**General:**

**Pet insurance** (Pet Model)- means a property insurance policy that provides coverage for accidents and illnesses of pets.

**Veterinarian** - an individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.

**Veterinary expenses** - the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by a veterinarian.

**Interrogatories:**

**External Review** (2022 Health) – An independent review of an adverse determination or final adverse determination.

**External (Independent) Review Organization** – An entity that conducts independent external review of adverse determinations or final adverse determination.

**Individual v. Group Policies** (2022 Disability Income)—Individual policies are marketed to, or are purchased directly by, individuals. Group policies are sold and purchased by or through group sponsors such as employers, or groups of employers. Policies that originated as group coverage, but covering individuals who are no longer members or eligible participants of the group sponsor and are not linked to some other group or trust, are to be reported as individual coverage.

**Policies / Certificates** (2022 STLD) - Refers to the coverage documents provided to individuals or families (i.e., state residents) who are enrolled in coverage

**Policyholder / Certificateholder** (2022 STLD) – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside. Policyholder is the individual when purchased in the individual market. Certificateholder is the individual when purchased through a group, which is the policyholder.

**Managing General Agent (MGA)** (State Licensing Handbook, Chapter 24, pg 91) - an insurance producer authorized by an insurance company to manage all or part of the insurer’s business in a specific geographic territory. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs.

**National Producer Number (NPN)** (2021, 2022 Other Health Data Call and Definitions, NAIC website) - 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).

**Third-Party Administrator (TPA)** (Chapter 28, pg 97, State Licensing Handbook) - an entity that directly or indirectly underwrites, collects charges or premium from, or adjusts or settles claims on residents of a state, in connection with coverage offered or provided by an insurer, unless accepted by statute.

**Underwriting Section:**

**Cancellations** (2022 Homeowners) - Includes all cancellations of the policies where the cancellation effective date is during the reporting year.

* + These should be reported every time a policy cancels during the reporting period. (i.e., if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.)

Exclude:

* Policies cancelled for ‘re-write’ purposes where there is no lapse in coverage.

**Renewal** (Pet Model)– to issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

**Number of policies renewed** (2022 Health) – Number of pet insurance policies renewed during the specified period. If the policyholder number remains the same, count the policy as renewed.

Group Policy Clarifications:

* One group policy should be reported regardless of the number of products made available to the group.
* An insured group that changes products to another product offered by the same carrier should not be reported as a termination.t renewal, if a group changes to a new product with the same carrier this should be reported as a policy renewal (not as a policy issued).

Individual Policy Clarifications:

* An individual that changes policies to another policy offered by the same carrier should be reported as a termination.
* At renewal, if an individual changes to a new product with the same carrier this should be reported as a policy issued (not as a policy renewal).

**Policyholder cancellations** (2022 Disability Income) — Policies cancelled at any point during the reporting period at the request of or in response to the policyholder. Exclude policies terminated for nonpayment of premium.

**Insurer non-renewals** (2022 Disability Income) — Non-renewals initiated by the reporting entity. A non-renewal is the termination of coverage at the end of the policy contract period.

Exclude:

* non-renewals occurring as a result of nonpayment of premium (these data are reported separately.

Right to Examine and Return the Policy (2022 Life & Annuities) – A set number of days provided in an insurance contract that allows time for the purchaser to review the contract provisions with the right to return the contract for a full refund of all monies paid. Report the number of policies or contracts that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.

**Claims Section:**

**Claim** (2022 Homeowners) - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately.

Include:

* Both first and third party claims.

Exclude:

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

**Claims Closed with payment** (2022 Homeowners)– Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. See also “Date of Final Payment”.

Exclude:

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

Clarification:

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

Calculation Clarification:

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

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment for claims closed with payment during the reporting period:

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

**Claims Closed Without Payment** (2022 Homeowners)– Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. See also “Date of Final Payment”.

Include:

* All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
* Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
* A demand for payment for which it was determined that no relevant policy was in-force at the time of the loss if a claim file was set up and the loss was investigated.
* Claims that are closed because the amount claimed is below the insured’s deductible.

Calculation Clarification:

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

**Chronic condition** (Pet Model)– a condition that can be treated or managed, but not cured.

**Congenital anomaly or disorder** (Pet Model) – a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

**Hereditary disorder** (Pet Model) – an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

**Preexisting condition** (Pet Model) – any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

(1) A veterinarian provided medical advice;

(2) The pet received previous treatment; or

(3) Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

A condition for which coverage is afforded on a policy cannot be considered a preexisting condition on any renewal of the policy.

**Median** (2022 Disability Income) - the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

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

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

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

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

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

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

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

**Closing Time# of Claims**

< 30 22

31-60 13

61-90 18

>90 16

The sum of the claims reported across each closing time interval is 69, so that the median is the 35th claim. This claim falls into the closing time interval “31-60 days.” Any reported median that falls outside of this range (i.e. less than 31 or greater than 60) will indicate a data error.

**Waiting period** (Pet Model) – the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

**Wellness program** (Pet Model) – a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. If any wellness program [insert language from state statute or regulation that defines the trigger for insurance contracts, which might include language such as: [undertakes to indemnify another], or [pays a specified amount upon determinable contingencies] or [provides coverage for a fortuitous event]], it is transacting in the business of insurance and is subject to the insurance code. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being “the business of insurance,” unless other indications of insurance also exist.

**Marketing and Sales Section:**

**Commissions** (2022 Short-Term Limited Duration) - 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.

**Lawsuit and Complaint Activity Section:**

**Complaint** (2022 Homeowners, Private Passenger Auto, Private Flood, Life & Annuities) – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

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

**Complaints Received Directly from any Person or Entity Other than the Department of Insurance** (2022 Travel, Lender-Placed Home & Auto, Disability Income) – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the jurisdiction’s insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

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

**Lawsuit** (2022 Travel, Short-Term Limited Duration, Private Flood, Long-Term Care, Life & Annuities, Property & Casualty, Disability Income) – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits in the MCAS blank:

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

**Lawsuits Closed During the Period with Consideration for the Consumer** (2022 Travel, Short-Term Limited Duration, Private Flood, Long-Term Care, Life & Annuities, Property & Casualty, Disability Income) – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant or policyholder in an amount greater than offered by the reporting company before the lawsuit was brought.