLD Insurance MCAS blank, and when work begins for the other health products, calling that the Other Health MCAS blank.

Ms. Nickel made motion, seconded by Mr. Oberholtzer, to adopt the draft as the STLD Insurance MCAS blank. Ms. Crittenden advised that in line 1-07 there is an extra "to" that needs to be deleted, in line 1-09 a period needs to be added after the parentheses, and there is a typo in line 2-26 that should be 2-28. Ms. Rebholz confirmed that those corrections would be made. Ms. Amann asked if there is a comment period after today if the blank is adopted. Mr. Helder stated that comments can be made between June 1 and Aug. 1, prior to the Market Regulation and Consumer Affairs (D) Committee reviewing this. The motion passed unanimously.

4. Considered the Digital Claims Edits to the Homeowners and PPA MCAS Lines of Business

Ms. Rebholz stated that Digital Claims edits to the Homeowners and Private Passenger Auto (PPA) lines of business need to be considered. She stated that two interrogatories related to Digital Claims were added for each line of business. For PPA, claims-related data elements for the Collision, Comprehensive/Other Than Collision, Property Damage and Uninsured Motorists and Underinsured Motorists (UMPD) coverages are broken out to identify Digital Claims, Digital/Traditional Hybrid Claims, and Traditional/Other than Digital Claims. For Homeowners reporting, the Digital claims breakouts apply to the Dwelling and Personal Property coverages. Definitions were also added for Digital Claim Settlement, Digital/Traditional Hybrid claim settlement, and Traditional/Other than Digital claim settlement.

Ms. Kroll stated that Ms. LeDuc had to step away, but she had some questions on this agenda item. The first question was why a list of vendors was being asked for in the interrogatories section. Ms. Nickel stated that digital claims are sometimes processed through drone companies; and at times, carriers just use a vendor to inspect vehicles or homes and make an analysis, so this question would provide more information on who the carrier is using to process their claims. Ms. Rebholz stated that there was some conversation in the SME group that there could be a possible correlation to specific vendors listed and high complaint numbers, which could be an indicator for state insurance regulators to take a closer look at the data. The next question asked was regarding the other breakout section and which lines are to be broken out; 2-26 through 2-46 for PPA and 2-23 through 2-39 for Homeowners. Mr. Birnbaum stated that the breakout applies to the claims-related data elements and only applies to those coverages that provide property damage benefits, so it does not apply to liability coverages. The additional questions on this agenda item will be discussed on the May 27 Working Group call.

Ms. Cross asked if the comments that are due by Aug. 1 for any proposals adopted will be reviewed by the Working Group or directly by the Market Regulation and Consumer Affairs (D) Committee. Ms. Rebholz confirmed that the comments would be reviewed by the Committee after adoption by the Working Group.

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

W:\National Meetings\2021\Summer\Cmte\D\MCAS WG\0526 Meeting.docx

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

Line of Business: Homeowners

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

Filing Deadline: April 30, 20XX

Contact Information

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

Schedule 1—Interrogatories

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

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

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

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 through an algorithm 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/claimant 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/claimant 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 through an algorithm 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/claimant 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/claimant as the loss settlement. Insured/claimant 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/claimant 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.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

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.
- 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.

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

Line of Business: Private Passenger Auto

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

Filing Deadline: April 30, 20XX

Contact Information

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

Schedule 1—Interrogatories

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

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

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. Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment. (This applies only to claims related data elements and not to lawsuit data elements.)

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

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

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

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

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

Schedule 3—Private Passenger Auto Underwriting

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

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 through an algorithm 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/claimant 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/claimant as the loss settlement and the insured/claimant accepts.
- Insured/claimant 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/claimant. 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/claimant as the loss settlement and the insured/claimant accepts.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital/Traditional Hybrid claim settlement – A claim involving loss appraisal and initial claim settlement offer utilizing digital information only through an algorithm 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/claimant 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/claimant. Insurer applies loss settlement algorithm to photo data with no human visual inspection, offers the algorithm-developed value to the insured/claimant as the loss settlement. Insured/claimant 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/claimant 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/claimant. 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

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	Claims Comments	Comment
1-20	Underwriting Comments	Comment

Coverages

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

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

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

ID	Description
2-21	Number of claims open at the beginning of the period
2-22	Number of claims opened during the period
2-23	Number of claims closed during the period, with payment
2-24	Number of claims closed during the period, without payment
2-25	Number of claims open at the end of the period
2-26	Median days to final payment
2-27	Number of claims closed with payment within 0-30 days
2-28	Number of claims closed with payment within 31-60 days
2-29	Number of claims closed with payment within 61-90 days
2-30	Number of claims closed with payment within 91-180 days
2-31	Number of claims closed with payment within 181-365 days
2-32	Number of claims closed with payment beyond 365 days
2-33	Number of claims closed without payment within 0-30 days
2-34	Number of claims closed without payment within 31-60 days
2-35	Number of claims closed without payment within 61-90 days
2-36	Number of claims closed without payment within 91-180 days

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

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

Schedule 3—Homeowners Underwriting Activity

ID	Description
3-44	Number of dwellings which have policies in-force at the end of the period
3-45	Number of dwelling fire policies in force at the end of the period.
3-46	Number of homeowner policies in force at the end of the period.
3-47	Number of tenant/renter/condo policies in force at the end of the period.
3-48	Number of all other residential property policies in force at the end of the period.
3-49	Number of new business policies written during the period
3-50	Dollar amount of direct premium written during the period
3-51	Number of Company-Initiated non-renewals during the period
3-52	Number of cancellations for non-pay or non-sufficient funds
3-53	Number of cancellations at the insured's request
3-54	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-55	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-56	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-57	Number Of Complaints Received Directly From Any Person or Entity Other than the DOI
3-58	Number of non-claim related lawsuits open at beginning of the period
3-59	Number of non-claim related lawsuits opened during the period
3-60	Number of non-claim related lawsuits closed during the period
3-61	Number of non-claim related lawsuits open at end of period
3-62	Number of non-claim related lawsuits closed with consideration for the consumer.

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

Definitions:

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

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 **claim related** lawsuits for Homeowner products:

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:

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

For purposes of reporting **non-claim related** lawsuits for Homeowner products:

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

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

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