MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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Draft Pending Adoption

Draft: 8/15/25

Market Regulation and Consumer Affairs (D) Committee
Minneapolis, Minnesota
August 13, 2025

The Market Regulation and Consumer Affairs (D) Committee met in Minneapolis, MN, Aug. 13, 2025. The following Committee members participated: Dean L. Cameron, Chair (ID); Trinidad Navarro, Co-Vice Chair (DE); Holly W. Lambert, Co-Vice Chair (IN); Alan McClain represented by Crystal Phelps (AR); Peter M. Fuimaono represented by Elizabeth Perri (AS); Sharon P. Clark (KY); Robert L. Carey represented by Robert Wake (ME); Angela L. Nelson represented by Jo A. LeDuc (MO); Mike Causey represented by Jacqueline Obusek (NC); Ned Gaines (NV); Carter Lawrence represented by Bill Huddleston (TN); Cassie Brown (TX); and Allan L. McVey and Joylynn Fix (WV). Also participating were: David Buono and Shannen Logue (PA); Matthew Gendron (RI); Larry D. Deiter (SD); and Jon Pike (UT).

1. Adopted its July 25 Minutes

The Committee met July 25. During this meeting, it took the following action: 1) adopted its April 30 minutes; and 2) adopted revisions to the Market Conduct Annual Statement (MCAS) data call and definitions for private passenger auto (PPA), homeowners, lender-placed, pet, and other health lines of business.

Commissioner Clark made a motion, seconded by LeDuc, to adopt the Committee's July 25 minutes (Attachment One). The motion passed unanimously.

2. Received an Update on the Development of Examination and Licensing PBMs

Fix said the Pharmacy Benefit Management (D) Working Group has drafting groups working on examination standards and licensing and registration standards for pharmacy benefit managers (PBMs). She said the Working Group's PBM Examination Chapter Drafting Group has completed work on two sections of the draft PBM examination chapter and plans to complete the remaining sections soon after the Summer National Meeting. The examination standards address operations/governance of PBMs, engagement between PBMs and pharmacy networks, PBM relationships with clients, PBM relationships with consumers, and drug reviews/clinical issues. After the Working Group receives all the sections and completes its own review, it plans to expose the initial draft of the PBM examination chapter for a public comment period.

Fix said the Licensing and Registration Standards Drafting Group, which the Working Group established after the Spring National Meeting to develop an initial draft of the standards, recently finished its work and forwarded the draft to the full Working Group for review. She said that following the completion of this review, the Working Group will expose the draft for a public comment period.

Fix said the Working Group has also been discussing the changes that need to be made to the State Based Systems (SBS) to better handle PBM complaints. She said Susan Jennette (DE) will lead a group of volunteers to work on the project and plans to continue working with them over the next few months to develop recommendations for the full Working Group's discussion. She said she expects the work to roll into next year.

3. Discussed the Draft Cybersecurity Incident Response Framework

Director Cameron said the purpose of the cybersecurity incident response framework initiative is to assist NAIC members in assessing the significance of cybersecurity events and developing protocols for multistate coordination after a cybersecurity event has occurred. He said key concepts to be addressed include: 1) criteria to

assess the impact of a cybersecurity event to trigger the need for multistate coordination; 2) establishing the threshold impacts, such as financial impact or consumer impact, that would trigger the use of the multistate protocols; 3) procedures to quickly identify a lead state to coordinate the efforts of state departments; and 4) the respective and appropriate roles of the Cybersecurity (H) Working Group, Market Actions (D) Working Group, and Financial Analysis (E) Working Group.

Director Cameron said that at a high level, the framework would likely include this Committee working in collaboration with the Innovation, Cybersecurity, and Technology (H) Committee to conduct an initial assessment of a cybersecurity event. This assessment would include whether the primary impact is a market conduct impact, a financial impact, or both. After the assessment, the Cybersecurity (H) Working Group would maintain an advisory role, and an assessment group comprised of members of this Committee, the Innovation, Cybersecurity, and Technology (H) Committee, and the Financial Condition (E) Committee would identify an appropriate lead state based on selection criteria to be established. He said the identified lead state would then coordinate with the appropriate subject matter experts (SMEs) under this Committee and/or the Financial Condition (E) Committee to take any needed action. Throughout the response, the Cybersecurity (H) Working Group would continue to provide advisory expertise and oversight.

Buono said that a Pennsylvania domestic company recently had a cybersecurity event. The company was completely shut down and unable to electronically process underwriting, claims, and other policyholder services. He said it is important to streamline the regulatory response to not overwhelm the company that is already struggling to meet consumer demands and restore its systems. Director Cameron noted that Pennsylvania treated the response similarly to a catastrophic event, and its work should be applauded. The goal was to first protect the consumer.

Commissioner Brown asked for the materials displayed on the monitors but not included in the materials. Director Cameron said they would be distributed to the Committee members for consideration and further discussion after they are reviewed.

Erica Weyhenmeyer (National Association of Mutual Insurance Companies—NAMIC) asked if interested parties could review the cybersecurity incident response. Director Cameron said interested parties will be included, but he did not have a timeframe yet.

4. Received an Update on Marketplace Issues Discussed at the Market Actions (D) Working Group

Commissioner Lambert highlighted the importance of the work being done by the Market Actions (D) Working Group and introduced Buono as the Working Group chair. Buono said he chairs the Working Group with the assistance of vice chair Pamela O'Connell (CA). He said the Working Group is a diverse set of market regulators across all the NAIC zones. He said they want to reintroduce themselves with more transparency on their processes and share what information they can without breaching any confidentiality. He said that even though it is called the Market Actions (D) Working Group, the Working Group does more than market conduct actions. Buono said the Working Group is also a forum for the members and Collaborative Action Designees (CADs) to educate themselves on company processes and gain information on marketplace issues. Buono said the meetings are closed and the discussions kept confidential to avoid publicizing allegations that turn out to be nothing.

Buono said Director Cameron requested that every NAIC jurisdiction's chief regulator affirm who their CAD and alternate CAD are. He said that for the first time, every jurisdiction now has an appointed CAD. He said all CADs are invited to all meetings and encouraged to participate in the discussions of the Working Group.

Buono said that at this national meeting, the Working Group discussed concerns around total loss evaluations and began discussions on restarting and improving the Working Group's national analysis program.

5. Received an Update on the Development of a Playbook to Coordinate State Enforcement Actions on Unlicensed Entities

Gendron said the Market Action (D) Working Group's second charge is to facilitate interstate communication and coordinate collaborative state regulatory activities involving nontraditional market actions through the Coordinated Market Investigation Subgroup. He said he and Dan Bumpus (VA) co-chair the Subgroup. Throughout the year, the Subgroup has been looking into two companies. Based on their experiences, they believe a playbook would be valuable, and they have begun to develop a list of things for states to consider when addressing an unlicensed entity in the insurance market. They will use the current investigations to inform what would be in the playbook.

6. Discussed the Viability and Functionality of the Consumer Agent Broker Search Tool

Commissioner Navarro said that during its April 30 meeting, the Committee received three presentations. Harry Ting (Health Care Consumer Advocate) provided a presentation regarding the need for an NAIC consumer-facing tool to assist consumers in finding ethical, knowledgeable insurance producers for all lines of insurance; Gary Lisker (Financial Industry Regulatory Authority—FINRA) provided an overview of FINRA's BrokerCheck, which is a web-based tool consumers can use to find information on securities investment advisors and brokers; and Tim Mullen (NAIC) provided an overview of an initial prototype of a consumer agent/broker search tool based on the project's original scope and feedback from the SMEs.

Commissioner Navarro said presentations provided important background on the concept, and it was clear that further discussion and direction were needed by the Committee, in conjunction with receiving input from both the Antifraud (D) Task Force and Producer Licensing (D) Task Force.

Commissioner Navarro said the idea of an NAIC consumer-facing agent/broker search tool arose from the Improper Marketing of Health Insurance (D) Working Group, which reports to the Antifraud (D) Task Force. He said the Improper Marketing of Health Insurance (D) Working Group recognized that one of the best ways to protect insurance consumers from fraud is to provide consumers the ability to verify an individual's licensing status prior to purchasing an insurance product. This project also complemented the national system of producer licensing and would eliminate any reputational risk of state insurance regulators for not providing a level of transparency similar to what is provided in other sectors of the financial services industry. He noted, for example, FINRA's public portal BrokerCheck, which is a free tool to help consumers research the professional background of brokers and brokerage firms. He said the Conference of State Bank Supervisors (CSBS) also has a public portal called the Nationwide Multistate Licensing System Consumer Access Portal (NMLS Consumer Access).

Commissioner Navarro said a prototype was first provided to the Antifraud (D) Task Force at the 2024 Summer National Meeting, but regulator feedback during the second part of 2024 was mixed. The design allows a consumer to access the NAIC website and determine where a person is licensed and for what lines of authority. The consumer would then be provided with a link to each state website to obtain additional information. The current design leverages the SBS Licensee Lookup available in 34 jurisdictions.

Commissioner Navarro said that before having a more detailed discussion, the Committee needs to address whether the NAIC should serve as direct communication to consumers or whether communication to consumers about licensed individuals should only come from individual state insurance departments.

Commissioner Clark said Kentucky already provides a lot of agent information to consumers in their state. She said citizens are more likely to turn to the state department of insurance (DOI) than to the NAIC, which many have never heard of. Commissioner Navarro said that at the Antifraud (D) Task Force meeting during this national

meeting, it discussed the entity operating in multiple states. Some states may not have information on a bad actor and would not be able to provide this information to their consumers. He said that in another Task Force discussion, it was learned that an agent could obtain a license in a different state after being convicted of insurance fraud in another state.

Director Deiter agreed with Commissioner Clark and said each state has different standards regarding what types of enforcement information would be included. Director Deiter also noted that FINRA is a regulatory body, and the NAIC is not.

Commissioner Pike said the idea is worth exploring. He said many of his state's producer problems arise from out-of-state. Gendron supported multistate efforts to show producer misconduct. Producers will often move to different states when caught.

Wake said this is a "both/and" solution, not an "either/or" one. He said the NAIC provides numerous services to the states, and all the producer information goes through the NAIC. The state and NAIC efforts would be coordinated. He said an agent/broker look-up tool would have a consumer focus. If there is information about producer misconduct, it should be available to the consumer. Commissioner Navarro said states only have state data, but the NAIC can provide national-level data. He said that not sharing misconduct information with consumers is irresponsible.

Dr. Ting said the function of the state DOIs is to protect consumers, which includes protecting them from engaging with fraudulent producers. He said there is currently no good website available to consumers to research insurance producers. He said each state only has data on its own enforcement actions on producers and does not have national data. He said the NAIC should be allowed to share information about producers with consumers. He said not doing so would be irresponsible. He noted that the National Insurance Producer Registry (NIPR) shares the information with companies. Commissioner Clark asked if consumers should have access to information on consumers in good standing, and whether any and all actions by a DOI against a producer should be included. Dr. Ting said the actions that should be shared are serious actions, such as fraud, misappropriating premiums, and misrepresenting coverage. He said the NAIC could determine what should be shared. Wake noted that this is already public information and not confidential.

Buono said Pennsylvania has a consumer portal similar to Kentucky, and he understands Dr. Ting's frustration. State portals do not show national data. He said Pennsylvania is trying to link to the Regulatory Information Retrieval System (RIRS) data, but it only flags that there are RIRS actions with no details.

Director Deiter said FINRA is a regulator and must provide the information, but the NAIC is quasi-regulatory. He asked whether states would have to opt in to an agent/broker look-up tool.

Director Cameron said the issue requires more exploration. He said there may be a solution that could allow this to be built out while still respecting the states' regulatory authority. He asked the members to think further about this, what resources could be used, and the roles of the Producer Licensing (D) Task Force, the Antifraud (D) Task Force, and NIPR.

7. Received an Update on NAIC PICS Alerts for the NIPR Attachment Warehouse

Mullen said that after the Committee's discussion at the Spring National Meeting, NAIC staff implemented an "Alert Manager Shared" inbox to proactively manage "bounce backs" for all NAIC alerts to identify individuals who have signed up for the alerts but failed to receive the alert. He said this is an important improvement with NAIC staff being more proactive in assisting states when there is a change in personnel and there is a need to deactivate a state user account and add a new state user account. As part of this process, the NAIC added a verification step

with the state NAIC information technology (IT) liaisons to confirm a need for deactivation. Mullen said that while not specific to Personalized Information Capture System (PICS) alerts for the Attachment Warehouse, 14 PICS deactivation requests were submitted in June, and 27 deactivation requests were submitted in July.

Mullen said that to complement these actions, NAIC staff compiled a list of regulators in each state receiving the Attachment Warehouse PICS alerts. He said NAIC staff will be conducting outreach to these state contacts to confirm the proper individuals are receiving the alerts.

Mullen said the NAIC will work with NIPR staff to schedule a webinar this fall to provide additional outreach and training to states regarding the Attachment Warehouse and the management and use of PICS alerts.

Director Cameron said there is room for improvement, and NIPR is working on improvements for 2026.

8. Adopted the Reports of its Working Groups

Commissioner Navarro made a motion, seconded by Commissioner Clark, to adopt the reports of the following task forces and working groups, which met after the Market Regulation and Consumer Affairs conference call of July 25: 1) Antifraud (D) Task Force; 2) Producer Licensing (D) Task Force; 3) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Two); 4) Market Regulation Certification (D) Working Group (Attachment Three); and 5) Pharmacy Benefit Management (D) Working Group (Attachment Four). The motion passed unanimously.

9. Discussed Other Matters

Logue said 24 states have adopted the *Model Bulletin on the Use of Artificial Intelligence Systems by Insurers* and a handful of states are in the process of adoption. She said that this year, the Big Data and Artificial Intelligence (H) Working Group has a charge to develop an artificial intelligence (AI) evaluation tool to help regulators conduct market or financial examinations and assess the controls and practices insurers have as it pertains to AI systems.

Logue said the AI evaluation tool is intended to be an interim solution for states to pilot during their examinations to gather input and develop recommendations for long-term solutions, which may include updates to examination handbooks, MCAS data, Corporate Governance Annual Disclosure (CGAD) templates, etc.

Logue said a draft version of the AI systems evaluation tool has been exposed for a public comment period ending Sept. 5. After the conclusion of the comment period, the feedback will be reviewed, and updates to the tool will be made. She said a copy of the tool is available on the Working Group's web page, and anyone can reach out to Miguel Romero (NAIC), Scott Sobel (NAIC), or Dorothy Andrews (NAIC) to get up to speed on the initiative.

Logue said the Working Group wants to encourage regulators, insurers, and interested parties to review the draft tool and provide feedback; recruit states that are interested in being a pilot user of the tool in order to provide input on the long-term solutions; and identify AI training needs for regulators who would be evaluating insurers' use of AI Systems.

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

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Draft: 8/9/25

Market Regulation and Consumer Affairs (D) Committee
Virtual Meeting
July 25, 2025

The Market Regulation and Consumer Affairs (D) Committee met July 25, 2025. The following Committee members participated: Dean L. Cameron, Chair (ID); Trinidad Navarro, Co-Vice Chair (DE); Holly W. Lambert (IN); Sharon P. Clark (KY); Robert L. Carey (ME); Angela L. Nelson represented by Jo A. LeDuc (MO); Mike Causey represented by Robert Croom (NC); Carter Lawrence (TN); and Cassie Brown represented by Matt Tarpley. Also participating was: Joshua Guillory (LA).

1. Adopted its April 30 Minutes

The Committee met April 30. During this meeting, it took the following action: 1) adopted its Spring National Meeting minutes; 2) heard a presentation on consumers' need for help finding insurance agents/brokers; 3) heard a presentation from the Financial Industry Regulatory Authority (FINRA) on its BrokerCheck tool; and 4) heard a presentation on the NAIC's prototype consumer agent broker search tool.

Commissioner Clark made a motion, seconded by Commissioner Navarro, to adopt the Committee's April 30 minutes (Attachment One-A). The motion passed unanimously.

2. Adopted Proposed Changes to MCAS Blanks and Instructions

Director Cameron said the Market Conduct Annual Statement (MCAS) revision process established by the NAIC Members requires the Market Regulation and Consumer Affairs (D) Committee to circulate proposed changes to the MCAS Blanks and Instructions (Attachment One-B) for a 30-day comment period. The proposed changes were circulated for a 30-day comment period that ended on July 18, and no comments were received. Director Cameron said the MCAS revision process also requires the Market Regulation and Consumer Affairs (D) Committee to adopt proposed changes to the MCAS by Aug. 1 to provide companies with sufficient notification of the pending changes. Any changes adopted today will be reflected in 2026 MCAS data collected in 2027.

Guillory, Chair of the Market Analysis Procedures (D) Working Group, provided an overview of the following changes:

- **Other health MCAS blank**: Clarifications were made to the interrogatory section and the data call definitions to create more consistency in reporting.
- **Private passenger auto (PPA) and homeowner MCAS blanks**: Then, the reporting of non-standard business was moved from the interrogatories to the underwriting section to ensure the reporting of numeric values.
- **PPA blank**: A new data element was added for policies in force at the end of the period for each of the nine coverage types. A data element was also added for reporting the number of policies in force at the end of the period that are enrolled in telematics or usage-based data products.
- **Lender-placed home and auto MCAS blanks**: New data elements were added for the number of certificates for which term of coverage was completed during the period and the number of individual policies for which term of coverage was completed during the period. A definition for term of coverage completed was added. The blank was changed to add a clarification on the reporting of cancellations. The clarification states that "coverage under an individual policy or a certificate under a group policy ending

at the end of the term of coverage is not a cancellation, even if the coverage is renewed through a subsequent individual policy or certificate."

- **Pet insurance MCAS blank**: Removed the exclusion of maximum benefit limits from the reporting of partial payments.

There were no comments or questions.

Superintendent Carey made a motion, seconded by Commissioner Clark, to adopt the proposed changes to MCAS blanks and instructions. The motion passed unanimously.

3. Adopted the Reports of its Working Groups

LeDuc said the Market Analysis Procedures (D) Working Group held a regulator-to-regulator session on July 21 to discuss NAIC prioritization tools for market analysis. LeDuc said the Market Analysis Procedures (D) Working Group did not adopt its June 23 minutes during its July 21 meeting because it met in regulator-to-regulator session.

Guillory said the Market Conduct Annual Statement Blanks (D) Working Group held two meetings in May to finalize the previously presented changes to the MCAS Blanks and Instructions.

Tarpley said the Market Conduct Examination Guidelines (D) Working Group met July 23 to discuss updates to the property/casualty (P/C) travel insurance examination chapter and a new pet insurance examination chapter, for inclusion in the NAIC *Market Regulation Handbook*. Tarpley said the Market Conduct Examination Guidelines (D) Working Group is monitoring the work of the Big Data and Artificial Intelligence (H) Working Group, as that Working Group is developing an AI Systems Evaluation Toolkit.

Randy Helder (NAIC) said the Market Information Systems (D) Working Group has been working on a metrics analysis report to assess the completeness, accuracy, and timeliness of data submissions to NAIC's Market Information Systems (MIS).

Helder said the Market Regulation Certification (D) Working Group formed a peer review team to evaluate provisional certification applications. The Working Group also discussed a draft proposal that would require state insurance departments to complete six Market Analysis Review System (MARS) or Market Action Tracking System (MATS) entries per year per full-time market regulation section employee.

Helder said the Speed to Market (D) Working Group reviewed suggestions for updates to the product coding manual. Helder said the Working Group is considering either adding type of insurance (TOI) codes for Affordable Care Act (ACA)-related non-pediatric dental plans or including the plan in the description of currently available TOIs.

LeDuc made a motion, seconded by Superintendent Carey, to adopt the reports of the following working groups: 1) Market Analysis Procedures (D) Working Group (Attachment One-C); 2) Market Conduct Annual Statement Blanks (D) Working Group; 3) Market Conduct Examination Guidelines (D) Working Group (Attachment One-D); 4) Market Information Systems (D) Working Group; 5) Market Regulation Certification (D) Working Group; and 6) Speed to Market (D) Working Group (Attachment One-E). The motion passed unanimously.

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

SharePoint/Support Staff Hub/Committees/D CMTE/2025 Summer …

Draft: 6/3/25

Market Regulation and Consumer Affairs (D) Committee
Virtual Meeting
April 30, 2025

The Market Regulation and Consumer Affairs (D) Committee met April 30, 2025. The following Committee members participated: Dean L. Cameron, Chair (ID); Trinidad Navarro, Co-Vice Chair (DE); Scott Kipper, Co-Vice Chair (NV); Alan McClain represented by Teri Ann Mecca (AR); Peter M. Fuimaono represented by Elizabeth Perri (AS); Holly W. Lambert (IN); Sharon P. Clark (KY); Robert L. Carey (ME); Angela L. Nelson represented by Jo A. LeDuc (MO); Mike Causey represented by Robert Croom (NC); D.J. Bettencourt represented by Joan Lacourse (NH); Carter Lawrence (TN); Cassie Brown represented by Leah Gillum (TX); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted Its Spring National Meeting Minutes

Commissioner Kipper made a motion, seconded by Commissioner Clark, to adopt the Committee's March 27 minutes (*see NAIC Proceedings – Spring 2025, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Heard a Presentation on Consumers' Need for Help Finding Insurance Agents/Brokers

Director Cameron said the concept of an NAIC consumer-facing agent/broker search tool arose from an Improper Marketing of Health Insurance (D) Working Group discussion. The development of the tool became part of the NAIC's Marketing of Insurance Strategic Regulatory Priority in 2023 and 2024. Director Cameron said an initial prototype was provided to the Working Group's parent group, the Antifraud (D) Task Force, at the 2024 Summer National Meeting.

Harry Ting (Health Care Consumer Advocate) said it is important for consumers to find ethical, knowledgeable insurance producers and advisors for all lines of insurance. Dr. Ting said there are no good tools to help consumers find appropriate insurance producers, and consumers can be harmed if they begin working with a producer that is misrepresenting products. He said some producers misrepresent health insurance products to consumers, and some consumers purchase the wrong policy for their needs. Dr. Ting said some producers fail to provide consumers with the proper guidance to understand what coverage they need.

Dr. Ting said state insurance regulators should help consumers be informed, and an important step in achieving this goal is to provide information on producers' credentials and company appointments. This would provide consumers with information about the companies a producer represents. Dr. Ting said it is important to disclose serious disciplinary actions to consumers. He said it is difficult to find information on state insurance department websites.

Dr. Ting said the Financial Industry Regulatory Authority's (FINRA's) BrokerCheck provides similar information on investment advisors and brokers. He said BrokerCheck is a good model of an online search tool and information sharing that is helpful to consumers. Dr. Ting said the NAIC could produce a similar tool for consumers to find information on insurance producers. He said the tool could include background information on producers and certain producer certifications, such as the ability to sell Medicare products. The tool could also allow consumers to search for producers if they do not have a specific producer for which to search. Dr. Ting said the tool could provide information on producers who have had serious disciplinary actions taken against them in any state and provide consumers with links to State Health Insurance Assistance Program (SHIP) counseling programs.

Dr. Ting said the NAIC is the correct organization to provide this service to consumers. He said that the NAIC directing consumers back to individual state websites is not the best solution because the NAIC can provide: 1) consistent, consumer friendly terminology; 2) information on serious disciplinary actions taken across the U.S.; 3) the ability to search producers even if consumers do not have a producer's name; and 4) links to SHIP counseling programs.

Dr. Ting said that the NAIC would not violate state-based regulations by providing this tool. Regarding liability concerns that have been raised, Dr. Ting said the NAIC Uniform Producer Licensing Application includes an attestation through which a producer applicant gives permission for information to be shared and releases organizations receiving the application from any liability related to sharing information from the producer's application.

Dr. Ting said the NAIC prototype does not provide the functionality needed to help consumers. Commissioner Navarro agreed and added that the current design is insufficient.

3. Heard a Presentation on FINRA's BrokerCheck

Gary Lisker (FINRA) said BrokerCheck is a web-based tool consumers can use to find information on securities investment advisors and brokers. Lisker said consumers can find information by conducting a "name search" and then can narrow the search by entering a city, state, or ZIP code. Lisker demonstrated a search that provided results regarding the registration status of the searched name. Lisker said BrokerCheck uses different shading/coloring, which allows a consumer to quickly identify whether a person is currently registered and whether there are enforcement actions. For example, Lisker said a gray background means the person was previously registered, and a red background means the person has been barred from the securities industry by either FINRA or the U.S. Securities and Exchange Commission (SEC). Lisker said a consumer can also see the years of experience the person has.

Lisker provided an overview of FINRA's "summary page" for an individual. This page provides registration information, a primary business address, firm association, disclosures (if any), years of experience, states in which a person holds registrations, and different firms a person has worked for during their career. Lisker said consumers can also generate a printable PDF report. Lisker presented how consumers can obtain disclosure information, allegations of misconduct, and regulatory actions on BrokerCheck. Lisker said investment advisors and brokers are offered an opportunity to file a comment to provide their position on the displayed information, which is also made available on BrokerCheck. Lisker said all disclosures are included so consumers can make informed decisions regarding conducting business with individuals.

In addition to "name search" capabilities, Lisker said BrokerCheck provides consumers with a "location search," which allows a consumer to enter a ZIP code and receive a list of investment advisors and brokers conducting business there.

Lisker said one of the challenges with BrokerCheck is not to provide a consumer with too much information. Because of this, Lisker said BrokerCheck lists the most important information, such as whether the person is licensed and the FINRA registrations the person holds, at the top of search results. Lisker said most consumers look at individual profiles on BrokerCheck rather than firm profiles. Lisker said BrokerCheck will display whether a person was previously registered with a firm that was expelled from the industry and why the firm was expelled.

Lisker provided an example of a person who was barred by FINRA for selling fraudulent corporate promissory notes and then moved laterally to another financial services industry. Lisker said the individual engaged with

consumers who had no idea FINRA had barred him. Lisker said these consumers probably would not have trusted this individual had they known about FINRA barring him. Lisker said consumers can make better decisions if more information is made available to the public.

In response to questions from Superintendent Carey regarding the source of information displayed on BrokerCheck, Lisker said the information comes from uniform registration forms individuals submit as part of the registration process and from FINRA's Central Registration Depository (CRD). Lisker said the CRD is used by state securities regulators and the SEC, which can both report disciplinary actions to the CRD. Lisker said the information in BrokerCheck is updated daily and reviewed for accuracy. Lisker said confidential information, such as Social Security numbers (SSNs), customer names, personal addresses, and phone numbers, is not displayed on BrokerCheck.

Director Deiter said the public disclosure of information to consumers is a meaningful endeavor, but FINRA and the NAIC are different types of organizations. He said FINRA is a self-regulatory organization, while the NAIC is not a regulator. Director Deiter said state insurance departments have different views regarding the seriousness of actions, what is reported to the NAIC, and how to communicate with consumers in their respective states.

In response to a question from Commissioner Navarro regarding the use of BrokerCheck, Lisker said FINRA does not track the internet protocol (IP) addresses of people who access BrokerCheck. He said there are 27 million searches per month. Lisker said FINRA does track what information is reviewed during a search and how long a person stays on a particular page of the site.

4. Heard a Presentation on the NAIC's Prototype Consumer Agent Broker Search Tool

Tim Mullen (NAIC) said he thinks the NAIC Members need to provide further direction on whether the NAIC should engage in direct communication with consumers and, if so, what information the NAIC should communicate to consumers on behalf of the NAIC Members.

Mullen said the NAIC provided a demonstration of an initial prototype of the search tool at the 2024 Summer National Meeting and engaged in a series of calls with regulator subject matter experts (SMEs) to arrive at the current design. Mullen said the current design primarily provides "name search" functionality. Mullen said a consumer can also search by National Producer Number (NPN), but most consumers will not know an individual's NPN. Mullen demonstrated a search that returned a list of states in which an individual is licensed, the lines of authority licensed to sell, and the individual's primary business address. Mullen said the search results intentionally limit the amount of information displayed. He said the design provides a link to the appropriate state insurance department if a consumer is seeking more information.

Mullen said the current design has led to questions about whether the search tool provides consumers with valuable information and whether the tool provides consumers with a consistent user experience, since consumers are referred to each state insurance department website for information. Mullen said a consumer will need to begin a new search once referred to a state insurance department. He said search functionality and search results will vary by state. Mullen said 34 states use the NAIC's State Based System (SBS) producer licensing look-up tool, which provides uniformity across these states. Mullen said no enforcement information is released through SBS.

Mullen said the current design limits the information disclosed to consumers from the NAIC and primarily directs consumers to state insurance departments, where a consumer must start a new search to obtain additional information. Mullen said the design reflects the desired functionality communicated to the NAIC. He said there is

a need for further direction from the NAIC Members regarding the current design and what role the NAIC should have in creating a national system for the disclosure of information about insurance producers.

Director Cameron said the Committee should provide recommendations regarding the appropriate policy direction for the disclosure of producer information through the NAIC website for the full NAIC Membership to consider.

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

MCAS Market Conduct Annual Statement

Other Health Insurance (2026)

Other Health Insurance Interrogatories

	Interrogatories - Individual Products	Yes/No Response	Explanation
01	Accident Only: Were there policies in force during the reporting period?		--
02	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
03	Accident Only: Do the reported products include closed or frozen blocks of business?		--
04	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
05	Accidental Death and Dismemberment: Were there policies in force during the reporting period?		--
06	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
07	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
08	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
09	Specified Disease – Limited Benefit/Critical Illness: Were there policies in force during the reporting period?		--
10	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
11	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
12	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
13	Hospital/Other Indemnity: Were there policies in force during the reporting period?		--
14	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
15	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
16	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
17	Hospital/Surgical/Medical Expense: Were there policies in force during the reporting period?		--
18	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
19	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
20	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
21	Has the company had a significant event/business strategy change that would affect the Individual product data reported this period?		--
22	If yes, explain the situation and how it may affect the data	--	
23	Additional jurisdiction-specific Individual product comments (optional):	--	

	Interrogatories - Associations/Trusts Products	Yes/No Response	Explanation
24	Accident Only: Were there policies/certificates in force during the reporting period?		--
25	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
26	Accident Only: Do the reported products include closed or frozen blocks of business?		--
27	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
28	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?		--
29	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
30	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
31	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
32	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?		--
33	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
34	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
35	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
36	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?		--
37	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
38	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
39	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
40	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?		--
41	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
42	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
43	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
44	Does the company have a contractual relationship (outside or in addition to the group policies issued to the Association/Trust) with each Association/Trust?		--
45	Does the company delegate authority to any of the associations/trusts to market products?		--
46	If yes, does the company conduct compliance audits of all associations/trusts allowed to market products?		--
47	Does the company delegate authority to any of the associations/trusts to collect policy or contract premiums?		--
48	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect policy or contract premiums?		--
49	Does the company delegate authority to any of the associations/trusts to collect and pay commissions?		--
50	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect and pay commissions?		--

Other Health Insurance (2026)			
51	Does the company delegate authority to any of the associations/trusts to adjudicate claims?		--
52	If yes, does the company conduct compliance audits of all associations/trusts allowed to adjudicate claims?		--
53	Has the company had a significant event/business strategy change that would affect the Associations/Trusts product data reported this period?		--
54	If yes, explain the situation and how it may affect the data	--	
55	Additional jurisdiction-specific Associations/Trusts product comments (optional):	--	
Interrogatories - Employer Group Products		Yes/No Response	Explanation
56	Accident Only: Were there policies/certificates in force during the reporting period?		--
57	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?		--
58	Accident Only: Do the reported products include closed or frozen blocks of business?		--
59	Accident Only: Do any of the reported products contain pre-existing condition exclusions?		--
60	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?		--
61	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?		--
62	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?		--
63	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?		--
64	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?		--
65	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?		--
66	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?		--
67	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?		--
68	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?		--
69	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?		--
70	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?		--
71	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?		--
72	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?		--
73	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?		--
74	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?		--
75	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?		--
76	Does the company allow any of the Employer Groups to adjudicate claims?		--
77	If yes, does the company have a contractual relationship (outside or in addition to the group policy issued to the Employer Group) with each Employer Group with this delegated authority?		--
78	If yes, does the company conduct compliance audits of all Employer Groups allowed to adjudicate claims?		--
79	Has the company had a significant event/business strategy change that would affect the Employer Group product data reported this period?		--
80	If yes, explain the situation and how it may affect the data	--	
81	Additional jurisdiction-specific Employer Group product comments (optional):	--	
Interrogatories - Third-Party Administrators/Vendors		Yes/No Response	Explanation
82	Does the company contract with third-parties, either third-party administrators or other vendors (other than Associations/Trusts and Employer Groups) for any administrative services related to Other Health products?		--
83	If yes, does the company issue any Other Health products through administrators/TPAs?		--
84	If yes, does the company contract any claims services related to Other Health products?		--
85	If yes, does the company contract any complaints handling related services related to Other Health products?		--
86	If yes, does the company contract any medical underwriting services related to Other Health products?		--
87	If yes, does the company contract any pricing services related to Other Health products?		--
88	If yes, does the company contract any producer appointment services related to Other Health products?		--
89	If yes, does the company contract any marketing, advertisement, or lead generation, services related to Other Health products?		--
90	If yes, does the company contract any policyholder services related to Other Health products?		--
91	If yes, does the company contract any premium collection services related to Other Health products?		--
92	If yes, does the company conduct compliance audits of all third parties to whom responsibilities have been delegated?		--
93	Additional jurisdiction-specific Third-Party Administrators/Vendors comments (optional):	--	
Interrogatories - General		Yes/No Response	Explanation
94	Does your company distribute its product through independent agents?		--
95	Does your company distribute its products through captive agents?		--
96	Does your company distribute its products through its employees?		--
97	Does the company contract with producers to collect premium or bind coverage on behalf of the company?		--
98	Does the company charge fees (other than commissions) to applicants or policyholders/certificate holders that are included in reported premium?		--
99	Additional jurisdiction-specific General comments (optional):	--	

Other Health Insurance (2026)

Policy/Certificate Administration

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
100	Direct Written Premium during the period.															
101	Earned premiums for reporting year.															
102	Number of policies/certificates in force at the beginning of the period.															
103	Number of covered lives on policies/certificates in force at the beginning of the period.											--	--	--	--	--
104	Number of new policy/certificate applications/enrollments received during the period.															
105	Number of new policy/certificates issued during the period.															
106	Number of covered lives on new policies/certificates issued during the period.											--	--	--	--	--
107	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period.															
108	Number of policies/certificates cancelled during the free look period during the period.															
109	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period.											--	--	--	--	--
110	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period.															
111	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period.															
112	Number of rescissions during the period.						--	--	--	--	--	--	--	--	--	--
113	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder during the period.											--	--	--	--	--
114	Number of covered lives impacted on terminations and cancellations due to non-payment during the period.											--	--	--	--	--
115	Number of covered lives impacted by rescissions during the period.						--	--	--	--	--	--	--	--	--	--
116	Number of policies/certificates in force at the end of the period.															
117	Number of covered lives on policies/certificates in force at the end of the period.											--	--	--	--	--

Claims Administration (Including Pharmacy)

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
118	Number of claims pending at the beginning of the period.															
119	Total ~~N~~number of all claims received ~~(include non-clean claims)~~ during the period.															
120	Total number of claims denied, rejected or returned during the period.															
121	Number denied, rejected, or returned during the period as non-covered or maximum benefit exceeded.															
122	Number denied, rejected, or returned during the period as subject to pre-existing condition exclusion.															
123	Number denied, rejected, or returned during the period due to failure to provide adequate documentation.															
124	Number denied, rejected, or returned during the period due to being within the waiting period.		--					--					--			
125	Number of claims pending at the end of the period.															
126	Median number of days from receipt of claim to decision for denied claims during the period.															
127	Average number of days from receipt of claim to decision for denied claims during the period.															
128	Median number of days from receipt of claim to decision for approved claims during the period.															
129	Average number of days from receipt of claim to decision for approved claims during the period.															
130	Number of claims paid (include partially paid claims) during the period.															
131	Aggregate dollar amount of paid claims during the period.															
132	Number of claims during the period where the claims payment was reduced by premium owed.															
133	Dollar amount of claims payments during the period applied to unpaid premiums.															

Other Health Insurance (2026)

Consumer Complaints and Lawsuits

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
134	Number of complaints received ~~by Company (other than through the DOI) during the period~~ directly from any person or entity other than the DOI. ~~Number of complaints received through DOI.~~															
135	Number of complaints during the period resulting in claims reprocessing.															
136	Number of lawsuits open at the beginning of the period.															
137	Number of lawsuits opened during the period.															
138	Number of lawsuits closed during the period.															
139	Number of lawsuits closed during the period with consideration for the consumer.															
140	Number of lawsuits open at the end of the period.															

Marketing and Sales

		Individual					Association					Employer Group				
		Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense	Accident Only	Accidental Death and Dismemberment	Specified Disease - Limited Benefit/ Critical Illness	Hospital/ Other Indemnity	Hospital/ Surgical/ Medical Expense
141	Number of individual applications/enrollments pending at the beginning of the period.															
142	Number of individual applications/enrollments denied during the period for any reason.															
143	Number of individual applications/enrollments denied during the period - health status or condition.															
144	Number of individual applications/enrollments approved during the period.															
145	Number of individual applications/enrollments pending at the end of the period.															
146	Number of applications/enrollments received via phone (audio only) during the period.						--	--	--	--	--	--	--	--	--	--
147	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) during the period.						--	--	--	--	--	--	--	--	--	--
148	Number of applications/enrollments received online (electronically) during the period.						--	--	--	--	--	--	--	--	--	--
149	Number of applications/enrollments received by mail during the period.						--	--	--	--	--	--	--	--	--	--
150	Number of applications/enrollments received by any other method during the period.						--	--	--	--	--	--	--	--	--	--
151	Commissions paid during reporting period (dollar amount of commissions incurred during the period).															
152	Unearned commissions returned to company on policies/certificates sold during the period.															

Other Health Insurance Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
153	First Attestor Information.						--
154	Second Attestor Information.						--
155	Overall Comments for the Filing Period.	--	--	--	--	--	

MCAS Market Conduct Annual Statement

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Line of Business: Other Health Insurance
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: May 31, 2027

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 – Individual Products

ID	Description	Response
1-01	~~Are you currently marketing these products in this jurisdiction?~~ Accident Only: Were there policies in force during the reporting period?	Yes/No
1-02	~~Do the products you are reporting on in response to this blank include closed or frozen blocks of business?~~ Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-03	~~If yes, list the closed or frozen blocks of business?~~ Accident Only: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-04	~~Number of Other Health products offered to residents in this state~~ Accident Only: Do any of the reported products contain pre-existing condition exclusions?	~~Number~~ Yes/No
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.~~ Accidental Death and Dismemberment: Were there policies in force during the reporting period?	~~Comment~~ Yes/No
1-06	~~For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?~~ Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-07	~~If yes, list the associations/trusts.~~ Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-08	~~If yes, do you have a contractual relationship with any association/trust?~~ Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-09	~~If yes, please identify which associations/trusts.~~ Specified Disease – Limited Benefit/Critical Illness: Were there policies in force during the reporting period?	~~Comment~~ Yes/No
1-10	~~If yes, does the contract allow any association/trust to market the product?~~ Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-11	~~If yes, please identify which associations/trusts.~~ Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-12	~~If yes, does the contract allow any association/trust to collect policy or contract premiums?~~ Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-13	~~If yes, does the contract allow any association/trust to collect and pay commissions?~~ Hospital/Other Indemnity: Were there policies in force during the reporting period?	Yes/No
1-14	~~If yes, please identify which associations/trusts.~~ Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	~~Comment~~ Yes/No
1-15	~~If yes, does the contract allow any association/trust to adjudicate claims?~~ Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No
1-16	~~If yes, please identify which associations/trusts.~~ Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-17	~~Has the company filed the associations by-laws and articles of incorporation in their state of domicile?~~ Hospital/Surgical/Medical Expense: Were there policies in force during the reporting period?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-18	~~Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?~~ Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-19	~~If yes please provide the state, and the SERFF tracking number, if applicable~~ Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
1-20	~~Has the company filed the association by-laws and articles of incorporation in the filing state?~~ Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-21	~~Has the company filed the certificate of insurance in the filing state, if applicable?~~ Has the company had a significant event/business strategy change that would affect the Individual product data reported this period?	Yes/No
1-22	~~Does the company contract with third-party administrators for administrative services related to Other Health products?~~ If yes, explain the situation and how it may affect the data.	~~Yes/No~~ Comment
1-23	~~If yes, does the company issue Other Health products through administrators/TPAs?~~ Additional jurisdiction-specific Individual product comments (optional):	~~Yes/No~~ Comment

Schedule 1 – Interrogatories – Associations/Trusts Products

1-24	~~If yes, how many administrators/TPAs?~~ Accident Only: Were there policies/certificates in force during the reporting period?	~~Number~~ Yes/No
1-25	~~If yes, list the TPAs and provide their respective National Producer Number (NPN), if required by the state.~~ Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	~~Comment~~ Yes/No
1-26	~~If yes, does your company contract claims services related to Other Health products?~~ Accident Only: Do the reported products include closed or frozen blocks of business?	Yes/No
1-27	~~If yes, does your company contract complaints-related services related to Other Health products?~~ Accident Only: Do any of the reported products contain pre-existing condition exclusions?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-28	~~If yes, does your company contract medical underwriting services related to Other Health products?~~ Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?	Yes/No
1-29	~~If yes, does your company contract pricing services related to Other Health products?~~ Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-30	~~If yes, does your company contract producer appointment services related to Other Health products?~~ Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	Yes/No
1-31	~~If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?~~ Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-32	~~If yes, does your company contract policyholder services related to Other Health products?~~ Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?	Yes/No
1-33	~~If yes, does your company contract premium collection services related to Other Health products?~~ Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-34	~~Does your company audit third parties to whom you have delegated responsibilities?~~ Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	Yes/No
1-35	~~If yes, please provide frequency of audits.~~ Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-36	~~Does your company distribute its product through independent agents?~~ Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?	Yes/No
1-37	~~Does your company distribute its products through captive agents?~~ Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-38	~~Does your company distribute its products through its employees?~~ Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-39	~~Does the company use pre-existing condition exclusions?~~ Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-40	~~If yes, identify which products.~~ Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?	~~Comment~~ Yes/No
1-41	~~Does the company contract with producers to collect premium or bind coverage on behalf of the company?~~ Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	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.~~ Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	~~Comment~~ Yes/No
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.~~ Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	~~Comment~~ Yes/No
1-44	~~Additional state specific comments (optional)~~ Does the company have a contractual relationship (outside or in addition to the group policies issued to the Association/Trust) with each Association/Trust?	~~Comment~~ Yes/No
1-45	Does the company delegate authority to any of the associations/trusts to market products?	Yes/No
1-46	If yes, does the company conduct compliance audits of all associations/trusts allowed to market products?	Yes/No
1-47	Does the company delegate authority to any of the associations/trusts to collect policy or contract premiums?	Yes/No
1-48	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect policy or contract premiums?	Yes/No
1-49	Does the company delegate authority to any of the associations/trusts to collect and pay commissions?	Yes/No
1-50	If yes, does the company conduct compliance audits of all associations/trusts allowed to collect and pay commissions?	Yes/No
1-51	Does the company delegate authority to any of the associations/trusts to adjudicate claims?	Yes/No
1-52	If yes, does the company conduct compliance audits of all associations/trusts allowed to adjudicate claims?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-53	Has the company had a significant event/business strategy change that would affect the Associations/Trusts product data reported this period?	Yes/No
1-54	If yes, explain the situation and how it may affect the data	Comment
1-55	Additional jurisdiction-specific Associations/Trusts product comments (optional):	Comment

Schedule 1 – Interrogatories – Employer Group Products

1-56	Accident Only: Were there policies/certificates in force during the reporting period?	Yes/No
1-57	Accident Only: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-58	Accident Only: Do the reported products include closed or frozen blocks of business?	Yes/No
1-59	Accident Only: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-60	Accidental Death and Dismemberment: Were there policies/certificates in force during the reporting period?	Yes/No
1-61	Accidental Death and Dismemberment: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-62	Accidental Death and Dismemberment: Do the reported products include closed or frozen blocks of business?	Yes/No
1-63	Accidental Death and Dismemberment: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-64	Specified Disease – Limited Benefit/Critical Illness: Were there policies/certificates in force during the reporting period?	Yes/No
1-65	Specified Disease – Limited Benefit/Critical Illness: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-66	Specified Disease – Limited Benefit/Critical Illness: Do the reported products include closed or frozen blocks of business?	Yes/No
1-67	Specified Disease – Limited Benefit/Critical Illness: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-68	Hospital/Other Indemnity: Were there policies/certificates in force during the reporting period?	Yes/No
1-69	Hospital/Other Indemnity: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-70	Hospital/Other Indemnity: Do the reported products include closed or frozen blocks of business?	Yes/No
1-71	Hospital/Other Indemnity: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-72	Hospital/Surgical/Medical Expense: Were there policies/certificates in force during the reporting period?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-73	Hospital/Surgical/Medical Expense: Was the company actively writing policies in the jurisdiction at year-end?	Yes/No
1-74	Hospital/Surgical/Medical Expense: Do the reported products include closed or frozen blocks of business?	Yes/No
1-75	Hospital/Surgical/Medical Expense: Do any of the reported products contain pre-existing condition exclusions?	Yes/No
1-76	Does the company allow any of the Employer Groups to adjudicate claims?	Yes/No
1-77	If yes, does the company have a contractual relationship (outside or in addition to the group policy issued to the Employer Group) with each Employer Group with this delegated authority?	Yes/No
1-78	If yes, does the company conduct compliance audits of all Employer Groups allowed to adjudicate claims?	Yes/No
1-79	Has the company had a significant event/business strategy change that would affect the Employer Group product data reported this period?	Yes/No
1-80	If yes, explain the situation and how it may affect the data	Comment
1-81	Additional jurisdiction-specific Employer Group product comments (optional):	Comment

Schedule 1 – Interrogatories – Third Party Administrators/Vendors

1-82	Does the company contract with third-parties, either third-party administrators or other vendors (other than Associations/Trusts and Employer Groups) for any administrative services related to Other Health products?	Yes/No
1-83	If yes, does the company issue any Other Health products through administrators/TPAs?	Yes/No
1-84	If yes, does the company contract any claims services related to Other Health products?	Yes/No
1-85	If yes, does the company contract any complaints handling related services related to Other Health products?	Yes/No
1-86	If yes, does the company contract any medical underwriting services related to Other Health products?	Yes/No
1-87	If yes, does the company contract any pricing services related to Other Health products?	Yes/No
1-88	If yes, does the company contract any producer appointment services related to Other Health products?	Yes/No
1-89	If yes, does the company contract any marketing, advertisement, or lead generation, services related to Other Health products?	Yes/No
1-90	If yes, does the company contract any policyholder services related to Other Health products?	Yes/No

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

1-91	If yes, does the company contract any premium collection services related to Other Health products?	Yes/No
1-92	If yes, does the company conduct compliance audits of all third parties to whom responsibilities have been delegated?	Yes/No
1-93	Additional jurisdiction-specific Third-Party Administrators/Vendors comments (optional):	Comment

Schedule 1 – Interrogatories – General

1-94	Does your company distribute its product through independent agents?	Yes/No
1-95	Does your company distribute its products through captive agents?	Yes/No
1-96	Does your company distribute its products through its employees?	Yes/No
1-97	Does the company contract with producers to collect premium or bind coverage on behalf of the company?	Yes/No
1-98	Does the company charge fees (other than commissions) to applicants or policyholders/certificate holders that are included in reported premium?	Yes/No
1-99	Additional jurisdiction-specific General 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/trust
Association ADD	Accidental Death and Dismemberment. Purchased through an association/trust
Association SD	Specified Disease-Limited Benefit/Critical Illness. Purchased through an association/trust
Association H-H/OI	Hospital/Other Indemnity. Purchased through an association/trust
Association H-HSME	Hospital/Surgical/Medical Expense. Purchased through an association/trust
Employer Group H-AO	Accident Only. Purchased through an employer group
Employer Group ADD	Accidental Death and Dismemberment. Purchased through an employer group

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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

Schedule 2 – Policy/Certificate Administration

ID	Description
~~2-45~~ 2-100	Direct written premium during the period.
~~2-46~~ 2-101	Earned premiums for reporting year
~~2-47~~ 2-102	Number of policies/certificates in force at the beginning of the period
~~2-48~~ 2-103	Number of covered lives on policies/certificates in force at the beginning of the period (only answer for individual and association products)
~~2-49~~ 2-104	Number of new policy/certificate applications/enrollments received during the period
~~2-50~~ 2-105	Number of new policy/certificates issued during the period
~~2-51~~ 2-106	Number of Covered Lives on New Policies/Certificates Issued During the Period (only answer for individual and association products)
~~2-52~~ 2-107	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
2-53 2-108	Number of policies/certificates cancelled during the free look period during the period.
~~2-54~~ 2-109	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period (only answer for individual and association products)
~~2-55~~ 2-110	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period
~~2-56~~ 2-111	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
~~2-57~~ 2-112	Number of rescissions during the period (only answer for individual products)
~~2-58~~ 2-113	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder during the period (only answer for individual and association products)
~~2-59~~ 2-114	Number of covered lives impacted on terminations and cancellations due to non-payment during the period (only answer for individual and association products)

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

~~2-60~~ 2-115	Number of covered lives impacted by rescissions during the period (only answer for individual products)
~~2-61~~ 2-116	Number of policies/certificates in force at the end of the period
~~2-62~~ 2-117	Number of covered lives on policies/certificates in force at the end of the period (only answer for individual and association products)

Schedule 3 – Claims Administration (Including Pharmacy)

ID	Description
~~3-63~~ 3-118	Number of claims pending at the beginning of the period
~~3-64~~ 3-119	Total ~~N~~number of all claims received ~~(include non-clean claims)~~ during the period
~~3-65~~ 3-120	Total number of claims denied, rejected or returned during the period
~~3-66~~ 3-121	Number denied, rejected, or returned during the period as non-covered or maximum benefit exceeded
~~3-67~~ 3-122	Number denied, rejected, or returned during the period as subject to pre-existing condition exclusion
~~3-68~~ 3-123	Number denied, rejected, or returned during the period due to failure to provide adequate documentation
~~3-69~~ 3-124	Number denied, rejected, or returned during the period due to being within the waiting period (do not answer for ADD products)
~~3-70~~ 3-125	Number of claims pending at the end of the period
~~3-71~~ 3-126	Median number of days from receipt of claim to decision for denied claims during the period
~~3-72~~ 3-127	Average number of days from receipt of claim to decision for denied claims during the period
~~3-73~~ 3-128	Median number of days from receipt of claim to decision for approved claims during the period
~~3-74~~ 3-129	Average number of days from receipt of claim to decision for approved claims during the period
~~3-75~~ 3-130	Number of claims paid (include partially paid claims) during the period
~~3-76~~ 3-131	Aggregate dollar amount of paid claims during the period
~~3-77~~ 3-132	Number of claims during the period where the claims payment was reduced by premium owed
~~3-78~~ 3-133	Dollar amount of claims payments during the period applied to unpaid premiums.

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Schedule 4 – Consumer Complaints and Lawsuits

ID	Description
~~4-80~~ 4-134	Number of complaints received ~~by Company (other than through the DOI)~~ directly from any person or entity other than the DOI
~~4-81~~	~~Number of complaints received through DOI~~
~~4-82~~ 4-135	Number of complaints resulting in claims reprocessing
~~4-83~~ 4-136	Number of lawsuits open at the beginning of the period
~~4-84~~ 4-137	Number of lawsuits opened during the period
~~4-85~~ 4-138	Number of lawsuits closed during the period
~~4-86~~ 4-139	Number of lawsuits closed during the period with consideration for the consumer
~~4-87~~ 4-140	Number of lawsuits open at the end of the period

Schedule 5 – Marketing and Sales

ID	Description
~~5-88~~ 5-141	Number of individual applications/enrollments pending at the beginning of the period
~~5-89~~ 5-142	Number of individual applications/enrollments denied during the period for any reason
~~5-90~~ 5-143	Number of individual applications/enrollments denied during the period - health status or condition
~~5-91~~ 5-144	Number of individual applications/enrollments approved during the period
~~5-92~~ 5-145	Number of individual applications/enrollments pending at the end of the period
~~5-93~~ 5-146	Number of applications/enrollments received via phone (audio only) during the period (only answer for individual products)
~~5-94~~ 5-147	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) during the period (only answer for individual products)
~~5-95~~ 5-148	Number of applications/enrollments received online (electronically) during the period (only answer for individual products)
~~5-96~~ 5-149	Number of applications/enrollments received by mail during the period (only answer for individual products)
~~5-97~~ 5-150	Number of applications/enrollments received by any other method during the period (only answer for individual products)
~~5-98~~ 5-151	Commissions paid during reporting period (dollar amount of commissions incurred during the period)

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

~~5-99~~ 5-152	Unearned commissions returned to company on policies/certificates sold during the period

Schedule 6– Other Health Insurance Attestation

ID	Description
~~6-100~~ 6-153	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~6-101~~ 6-154	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~6-102~~ 6-155	Overall Comments for 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.

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

Exclude the following from Other Health MCAS reporting:

- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

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

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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 (does not include banks or credit unions).

Exclude the following from Other Health MCAS reporting:

- Medicare supplement
- Blanket policies
- Government plans, i.e. Medicare/Medicare Advantage/Medicaid/ Federal Employee Plans/ TriCare, etc.

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 situsued.

~~**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/trust)

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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/trust)

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.

Actively Writing Policies – Refers to premium written during the reporting period.

Pre-existing Condition - A medical condition of the policyholder/certificate holder that existed prior to eligibility for coverage under the Other Health policy.

Third party Entity – Licensed Administrators, licensed producers, vendors

Compliance Audits - A compliance audit is a formal review of an organization's procedures and operations mainly focusing on whether an entity is complying with internal rules, regulations, policies, decisions, and procedures. The audit ensures that the organization is fulfilling outside obligations such as agreements, rules and regulations, or standards.

Marketing - The process of actively promoting, selling, and distributing a product.

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:

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

- 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.

Schedule 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.

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

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 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.

Other Health Insurance Market Conduct Annual Statement Data Call & Definitions

Schedule 6– Other Health Insurance Attestation

By completing the attestation information, those named understand, agree, and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

MCAS Market Conduct Annual Statement

Private Passenger Auto (2026)

Private Passenger Auto Interrogatories

		Yes/No Response	Explanation
01	Were there policies in force during the reporting period that provided Collision coverage?		———
02	Were there policies in force during the reporting period that provided Comprehensive coverage?		———
03	Were there policies in force during the reporting period that provided Bodily Injury coverage?		———
04	Were there policies in force during the reporting period that provided Property Damage coverage?		———
05	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?		———
06	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?		———
07	Were there policies in force during the reporting period that provided Medical Payments coverage?		———
08	Were there policies in force during the reporting period that provided Combined Single Limits coverage?		———
09	Were there policies in force during the reporting period that provided Personal Injury Protection coverage?		———
10	Was the company actively writing policies in the state at year end?		———
11	Does the company write in the non-standard market?		———
~~12~~	~~If Yes, what percentage of your business is non-standard?~~	———	
~~13~~12	If Yes, how is non-standard defined?	———	
~~14~~13	Has the company had a significant event/business strategy that would affect data for this reporting period?		———
~~15~~14	If yes, add additional comments.	———	
~~16~~15	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?		———
~~17~~16	If yes, add additional comments.	———	
~~18~~17	How does the company treat subsequent supplemental or additional payments on previously closed claims?	———	
~~19~~18	Does the company use Managing General Agents (MGAs)?		———
~~20~~19	If yes, list the names of the MGAs	———	
~~21~~20	Does the company use Third Party Administrators (TPAs)?		———
~~22~~21	If yes, list the names of the TPAs	———	
~~23~~22	Does the company use telematics or usage-based data:?		———
~~24~~23	Does the company use digital claim settlement?		———
~~25~~24	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process	———	
~~26~~25	Additional state specific Claims comments (optional):	———	
~~27~~26	Additional state specific Underwriting comments (optional):	———	

Private Passenger Auto (2026)

Private Passenger Auto Claims Activity

		Collision				Comprehensive				Bodily Injury	Property Damage			
		Digital	Hybrid	Non-Digital	All	Digital	Hybrid	Non-Digital	All		Digital	Hybrid	Non-Digital	All
~~28~~27	Number of claims open at the beginning of the period.													
~~29~~28	Number of claims opened during the period.													
~~30~~29	Number of claims closed with payment during the period.													
~~31~~30	Number of claims closed without payment during the period.													
~~32~~31	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.													
~~33~~32	Number of claims remaining open at the end of the period.													
~~34~~33	Median days to final payment.													
~~35~~34	Number of claims closed with payment within 0-30 days.													
~~36~~35	Number of claims closed with payment within 31-60 days.													
~~37~~36	Number of claims closed with payment within 61-90 days.													
~~38~~37	Number of claims closed with payment within 91-180 days.													
~~39~~38	Number of claims closed with payment within 181-365 days.													
~~40~~39	Number of claims closed with payment beyond 365 days.													
~~41~~40	Number of claims closed without payment within 0-30 days.													
~~42~~41	Number of claims closed without payment within 31-60 days.													
~~43~~42	Number of claims closed without payment within 61-90 days.													
~~44~~43	Number of claims closed without payment within 91-180 days.													
~~45~~44	Number of claims closed without payment within 181-365 days.													
~~46~~45	Number of claims closed without payment beyond 365 days.													

Private Passenger Auto (2026)

Private Passenger Auto Claims Activity (Continued)

		UMBI and UIMBI	UMPD and UIMPD				Medical Payments	Combined Single Limits	Personal Injury Protection
			Digital	Hybrid	Non-Digital	All			
~~28~~27	Number of claims open at the beginning of the period.					———			
~~29~~28	Number of claims opened during the period.					———			
~~30~~29	Number of claims closed with payment during the period.					———			
~~31~~30	Number of claims closed without payment during the period.					———			
~~32~~31	Number of claims closed during the					———			
~~33~~32	Number of claims remaining open at the end of the period.					———			
~~34~~33	Median days to final payment.		———	———	———				
~~35~~34	Number of claims closed with payment within 0-30 days.					———			
~~36~~35	Number of claims closed with payment within 31-60 days.					———			
~~37~~36	Number of claims closed with payment within 61-90 days.					———			
~~38~~37	Number of claims closed with payment within 91-180 days.					———			
~~39~~38	Number of claims closed with payment within 181-365 days.					———			
~~40~~39	Number of claims closed with payment beyond 365 days.					———			
~~41~~40	Number of claims closed without payment within 0-30 days.					———			
~~42~~41	Number of claims closed without payment within 31-60 days.					———			
~~43~~42	Number of claims closed without payment within 61-90 days.					———			
~~44~~43	Number of claims closed without payment within 91-180 days.					———			
~~45~~44	Number of claims closed without payment within 181-365 days.					———			
~~46~~45	Number of claims closed without payment beyond 365 days.					———			

Private Passenger Auto (2026)

Private Passenger Auto Underwriting Activity

		Value
~~47~~46	Number of autos which have policies in force at the end of the period.	
~~48~~47	Number of policies in force at the end of the period.	
~~49~~48	Number of new policies written during the period.	
49	Number of non-standard policies issued during the period.	
50	Total number of policies in force at the end of the period that have Collision coverage.	
51	Total number of policies in force at the end of the period that have Comprehensive coverage.	
52	Total number of policies in force at the end of the period that have Bodily Injury coverage.	
53	Total number of policies in force at the end of the period that have Property Damage coverage.	
54	Total number of policies in force at the end of the period that have UMBI and UIMBI coverage.	
55	Total number of policies in force at the end of the period that have UMPD and UIMPD coverage.	
56	Total number of policies in force at the end of the period that have Medical Payments coverage.	
57	Total number of policies in force at the end of the period that have Combined Single Limits coverage.	
58	Total number of policies in force at the end of the period that have Personal Injury Protection coverage.	
59	Number of policies in force at the end of the period that are enrolled in a telematics or usage-based data product(s).	
~~50~~60	Dollar amount of direct written premium during the period.	
~~51~~61	Number of company-initiated non-renewals during the period.	
~~52~~62	Number of cancellations for non-pay or non-sufficient funds.	
~~53~~63	Number of cancellations at the insured's request	
~~54~~64	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.	
~~55~~65	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.	
~~56~~66	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.	
~~57~~67	Number of complaints received directly from any person or entity other than the DOI.	

Lawsuit Activity

		Collision	Comprehensive	Bodily Injury	Property Damage	UMBI and UIMBI	UMPD and UIMPD	Medical Payments	Combined Single Limits	Personal Injury Protection	Non-Claim Related Lawsuits
~~58~~68	Number of lawsuits open at beginning of the period.										
~~59~~69	Number of lawsuits opened during the period.										
~~60~~70	Number of lawsuits closed during the period.										
~~61~~71	Number of lawsuits open at end of period.										
~~62~~72	Number of lawsuits closed with consideration for the consumer.										

Private Passenger Auto Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
~~63~~73	First Attestor Information						———
~~64~~74	Second Attestor Information						———
~~65~~75	Overall Comments for the Filing Period	———	———	———	———	———	

MCAS Market Conduct Annual Statement

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

Line of Business: Private Passenger Auto
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

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

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

~~1-13~~ 1-12	If yes, how is non-standard defined?	Comment
~~1-14~~ 1-13	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
~~1-15~~ 1-14	If yes, add additional comments	Comment
~~1-16~~ 1-15	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~~ 1-16	If yes, add additional comments	Comment
~~1-18~~ 1-17	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~~ 1-18	Does the company use Managing General Agents (MGAs)?	Yes/No
~~1-20~~ 1-19	If yes, list the names of the MGAs.	Comment
~~1-21~~ 1-20	Does the company use Third Party Administrators (TPAs)?	Yes/No
~~1-22~~ 1-21	If yes, list the names of the TPAs.	Comment
~~1-23~~ 1-22	Does the company use telematics or usage-based data?	Yes/No
~~1-24~~ 1-23	Does the company use digital claim settlement?	Yes/No
~~1-25~~ 1-24	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process.	Comment
~~1-26~~ 1-25	Additional state specific Claims Comments	Comment
~~1-27~~ 1-26	Additional state specific Underwriting Comments	Comment

Coverages

Coverages	**Reported also at the Digital Claim Handling Process Level of Detail***
Collision	X
Comprehensive/Other Than Collision	X
Bodily Injury	
Property Damage	X

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

Uninsured Motorists and Underinsured Motorists (UMBI)	
Uninsured Motorists and Underinsured Motorists (UMPD)	X
Medical Payments	
Combined Single Limits	
Personal Injury Protection	

* Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only toclaims related data elements)
Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment.

Schedule 2—Private Passenger Auto Claim 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~~ 2-27	Number of claims open at the beginning of the period
~~2-29~~ 2-28	Number of claims opened during the period
~~2-30~~ 2-29	Number of claims closed with payment during the period.
~~2-31~~ 2-30	Number of claims closed without payment during the period.
~~2-32~~ 2-31	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.
~~2-33~~ 2-32	Number of claims remaining open at the end of the period
~~2-34~~ 2-33	Median days to final payment
~~2-35~~ 2-34	Number of claims closed with payment within 0-30 days
~~2-36~~ 2-35	Number of claims closed with payment within 31-60 days
~~2-37~~ 2-36	Number of claims closed with payment within 61-90 days

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

~~2-38~~ 2-37	Number of claims closed with payment within 91-180 days
~~2-39~~ 2-38	Number of claims closed with payment within 181-365 days
~~2-40~~ 2-39	Number of claims closed with payment beyond 365 days
~~2-41~~ 2-40	Number of claims closed without payment within 0-30 days
~~2-42~~ 2-41	Number of claims closed without payment within 31-60 days
~~2-43~~ 2-42	Number of claims closed without payment within 61-90 days
~~2-44~~ 2-43	Number of claims closed without payment within 91-180 days
~~2-45~~ 2-44	Number of claims closed without payment within 181-365 days
~~2-46~~ 2-45	Number of claims closed without payment beyond 365 days

Schedule 3 – Private Passenger Auto Underwriting Activity

ID	Description
~~3-47~~ 3-46	Number of autos which have policies in force at the end of the period.
~~3-48~~ 3-47	Number of policies in force at the end of the period.
~~3-49~~ 3-48	Number of new policies written during the period.
3-49	Number of non-standard policies issued during the period.
3-50	Total number of policies in force at the end of the period that have Collision coverage.
3-51	Total number of policies in force at the end of the period that have Comprehensive coverage.
3-52	Total number of policies in force at the end of the period that have Bodily Injury coverage.
3-53	Total number of policies in force at the end of the period that have Property Damage coverage.
3-54	Total number of policies in force at the end of the period that have UMBI and UIMBI coverage.
3-55	Total number of policies in force at the end of the period that have UMPD and UIMPD coverage.

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

3-56	Total number of policies in force at the end of the period that have Medical Payments coverage.
3-57	Total number of policies in force at the end of the period that have Combined Single Limits coverage.
3-58	Total number of policies in force at the end of the period that have Personal Injury Protection coverage.
3-59	Number of policies in force at the end of the period that are enrolled in a telematics or usage-based data product(s).
~~3-50~~ 3-60	Dollar amount of direct written premium during the period.
~~3-51~~ 3-61	Number of company-initiated non-renewals during the period.
~~3-52~~ 3-62	Number of cancellations for non-pay or non-sufficient funds.
~~3-53~~ 3-63	Number of cancellations at the insured's request.
~~3-54~~ 3-64	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
~~3-55~~ 3-65	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
~~3-56~~ 3-66	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
~~3-57~~ 3-67	Number of complaints received directly from any person or entity other than the DOI.

Schedule 4—Private Passenger Auto Lawsuit Activity

ID	Description
~~4-58~~ 4-68	Number of lawsuits open at beginning of the period.
~~4-59~~ 4-69	Number of lawsuits opened during the period.
~~4-60~~ 4-70	Number of lawsuits closed during the period.
~~4-61~~ 4-71	Number of lawsuits open at end of period.
~~4-62~~ 4-72	Number of lawsuits closed with consideration for the consumer.

Schedule 5—Private Passenger Auto Attestation

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

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
~~5-63~~ 5-73	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~5-64~~ 5-74	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~5-65~~ 5-75	Overall Comments for the Period

Definitions:

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

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

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

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

Report cancellations separately for:

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

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

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

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

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

Include:

- Both first- and third-party claims.

Exclude:

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

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

Exclude:

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

Clarifications:

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

Calculation Clarification:

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

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

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

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

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

Include:

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

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

Include:

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

Coverage - Collision Insurance – Coverage to provide protection against physical contact of an automobile with another inanimate object resulting in damage to the insured automobile.

Clarification:

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

- Rental/transportation/tow expenses which are paid as a result or part of a collision claim should not be counted as separate claims.

Coverage - Comprehensive/Other than Collision Insurance – Coverage providing protection in the event of physical damage (other than collision), including theft of the insured automobile.

Clarification:

- Rental/transportation/tow expenses which are paid as a result or part of a comprehensive/other than collision claim should not be counted as separate claims.

Coverage - Bodily Injury – Physical damage to one's person. The purpose of liability (casualty) insurance is to cover bodily injury to a third party resulting from the negligent acts and omissions of an insured.

Coverage - Property Damage Liability Insurance – Coverage in the event that the negligent acts or omissions of an insured result in damage or destruction to another's property.

Include:

- 'Property Damage Rental' coverage (i.e. amounts paid for a third party claimant's rental car).

Coverage - UMBI – Includes both Uninsured Motorist Coverage and Underinsured Motorists Coverage for bodily injury claims.

- **Underinsured Motorist Coverage (UIM)** – Provides coverage for bodily injury sustained by an insured who is involved in an accident caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Coverage (UM)** – Provides coverage for bodily injury sustained by an insured involved in an accident caused by an at-fault driver who does not have liability insurance.

Coverage - UMPD – Includes both Uninsured Motorist Property Damage Coverage and Underinsured Motorist Property Damage Coverage.

- **Underinsured Motorist Property Damage Coverage –** Provides coverage for property damage to covered property caused by an at-fault driver who does not have sufficient liability insurance to pay for the damages.

- **Uninsured Motorist Property Damage Coverage** – Provides coverage for property damage to covered property caused by an at-fault driver who does not have liability insurance.

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

Coverage - Medical Payments Coverage – First party coverage for injuries incurred in a motor vehicle accident.

Coverage - Combined Single Limit – Bodily injury liability and property damage liability expressed as a single sum of coverage.

Coverage - Personal Injury Protection (PIP) – A first party benefit. coverage to pay basic expenses for an insured and his/her family in states with no fault automobile insurance laws. No-fault laws generally require drivers to carry personal injury protection coverage to pay for basic medical needs of the insured, such as medical expenses, in the event of an accident. For the purposes of this project, all PIP coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

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

Calculation Clarification:

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

Example:

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

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 Claim Handling Process Level of Detail Breakdown:

Digital Claim – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim

was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the productionof the initial loss settlement offer. Digital claims utilize only digital information toestablish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property isconducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or dataprovided by in-vehicle or in-property sensors.

Hybrid C**laim** – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the useof human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

Non-Digital Claim – means any claim other than a Digital Claim or HybridClaim.

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.

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

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

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.

For purposes of reporting lawsuits for Private Passenger Auto products:

- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- 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 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 claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

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

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

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

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

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

Exclude:

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

- Subrogation payments should not be included.

Calculation Clarification / Example:

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

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

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

Claim	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.

Claim	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

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

61-90	18
91-180	11
181-365	12
>365	15

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

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

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

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- Renewals or 're-written' policies unless there was a lapse in coverage.

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the "non-renewal" clause of the policy.

Include:
- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:
- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:
- The number of non-renewals should be reported on a policy basis regardless of the number of autos insured under the policy.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

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

Private Passenger Auto Insurance – Those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household that are reported on lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement.

Include:

- This covers four-wheel vehicles including station wagons, vans, or pick-up trucks with a gross vehicle weight up to 10,000 pounds or less and not customarily used in the occupation, profession, or business of the insured.
- Vehicles as defined above that are reported on Lines 19.1, 19.2, and 21.1 of the state page of the financial annual statement which meet the definition of private passenger automobiles.
- Motorcycles
- Policies where the insured's vehicle is titled privately to the insured but is used by the insured for work should be included, unless the coverage is written on a commercial auto form.
- Policies written on a volunteer basis and those written through a residual market mechanism such as assigned risk pools should be included.
- Policies written on RV's and motor homes are included as they are licensed vehicles that fall under the various states' Motor Vehicle Responsibility laws.

Exclude:

- Policies written on antiques, collectibles, all-terrain vehicles, snowmobiles, trailers, dune buggies.
- Miscellaneous vehicles written on Inland Marine policies.
- Other vehicles classified by ISO as miscellaneous that do not fall under the various states' Motor Vehicle Responsibility laws.
- 'Fleet' policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as 'private passenger auto' insurance on lines 19.1, 19.2 or 21.1 of the state page of the financial annual statement.
- Non-owned vehicle insurance policies.
- Lender-placed or creditor-placed policies.
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.

Telematics and Usage-Based Data – Data which is collected through devices installed in a vehicle, through mobile applications, or other method. These devices then transmit the data in real time back to insurers. Examples of usage-based data collected via telematics includes - but is not limited to - miles driven, time of day, where the vehicle is driven (Global Positioning System or GPS), rapid acceleration, hard braking, hard cornering and air bag deployment.

MCAS Market Conduct Annual Statement

Homeowners (2026)

Homeowners Interrogatories

		Yes	No	Response	Explanation
01	Were there policies in-force during the reporting period that provided Dwelling coverage?				———
02	Were there policies in-force during the reporting period that provided Personal Property coverage?				———
03	Were there policies in-force during the reporting period that provided Liability coverage?				———
04	Were there policies in-force during the reporting period that provided Medical Payments coverage?				———
05	Were there policies in-force during the reporting period that provided Loss of Use coverage?				———
06	Was the company still actively writing policies in the state at year end?				———
07	Does the company write in the non-standard market?				———
~~08~~	~~If Yes, what percentage of your business is non-standard?~~			———	
~~09~~08	If Yes, how is non-standard defined?			———	
~~10~~09	Has the company had a significant event/business strategy that would affect data for this reporting period?				———
~~11~~10	If yes, add additional comments.			———	
~~12~~11	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?				———
~~13~~12	If yes, add additional comments.			———	
~~14~~13	How does the company treat subsequent supplemental or additional payments on previously closed claims?			———	
~~15~~14	Does the company use Managing General Agents (MGAs)?				———
~~16~~15	If yes, list the names of the MGAs.			———	
~~17~~16	Does the company use Third Party Administrators (TPAs)?				———
~~18~~17	If yes, list the names of the TPAs.			———	
~~19~~18	Does the company use digital claim settlement?				———
~~20~~19	If yes, list the names of the vendors providing third-party dataand algorithms used in the digital claim settlement process.			———	
~~21~~20	Additional state specific Claims comments (optional):			———	
~~22~~21	Additional state specific Underwriting comments (optional):			———	

Homeowners Claims Activity

		Dwelling				Personal Property			
		Digital	Hybrid	Non-Digital	All	Digital	Hybrid	Non-Digital	All
~~23~~22	Number of claims open at the beginning of the period.								———
~~24~~23	Number of claims opened during the period.								———
~~25~~24	Number of claims closed with payment during the period.								———
~~26~~25	Number of claims closed without payment during the period.								———
~~27~~26	Number of claims open at the end of the period.								———
~~28~~27	Median days to final payment.							———	
~~29~~28	Number of claims closed with payment within 0-30 days.								———

Version 2026.0.0 (Updated 05/22/2024)

Homeowners (2026)

Homeowners Claims Activity

		Dwelling				Personal Property			
		Digital	Hybrid	Non-Digital	All	Digital	Hybrid	Non-Digital	All
~~30~~29	Number of claims closed with payment within 31-60 days.								———
~~31~~30	Number of claims closed with payment within 61-90 days.								———
~~32~~31	Number of claims closed with payment within 91-180 days.								———
~~33~~32	Number of claims closed with payment within 181-365 days.								———
~~34~~33	Number of claims closed with payment beyond 365 days.								———
~~35~~34	Number of claims closed without payment within 0-30 days.								———
~~36~~35	Number of claims closed without payment within 31-60 days.								———
~~37~~36	Number of claims closed without payment within 61-90 days.								———
~~38~~37	Number of claims closed without payment within 91-180 days.								———
~~39~~38	Number of claims closed without payment within 181-365 days.								———
~~40~~39	Number of claims closed without payment beyond 365 days.								———

Homeowners Underwriting Activity

		Total
~~41~~40	Number of dwellings which have policies in force at the end of the period.	
~~42~~41	Number of dwelling fire policies in force at the end of the period.	
~~43~~42	Number of homeowner policies in force at the end of the period.	
~~44~~43	Number of tenant/renter/condo policies in force at the end of the period.	
~~45~~44	Number of all other residential property policies in force at the end of the period.	
~~46~~45	Number of new business policies written during the period.	
46	Number of non-standared policies issued during the period.	
47	Dollar amount of direct premium written during the period.	
48	Number of company-initiated non-renewals during the period.	
49	Number of cancellations for non-pay or non-sufficient funds.	
50	Number of cancellations at the insured's request	
51	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.	
52	Number of company-initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to a related company.	
53	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.	
54	Number of complaints received directly from any person or entity other than the DOI.	

Version 2026.0.0 (Updated 05/22/2024)

Homeowners (2026)

Lawsuit Activity

		Dwelling	Personal Property	Liability	Medical Payments
55	Number of lawsuits open at beginning of the period				
56	Number of lawsuits opened during the period				
57	Number of lawsuits closed during the period				
58	Number of lawsuits open at end of period				
59	Number of lawsuits closed with consideration for the consumer				

Homeowners Attestation

		First Name	Middle Name	Last Name	Suffix
60	First Attestor Information				
61	Second Attestor Information				
62	Overall Comments for the Filing Period	———	———	———	———

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

Line of Business: Homeowners

Reporting Period: January 1, 2026 through December 31, 2026

Filing Deadline: April 30, 2027

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~~ 1-08	If yes, how is non-standard defined?	Comment
~~1-10~~ 1-09	Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No	Yes/No
~~1-11~~ 1-10	If yes, add additional comments	Comment

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

~~1-12~~ 1-11	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~~ 1-12	If yes, add additional comments	Comment
~~1-14~~ 1-13	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~~ 1-14	Does the company use Managing General Agents (MGAs)?	Yes/No
~~1-16~~ 1-15	If yes, list the names of the MGAs.	Comment
~~1-17~~ 1-16	Does the company use Third Party Administrators (TPAs)?	Yes/No
~~1-18~~ 1-17	If yes, list the names of the TPAs.	Comment
~~1-19~~ 1-18	Does the company use digital claim settlement?	Yes/No
~~1-20~~ 1-19	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process.	Comment
~~1-21~~ 1-20	Claims Comments	Comment
~~1-22~~ 1-21	Underwriting Comments	Comment

Coverages	**Reported also at the Digital Claim Handling Process Level of Detail***
Dwelling (includes – Other Structures)	**X**
Personal Property	**X**
Liability	
Medical Payments	
Loss of Use	

***Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)**
Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment

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

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

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~~ 2-22	Number of claims open at the beginning of the period
~~2-24~~ 2-23	Number of claims opened during the period
~~2-25~~ 2-24	Number of claims closed during the period, with payment
~~2-26~~ 2-25	Number of claims closed during the period, without payment
~~2-27~~ 2-26	Number of claims open at the end of the period
~~2-28~~ 2-27	Median days to final payment
~~2-29~~ 2-28	Number of claims closed with payment within 0-30 days
~~2-30~~ 2-29	Number of claims closed with payment within 31-60 days
~~2-31~~ 2-30	Number of claims closed with payment within 61-90 days
~~2-32~~ 2-31	Number of claims closed with payment within 91-180 days
~~2-33~~ 2-32	Number of claims closed with payment within 181-365 days
~~2-34~~ 2-33	Number of claims closed with payment beyond 365 days
~~2-35~~ 2-34	Number of claims closed without payment within 0-30 days
~~2-36~~ 2-35	Number of claims closed without payment within 31-60 days
~~2-37~~ 2-36	Number of claims closed without payment within 61-90 days
~~2-38~~ 2-37	Number of claims closed without payment within 91-180 days
~~2-39~~ 2-38	Number of claims closed without payment within 181-365 days

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

~~2-40~~ 2-39	Number of claims closed without payment beyond 365 days

Schedule 3—Homeowners Underwriting Activity

ID	Description
~~3-41~~ 3-40	Number of dwellings which have policies in-force at the end of the period
~~3-42~~ 3-41	Number of dwelling fire policies in force at the end of the period.
~~3-43~~ 3-42	Number of homeowner policies in force at the end of the period.
~~3-44~~ 3-43	Number of tenant/renter/condo policies in force at the end of the period.
~~3-45~~ 3-44	Number of all other residential property policies in force at the end of the period.
~~3-46~~ 3-45	Number of new business policies written during the period
3-46	Number of non-standard policies issued during the period
3-47	Dollar amount of direct premium written during the period
3-48	Number of Company-Initiated non-renewals during the period
3-49	Number of cancellations for non-pay or non-sufficient funds
3-50	Number of cancellations at the insured's request
3-51	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-52	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
3-53	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-54	Number Of Complaints Received Directly From Any Person or Entity Other than the DOI

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

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
4-55	Number of lawsuits open at beginning of the period
4-56	Number of lawsuits opened during the period
4-57	Number of lawsuits closed during the period
4-58	Number of lawsuits open at end of period
4-59	Number of lawsuits closed with consideration for the consumer

Schedule 4– Homeowners Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

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

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
4-60	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
4-61	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
4-62	Overall Comments for the Period

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.

Please note: In the Underwriting Section there are questions asking for policies in-force by type of policy. These are asking for a count of the policies in-force that meet the specifications to be included on the MCAS. Please use the following as a guide to determine which policy types should be reported for each question:

(3-45) Number of dwelling fire policies in force at the end of the period.
Include dwelling policies that meet the definition of a dwelling policy as defined within this document. This would typically include policies written on forms DP-1, DP-2 and DP-3.

(3-46) Number of homeowner policies in force at the end of the period.
Include homeowner policies that meet the definition of a homeowner policy as defined within this document. This would typically include policies written on forms HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8.

(3-47) Number of tenant/renter/condo policies in force at the end of the period.
Include tenant/renter/condo policies that meet the definition of a tenant/renter/condo policy as defined within this document. This would typically include policies written on forms HO-4 and HO-6.

(3-48) Number of all other residential property policies in force at the end of the period.
Include other policies that meet the specifics of MCAS reporting, but that do not fall into one of the categories requested in questions 3-45, 3-46 and 3-47. If your company only write policies that fall into the forms specified for questions 3-45, 3-46 and 3-47, this number will be 0.

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

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

Report cancellations separately for:

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

Exclude:

- Policies cancelled for 're-write' purposes where there is no lapse in coverage.

Cancellations within the first 59 days – Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations from 60 to 90 days – Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

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

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

Include:
- Both first and third party claims.

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

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

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

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

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

Handling Additional Payment on Previously Reported Claim / Subsequent Supplemental Payment for claims closed with payment during the reporting period:
- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on that supplemental payment from the time the request for supplemental payment was received to the date of the final payment was made.

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

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

Include:

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

Calculation Clarification:

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

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

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

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

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

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

Coverage - Liability – Liability insurance provided under Homeowners Policies.

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

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

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 Claim Handling Process Level of Detail Breakdown:

Digital Claim – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the productionof the initial loss settlement offer. Digital claims utilize only digital information toestablish the extent of damage and to produce a loss settlement determination through the application of one or more automated loss algorithms applied to digital information. No human inspection or appraisal of the damaged property isconducted by the insurance company, independent adjuster, or other person relied upon by the insurance company during the life cycle of the claim.

Examples of digital claim information include, but are not limited to, photos taken by a claimant or insured, photos taken by a plane or drone, and/or dataprovided by in-vehicle or in-property sensors.

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

Hybrid Claim – A claim whereby the initial loss settlement determination began as a digital claim, however, at some point in the claim life cycle required the useof human resources in the loss appraisal process, settlement determination, and/or in the production of the initial or subsequent loss settlement offer.

Non-Digital Claim – means any claim other than a Digital Claim or HybridClaim.

Direct Written Premium - The total amount of direct written premium for all polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:

- Premium amounts should be determined in the same manner as used for the financial annual statement.
- If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.
- If there is a difference of 20% or more between the Direct Written Premium reported for market conduct annual statement and the Direct Written Premium reported on the financial annual statement, provide an explanation for the difference when filing the market conduct annual statement in order to avoid inquiries from the regulator receiving the market conduct annual statement filing.
- Reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

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

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

Include:

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

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

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

Include:
- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
- Renters insurance,-Policies covering log homes, land homes, and site built homes are included.
- Inland Marine or Personal Articles endorsements.
- Include policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms.

Exclude:
- Farmowners is not included as it is considered to be Commercial Lines for purposes of this project.
- Umbrella policies.
- Lender-placed or creditor-placed policies.

Inland Marine or Personal Articles Endorsements – Provides coverage via endorsement to a homeowners policy for direct physical loss to personal property as described in the endorsement.

Exclude:
- Stand-alone Inland Marine Policies.

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

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 lawsuits for Homeowner products:
- For non-claims related lawsuits, include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer as a defendant.

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

- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- 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.

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 claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Liability Insurance – Coverage for all sums that the insured becomes legally obligated to pay because of bodily injury or property damage, and sometimes other torts to which an insurance policy applies.

Loss Of Use – Coverage for additional living expenses incurred by the insured or fair rental value when the insured dwelling becomes uninhabitable as the result of an insured loss or when access to the dwelling is barred by civil authority.

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

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

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

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

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

Exclude:

- Subrogation payments.

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

Calculation Clarification / Example:

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

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

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

Claim	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.

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

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

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

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

Closing Time	**# of Claims**
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

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

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

Medical Payments Coverage – Provides coverage for medical expenses resulting from injuries sustained by a claimant regardless of liability.

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

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

New Business Policy Written – A newly written agreement that puts insurance coverage into effect during the reporting period.

Exclude:
- 'Re-written' policies unless there was a lapse in coverage.

Non-Renewals – A policy for which the insurer elected not to renew the coverage for circumstances allowed under the "non-renewal" clause of the policy.

Include:
- All company-initiated non-renewals of the policies where the non-renewal effective date is during the reporting period.

Exclude:
- Policies where a renewal offer was made and the policyholder did not accept the offer.
- Instances where the policyholder requested that the policy not be renewed.

Calculation Clarification:
- The number of nonrenewals should be reported on a policy basis regardless of the number of dwellings insured under the policy.

Other Structures – Structures on the residence premises (1) separated from the dwelling by a clear space or (2) connect to the dwelling by a fence, wall, wire, or other form of connection but not otherwise attached.

Personal Property Damage Coverage – Provides coverage for damage to dwelling contents or other covered personal property caused by an insured peril.

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

Personally Occupied – A dwelling in which the person owning the policy personally occupies the dwelling and lives there.

Property Damage Coverage – Provides coverage for damage to the dwelling and/or other insured structures caused by an insured peril.

Policy In-force – A policy in which the coverage is in effect as of the end of the reporting period.

Tenant/Renters/Condo Policies – Policies that provide coverage for the personal property of tenants, renters, condominium and cooperative unit owners. Include policies typically written on the HO-4 and HO-6 policy forms.

MCAS Market Conduct Annual Statement

Lender-Placed Insurance (2026)

Lender-Placed Insurance Interrogatories

		Yes/No Response	Explanation
01	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed auto coverage?		_____
02	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were single-interest lender-placed auto.	_____	
03	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed auto coverage?		_____
04	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were dual-interest lender-placed auto.	_____	
05	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners hazard coverage?		_____
06	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were single-interest lender-placed homeowners hazard	_____	
07	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners hazard coverage?		_____
08	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were dual-interest lender-placed homeowners hazard	_____	
09	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners flood coverage?		_____
10	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were single-interest lender-placed homeowners flood	_____	
11	Were there policies/certificates in-force during the reporting period that provided dual-		_____
12	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were dual-interest lender-placed homeowners flood coverage.	_____	
13	Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners wind-only coverage?		_____
14	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were single-interest lender-placed homeowners wind-only	_____	
15	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners wind-only coverage?		_____
16	If Yes, enter the percentage of all lender-placed home policies/certificates issued during the period which were dual-interest lender-placed homeowners wind-only	_____	

Lender-Placed Insurance (2026)

17	Were there policies-in-force during the reporting period that provided blanket vendor single-interest auto (vehicle) coverage?			———
18	Were there policies-in-force during the reporting period that provided blanket vendor single-interest home (residential property) coverage?			———
19	Was the company still actively writing policies/certificates in the state at year end?			———
20	Has the company had a significant event/business strategy that would affect data for this reporting period?			———
21	If yes, add additional comments:	———		
22	Has all or part of this block of business been sold, closed or moved to another company during the year?			———
23	If yes, add additional comments	———		
24	How does the company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? For example: Reopen original claim/open new claim	———		
25	Does the company require third parties it contracts with to forward insurance-related complaints to the company so the company may report the complaints in its complaints logs?			———
26	Additional comments if desired:	———		
27	Does the company monitor third parties it contracts with to ensure insurance complaints are forwarded to the company?			———
28	Additional comments if desired	———		
29	Additional state specific Claims comments	———		
30	Additional state specific Underwriting comments	———		

Lender-Placed Claims Activity

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
31	Number of claims open at the beginning of the period.										
32	Number of claims opened during the period.										
33	Number of claims closed during the period, with payment										
34	Number of claims closed during the period, without payment										

35	Number of claims remaining open at the end of the period										
35	Number of claims closed with payment within 0-30 days.										

Lender-Placed Insurance (2026)

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
36	Number of claims closed with payment within 31-60 days.										
37	Number of claims closed with payment within 61-90 days.										
39	Number of claims closed with payment within 91-180 days.										
40	Number of claims closed with payment within 181-365 days.										
41	Number of claims closed with payment beyond 365 days.										
42	Number of claims closed without payment within 0-30 days.										
43	Number of claims closed without payment within 31-60 days.										
44	Number of claims closed without payment within 61-90 days.										
45	Number of claims closed without payment within 91-180 days.										
46	Number of claims closed without payment within 181-365 days.										
47	Number of claims closed without payment beyond 365 days.										
48	Median days to final payment.										
49	Number of suits open at beginning of the period.										
50	Number of suits opened during the period.										
51	Number of suits closed during the period.										
52	Number of suits closed during the period with consideration for the borrower.										
53	Number of suits open at end of period.										

Lender-Placed Underwriting Activity

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
54	Number of master policies in-force at beginning of the period.										
55	Number of master policies added during the period.										
56	Number of master policies canceled for any reason during the period.										
57	Number of master policies in-force at the end of the period.										

Lender-Placed Insurance (2026)

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Blanket Vendor Single-Interest Auto	Blanket Vendor Single-Interest Home
58	Number of certificates in-force at the beginning of the period.										
59	Number of certificates written during the period.										
60	Number of certificates for which Term of Coverage Completed during the period.										
~~60~~ 61	Number of certificates in-force at the end of the period.										
~~61~~ 62	Number of certificates flat-cancelled during the period.										
~~62~~ 63	Number of certificates cancelled for reasons other than										
~~63~~ 64	Number of flat cancellations on certificates within 45 days of placement.										
~~64~~ 65	Number of flat cancellations on certificates within 45-90 days of placement.										
~~65~~ 66	Number of flat cancellations on certificates after 90 days from placement.										
~~66~~ 67	Number of individual policies in-force at the beginning of the period.										
~~67~~ 68	Number of individual policies written during the period.										
69	Number of individual policies for which Term of Coverage Completed during the period.										
~~68~~ 70	Number of individual policies in-force at the end of the period.										
~~69~~ 71	Number of individual policies cancelled for reasons other than flat cancellations during the period.										
~~70~~ 72	Number of individual policies flat-cancelled during the period.										
~~71~~ 73	Number of flat cancellations on individual policies within 45 days of placement.										
~~72~~ 74	Number of flat cancellations on individual policies within 45-90 days of placement.										
~~73~~ 75	Number of flat cancellations on individual policies after 90 days from placement.										
~~74~~ 76	Average gross placement rate during period.										

Lender-Placed Insurance (2026)

		Single-Interest Auto	Dual-Interest Auto	Single-Interest Home Hazard	Dual-Interest Home Hazard	Single-Interest Home Flood	Dual-Interest Home Flood	Single-Interest Home Wind-Only	Dual-Interest Home Wind-Only	Vendor Single-Interest Auto	Vendor Single-Interest Home
~~75~~ 77	Dollar amount of gross written premium during the period.										
~~76~~ 78	Dollar amount of net written premium during the period.										
~~77~~ 79	Net written premium during period for policies/certificates for which no separate charge is made to the borrower.										
~~78~~ 80	Dollar amount of premium earned during the period.										
~~79~~ 81	Dollars of claims paid during the period.										
~~80~~ 82	Dollars of claims incurred during the period.										
~~81~~ 83	Number of complaints received directly from the DOI.										
~~82~~ 84	Number of complaints received directly from any person or entity other than the DOI.										

Lender-Placed Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
~~83~~ 85	First Attestor Information						———
~~84~~ 86	Second Attestor Information						———
~~85~~ 87	Overall Comments for the Filing Period	———	———	———	———	———	

MCAS Market Conduct Annual Statement

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

Lines of Business: Lender-Placed Auto and Lender-Placed Homeowners
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

Contact Information

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

Schedule 1—Interrogatories

ID	Description	Response
1-01	Were there policies/certificates in-force during the	Yes/No
1-02	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which	Comment
1-03	Were there policies/certificates in-force during the	Yes/No
1-04	If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which	Comment
1-05	Were there policies/certificates in-force during the reporting period that provided single-interest lender-	Yes/No
1-06	If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during	Percentage
1-07	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-	Yes/No
1-08	If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during	Percentage
1-09	Were there policies/certificates in-force during the reporting period that provided single-interest lender-	Yes/No
1-10	If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during	Percentage
1-11	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-	Yes/No
1-12	If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during	Percentage

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

1-13	Were there policies/certificates in-force during the reporting period that provided single-interest lender-	Yes/No
1-14	If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued	Percentage
1-15	Were there policies/certificates in-force during the reporting period that provided dual-interest lender-	Yes/No
1-16	If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued	Percentage
1-17	Were there policies-in-force during the reporting	Yes/No
1-18	Were there policies-in-force during the reporting period that provided blanket vendor single interest	Yes/No
1-19	Was the company still actively writing	Yes/No
1-20	Has the company had a significant event/business	Yes/No
1-21	If yes, add additional comments	Comment
1-22	Has this block of business or part of this block of	Yes/No
1-23	If yes, add additional comments	Comment
1-24	How does the company treat subsequent supplemental payments on previously closed claims	Comment
1-25	Does the company require third parties it contracts with to forward insurance-related complaints to the	Yes/No
1-26	Add additional comment if desired	Comment
1-27	Does the company monitor third parties it contracts	Yes/No
1-28	Add additional comment if desired	Comment
1-29	Claims Comments	Comment (if necessary)
1-30	Underwriting Comments	Comment (if necessary)

Coverages

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

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

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

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

ID	Description
2-31	Number of claims open at the beginning of the period
2-32	Number of claims opened during the period
2-33	Number of claims closed during the period, with payment
2-34	Number of claims closed during the period, without payment
2-35	Number of claims remaining open at the end of the period
2-36	Number of claims closed with payment within 0-30 days
2-37	Number of claims closed with payment within 31-60 days
2-38	Number of claims closed with payment within 61-90 days
2-39	Number of claims closed with payment within 91-180 days
2-40	Number of claims closed with payment within 181-365 days
2-41	Number of claims closed with payment beyond 365 days
2-42	Number of claims closed without payment within 0-30 days
2-43	Number of claims closed without payment within 31-60 days
2-44	Number of claims closed without payment within 61-90 days
2-45	Number of claims closed without payment within 91-180 days
2-46	Number of claims closed without payment within 181-365 days
2-47	Number of claims closed without payment beyond 365 days
2-48	Median days to final payment
2-49	Number of suits open at beginning of the period
2-50	Number of suits opened during the period
2-51	Number of suits closed during the period
2-52	Number of suits closed during the period with consideration for the borrower
2-53	Number of suits open at end of the period

Schedule 3—Lender-Placed Auto and Home Underwriting Elements

ID	Description
3-54	Number of master policies in-force at beginning of the period
3-55	Number of master policies added during the period
3-56	Number of master policies canceled for any reason during the period
3-57	Number of master policies in-force at the end of the period
3-58	Number of certificates in-force at the beginning of the period
3-59	Number of certificates written during the period
3-60	Number of certificates for which Term of Coverage Completed during the period
~~3-60~~ 3-61	Number of certificates in-force at the end of the period

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

~~3-61~~ 3-62	Number of certificates flat-cancelled during the period
~~3-62~~ 3-63	Number of certificates cancelled for reasons other than flat cancellations during the period
~~3-63~~ 3-64	Number of flat cancellations on certificates within 45 days of placement
~~3-64~~ 3-65	Number of flat cancellations on certificates within 45-90 days of placement
~~3-65~~ 3-66	Number of flat cancellations on certificates after 90 days from placement
~~3-66~~ 3-67	Number of individual policies in-force at the beginning of the period
~~3-67~~ 3-68	Number of individual policies written during the period
3-69	Number of individual policies for which Term of Coverage Completed during the period
~~3-68~~ 3-70	Number of individual policies in-force at the end of the period
~~3-69~~ 3-71	Number of individual policies cancelled for reasons other than flat cancellations during the period
~~3-70~~ 3-72	Number of individual policies flat-cancelled during the period
~~3-71~~ 3-73	Number of flat cancellations on individual policies within 45 days of placement
~~3-72~~ 3-74	Number of flat cancellations on individual policies within 45-90 days of placement
~~3-73~~ 3-75	Number of flat cancellations on individual policies after 90 days from placement
~~3-74~~ 3-76	Average gross placement rate during period
~~3-75~~ 3-77	Dollar amount of gross written premium during the period
~~3-76~~ 3-78	Dollar amount of net written premium during the period
~~3-77~~ 3-79	Net written premium during period for policies/certificates for which no separate charge is made to the borrower
~~3-78~~ 3-80	Dollar amount of premium earned during the period
~~3-79~~ 3-81	Dollars of claims paid during the period

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

~~3-80~~ 3-82	Dollars of claims incurred during the period
~~3-81~~ 3-83	Number of complaints received directly from the DOI
~~3-82~~ 3-84	Number of complaints received directly from any person or entity other than the DOI

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

ID	Description
3-54	Number of master policies in-force at beginning of the period
3-55	Number of master policies added during the period
3-56	Number of master policies canceled for any reason during the period
3-57	Number of master policies in-force at the end of the period
3-58 3-77	Dollar amount of gross written premium during the period
3-59 3-78	Dollar amount of net written premium during the period
3-60 3-79	Net written premium during period for policies/certificates for which no separate charge is made to the borrower
3-61 3-80	Dollar amount of premium earned during the period
3-62 3-81	Dollar of claims paid during the period
3-63 3-82	Dollars of claims incurred during the period
3-64 3-83	Number of complaints received directly from the DOI
3-65 3-84	Number of complaints received directly from any person or entity other than the DOI

Schedule 4—Lender-Placed Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
~~4-83~~ 4-85	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~4-84~~ 4-86	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
~~4-85~~ 4-87	Overall Comments for the Period

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

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

Except for data element "Net premium written during period for policies/certificates for which no separate charge is made to the borrower," report experience for lender-placed insurance products for which a separate charge is made to the borrower regardless of

whether the charge to the borrower is made at loan origination, periodically while the loan is outstanding or following issuance of coverage under the master policy.

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

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

In determining what business to report for a particular state, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the CIEE. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

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

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

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

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

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

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

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

- Is provided through a blanket policy covering eligible collateral securing loans in the lender/servicer's portfolio
- Premium charges to the lender/servicer are based on aggregate exposures insured as opposed to any characteristics specific to any individual vehicle or property;

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

- No individual certificates or policies are issued to borrowers
- Has no ongoing tracking of insurance on borrower's loans; and
- If there is a charge to the borrower at loan origination, the same charge is made for all borrowers with eligible collateral regardless of insurance status.

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

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

Cancellations – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage. Coverage under an individual policy or a certificate under a group policy ending at the end of the term of coverage is not a cancellation, even if the coverage is renewed through a subsequent individual policy or certificate. See also Flat Cancellation

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

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

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

Include:
- Both first and third party claims.

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

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

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

Exclude:

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

Clarifications:

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

Calculation Clarification:

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

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

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

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

Include:

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

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

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

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties, including, but not limited to, lenders or servicers

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

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

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

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

Example:

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

- The number of days to final payment would be calculated as 30 days and reported in the "01" MCAS submission.

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

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

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

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

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

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

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

Example:

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

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

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;

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

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

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

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

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

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

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

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

Exclude:

- Subrogation payments.

Calculation Clarification / Example:

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

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

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

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

Claim	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.

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

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

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

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

Closing Time	# of Claims
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

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

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

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

Property & Casualty Market Conduct Annual Statement Lender-Placed Data Call & Definitions

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

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

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

Term of Coverage Completed – Include individual policies and certificates for which the term of coverage was completed and ended during the period.

MCAS Market Conduct Annual Statement

Line of Business: Pet

Reporting Period: January 1, 2026 through December 31, 2026

Filing Deadline: April 30, 2027

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	Did the company conduct any business related to individual pet insurance policies during the period?	Yes/No
1-02	Did the company conduct any business related to group pet insurance policies during the period?	Yes/No
1-03	Did the company conduct any stand-alone pet Wellness Insurance business during the reporting period?	Yes/No
1-04	Did the company conduct any Accident & Illness, Accident only, or Illness only pet insurance business during the reporting period?	Yes/No
1-05	Did the company conduct any pet insurance business during the reporting period that does not fit into the following categories: Wellness Only, Accident & Illness, Accident only, or Illness only?	Yes/No
1-06	If yes, describe the other types of pet insurance business conducted during the reporting period	Comment
1-07	On which annual statement line(s) of business on the state page of the statutory annual statement does the company report pet insurance experience?	Comment
1-08	Was the company still actively marketing or writing pet insurance in the jurisdiction at the end of the reporting period?	Yes/No
1-09	Has the company had a significant event/business strategy change	Yes/No

Market Conduct Annual Statement Pet Insurance Data Call & Definitions

	that would affect data for this reporting period?	
1-10	If yes, explain the situation and how it may affect the data	Comment
1-11	Has all or part of the company's pet insurance block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-12	If yes, describe the nature and extent of the transaction(s)	Comment
1-13	How does the company treat subsequent supplemental or additional payments on previously closed claims?	Comment
1-14	Does the company use pet program administrators, managing general agents (MGA) or insurance producers for purposes of supporting the pet insurance business being reported, other than the sale, solicitation, or negotiation of business?	Yes/No
1-15	If yes, provide the names, NPN (if applicable) and functions for each third party identified in question 14	Comment
1-16	Does the company have a system of supervision in place to oversee and potentially audit each type of third party identified in question 14?	Yes/No
1-17	If yes, please provide frequency of audits, if any, for each type of third party identified in question 14	Comment
1-18	Does the company require third parties identified in question 14 to forward insurance-related complaints to the company so the company may report the complaints in its complaint logs?	Yes/No
1-19	Does the company or any of its pet program administrators, managing general agents (MGA) or insurance producers offer a non-insurance wellness program to the consumers of the company's pet insurance products?	Yes/No
1-20	Additional comments if desired:	Comment
1-21	Additional state specific Underwriting Activity comments (optional)	Comment
1-22	Additional state specific Claims Activity comments (optional)	Comment
1-23	Additional state specific Marketing & Sales comments (optional)	Comment
1-24	Additional state specific Lawsuit and Complaint comments (optional)	Comment

Schedule 2 – Underwriting Activity

The Underwriting Activity schedule is to be reported for both Individual and Group policies/certificates

ID	Description
2-25	Number of policies in force at the beginning of the period

Market Conduct Annual Statement Pet Insurance Data Call & Definitions

2-26	Number of certificates in force at the beginning of the period (Group only)
2-27	Number of covered pets on policies/certificates in force at the beginning of the period
2-28	Number of policies in force during the period that included accident-only coverage
2-29	Number of certificates in force during the period that included accident-only coverage (Group only)
2-30	Number of policies in force during the period that included illness-only coverage
2-31	Number of certificates in force during the period that included illness-only coverage (Group only)
2-32	Number of policies in force during the period that included accident and illness coverage
2-33	Number of certificates in force during the period that included accident and illness coverage (Group only)
2-34	Number of policies in force during the period that included wellness coverages (other than a wellness only policy)
2-35	Number of certificates in force during the period that included wellness coverages (other than a wellness only policy) (Group only)
2-36	Number of policies in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness)
2-37	Number of certificates in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness) (Group only)
2-38	Number of policies returned during the period under the consumer's "Right to Examine and Return the Policy"
2-39	Number of certificates returned during the period under the consumer's "Right to Examine and Return the Policy" (Group only)
2-40	Number of policies cancelled/terminated during the period at the policyholder's request
2-41	Number of certificates cancelled/terminated during the period at the certificate holders request (Group only)
2-42	Number of policies cancelled/terminated during the period by the insurer
2-43	Number of certificates cancelled/terminated during the period by the insurer (Group only)
2-44	Number of policies cancelled/terminated during the period for non-pay or non-sufficient funds
2-45	Number of certificates cancelled/terminated during the period for non-pay or non-sufficient funds (Group only)
2-46	Number of company-initiated policy non-renewals during the period
2-47	Number of company-initiated certificate non-renewals during the period (Group only)

Market Conduct Annual Statement Pet Insurance Data Call & Definitions

2-48	Number of certificates expired during the period (Group only)
2-49	Number of new policies issued during the period
2-50	Number of new certificates issued during the period (Group only)
2-51	Number of covered pets on new policies/certificates issued during the period
2-52	Number of policies in force at end of the period
2-53	Number of certificates in force at the end of the period (Group only)
2-54	Number of covered pets on policies/certificates in force at the end of the period
2-55	Number of renewal policies issued during the period
2-56	Number of renewal certificates issued during the period (Group only)
2-57	Dollar amount of direct premium written during the period
2-58	Dollar amount of direct premium earned during the period
2-59	Number of applications pending at beginning of the period
2-60	Number of new applications received during the period (Individual Only)
2-61	Number of new applications denied for health status or condition during the period (Individual Only)
2-62	Number of new applications denied for any other reason during the period (Individual Only)
2-63	Number of applications pending at the end of the period (Individual Only)
2-64	Number of policies issued during the period that included a preexisting condition exclusion
2-65	Number of certificates issued during the period that included a preexisting condition exclusion (Group only)

Schedule 3 – Claims Activity

The Claims Activity schedule is to be reported for Wellness (Only), Accident & Illness, and Other policy types. Report median day data elements in aggregate only.

ID	Description
3-66	Number of claims open at the beginning of the period
3-67	Number of claims opened during the period
3-68	Number of claims closed during the period
3-69	Number of claims closed during the period with full payment
3-70	Dollar amount of claims closed with full payment during the period
3-71	Median days to claim closure for claims closed with full payment (Aggregate only)

Market Conduct Annual Statement Pet Insurance Data Call & Definitions

3-72	Number of claims closed during the period with partial payment
3-73	Dollar amount requested for claims closed with partial payment during the period
3-74	Dollar amount of claims closed with partial payment during the period
3-75	Median days to claim closure for claims closed with partial payment (Aggregate only)
3-76	Median days to final payment for all claims paid in full and closed with partial payment (Aggregate only)
3-77	Number of claims closed during the period, without payment
3-78	Dollar amount requested for claims closed without payment during the period
3-79	Median days to claim closure for claims closed without payment during the period (Aggregate only)
3-80	Number of claims open at the end of the period
3-81	Number of claims closed during the period with full payment 0-30 days
3-82	Number of claims closed during the period with full payment 31-60 days
3-83	Number of claims closed during the period with full payment 61-90 days
3-84	Number of claims closed during the period with full payment 91-180 days
3-85	Number of claims closed during the period with full payment 181-365 days
3-86	Number of claims closed during the period with full payment beyond 365 days
3-87	Number of claims closed during the period with partial payment 0-30 days
3-88	Number of claims closed during the period with partial payment 31-60 days
3-89	Number of claims closed during the period with partial payment 61-90 days
3-90	Number of claims closed during the period with partial payment 91-180 days
3-91	Number of claims closed during the period with partial payment 181-365 days
3-92	Number of claims closed during the period with partial payment beyond 365 days
3-93	Number of claims closed during the period without payment within 0-30 days
3-94	Number of claims closed during the period without payment within 31-60 days
3-95	Number of claims closed during the period without payment within 61-90 days
3-96	Number of claims closed during the period without payment within 91-180 days
3-97	Number of claims closed during the period without payment within 181-365 days
3-98	Number of claims closed during the period without payment beyond 365 days
3-99	Number of claims closed during the period without payment – ineligibility
3-100	Number of claims closed during the period without payment – preexisting condition exclusion
3-101	Number of claims closed during the period without payment – waiting period
3-102	Number of claims closed during the period without payment – maximum benefit limit
3-103	Number of claims closed during the period without payment – claim amount less than

	deductible
3-104	Number of claims closed during the period without payment – inadequate documentation
3-105	Number of claims closed during the period without payment – hereditary disorder exclusion
3-106	Number of claims closed during the period without payment – congenital anomaly or disorder exclusion
3-107	Number of claims closed during the period without payment – chronic condition exclusion
3-108	Number of claims closed during the period without payment for reasons other than questions 99-107
3-109	Number of claims closed during the period with partial payment – maximum benefit limit
3-110	Number of claims closed during the period with partial payment – inadequate documentation
3-111	Number of claims closed during the period with partial payment for reasons other than questions 109-110
3-112	Number of claimant requests/benefit requests subject to a preexisting condition exclusion

Schedule 4 – Marketing and Sales

The Marketing and Sales schedule is to be reported for both Individual and Group policies/certificates

ID	Description
4-113	Dollar amount of commissions incurred during the period
4-114	Unearned commissions returned to the company during the period

Schedule 5 – Lawsuit and Complaint Activity

The Lawsuit and Complaint Activity schedule is to be reported for both Individual and Group policies/certificates

ID	Description
5-115	Number of complaints received directly from any person or entity other than the DOI
5-116	Number of lawsuits open at the beginning of the period
5-117	Number of lawsuits opened during the period
5-118	Number of lawsuits closed during the period
5-119	Number of lawsuits open at the end of the period
5-120	Number of lawsuits closed with consideration for the consumer

Schedule 6 – Pet Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
6-121	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-122	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
6-123	Overall Comments for the Period

In determining what business to report for a particular jurisdiction, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

Market Conduct Annual Statement Pet Insurance Data Call & Definitions

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

Definitions for the purposes of MCAS reporting:

Cancellations – 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.
- Policies returned by the owner under the right to review or the free look provision.

Chronic Condition – A condition that can be treated or managed, but not cured.

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

Exclude:

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

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

Exclude:

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

Clarifications:

Market Conduct Annual Statement Pet Insurance Data Call & Definitions

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

Calculation Clarification:

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

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

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

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

Include:

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

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.

Commissions – Compensation, as defined as Commissions and Brokerage Expenses in the statutory financial annual statement instructions, paid to a producer or appropriately licensed entity for the sale, solicitation or negotiation of pet insurance.

Complaints Received Directly from any Person or Entity Other than the

Market Conduct Annual Statement Pet Insurance Data Call & Definitions

Department of Insurance – 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

Congenital Anomaly or Disorder – A condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

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

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

Example:

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

Hereditary Disorder – An abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

Individual vs. Group Policies – Report business associated with individual policy forms as individual. Report business associated with group policy forms, such as certificates, as group. Report business issued to individuals in the Individual column even if it is marketed through a group channel.

Insurer Non-Renewals – 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, as policyholder cancellations).

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

For purposes of reporting lawsuits in the Pet MCAS blank:

- 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 – 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.

Managing General Agent (MGA) – An insurance producer authorized by an insurance company to manage all or part of the insurer's business. 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.

Median – A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If

the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

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

Claim	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.

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

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

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

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

Closing Time	**# of Claims**
< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

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

National Producer Number (NPN) – 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).

Non-Insurance Wellness Program – 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. 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.

Number of Policies Renewed – 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 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).

Other Policy Type – Any policy type other than a Wellness Policy and/or an Accident/Illness Policy.

Partial Payment – A claim not paid in full for costs included within the terms of coverage of the insurance policy/certificate.

- Removal from a claim of charges for costs not covered in the policy – where there is full payment for costs covered in the policy – is not considered a partial payment.
- Do not report as partial payment claims that are reduced by deductibles, copays, ~~maximum benefit limits,~~ or other limitations set by the insurance policy/certificate.

Pet Insurance means a property insurance policy that provides coverage for one or more of the following: accidents, illnesses or wellness of pets. Pet insurance does not include non-insurance wellness programs for pets.

Pet Program Administrator – An individual or entity that directly or indirectly underwrites, collects charges or premium from, or adjusts or settles claims on residents of a state, in connection with pet coverage offered or provided by an insurer, unless excepted by statute.

Policies/Certificates – Refers to the coverage documents provided to individuals or

families (i.e., state residents) who are enrolled in coverage.

Policyholder/Certificate Holder – 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. Certificate holder is the individual when purchased through a group, which is the policyholder.

Policyholder Cancellations – 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.

Preexisting Condition – 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:

- A veterinarian provided medical advice;
- The pet received previous treatment; or
- 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.

Renewal – 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.

Right to Examine and Return the Policy (Free Look) – Report the number of policies/certificates 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.

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.

Waiting Period – 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.

MCAS Market Conduct Annual Statement

Disability Income (2026)

Disability Income Interrogatories

		Yes/No Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?		--
02	Does the company have Individual Voluntary Long-Term coverage to report?		--
03	Does the company have Individual Employer-Paid Short-Term coverage to report?		--
04	Does the company have Individual Employer-Paid Long-Term coverage to report?		--
05	Does the company have Group Voluntary Short-Term coverage to report?		--
06	Does the company have Group Voluntary Long-Term coverage to report?		--
07	Does the company have Group Employer-Paid Short-Term coverage to report?		--
08	Does the company have Group Employer-Paid Long-Term coverage to report?		--
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?		--
10	If Yes, explain.	--	
11	Has all or part of the reporting entity's disability income protection business been sold, closed, or moved to another insurer during the reporting period?		--
12	If Yes, explain.	--	
13	Number of class action lawsuits?	--	
14	Additional state specific Underwriting comments (optional):	--	
15	Additional state specific claims comments (optional):	--	
16	Additional comments (optional):	--	

Disability Income Claims Information

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
17	Pending benefit determinations, beginning of reporting period.								
18	Active paid claims, beginning of reporting period.								
19	Claims received during reporting period.								
20	New paid claim determinations during reporting period.								
21	Claim denials during reporting period.								
22	Paid claims closed during reporting period.								
23	Pending benefit determinations, end of reporting period.								
24	Active paid claims, end of reporting period.								

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Disability Income (2026)

Disability Income Claims Decisions Processed

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
25	Number of claims processed with initial claim decision within 1-14 days.		--		--		--		--
26	Number of claims processed with initial claim decision within 15-30 days.		--		--		--		--
27	Number of claims processed with initial claim decision within 31-45 days.		--		--		--		--
28	Number of claims processed with initial claim decision over 45 days.		--		--		--		--
29	Median Processing Time: The median processing time for claims resulting in payments reported in lines 25 through 28.		--		--		--		--
30	Number of claims processed with initial claim decision within 1-30 days.	--		--		--		--	
31	Number of claims processed with initial claim decision within 31-60 days.	--		--		--		--	
32	Number of claims processed with initial claim decision within 61-90 days.	--		--		--		--	
33	Number of claims processed with initial claim decision over 90 days.	--		--		--		--	
34	Median Processing Time: The median processing time for claims resulting in payments reported in lines 30 through 33.	--		--		--		--	

Disability Income Resulting in Closed Without Payment

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
35	Number of claims closed without payment within 1-14 days.		--		--		--		--
36	Number of claims closed without payment within 15-30 days.		--		--		--		--
37	Number of claims closed without payment within 31-45 days.		--		--		--		--
38	Number of claims closed without payment over 45 days.		--		--		--		--
39	Median Processing Time: The median processing time for claims closed without payment reported in lines 35 through		--		--		--		--
40	Number of claims closed without payment within 1-30 days.	--		--		--		--	
41	Number of claims closed without payment within 31-60 days.	--		--		--		--	
42	Number of claims closed without payment within 61-90 days.	--		--		--		--	
43	Number of claims closed without payment over 90 days.	--		--		--		--	
44	Median Processing Time: The median processing time for claims closed without payment reported in lines 40 through	--		--		--		--	

Disability Income Claims Denied - Reasons

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
45	Claimant not covered under the policy as of date of disability onset.								
46	Claimant returned to work during elimination period.								
47	Pre-existing condition.								
48	Claimant not disabled under the policy definition of disabled.								
49	Lack of documentation.								
50	Disability arising from diagnosis excluded under the policy.								
51	Disability due to work-related injury or condition excluded under the policy.								
52	Disability caused by excluded circumstance other than a work-related injury.								
53	Misrepresentation.								
54	All other denials.								

Disability Income (2026)

Disability Income Claims Closed After Initial Payment(s)

		Individual Voluntary Short-Term	Individual Voluntary Long-Term	Individual Employer-Paid Short-Term	Individual Employer-Paid Long-Term	Group Voluntary Short-Term	Group Voluntary Long-Term	Group Employer-Paid Short-Term	Group Employer-Paid Long-Term
55	Claimant returned to work - own occupation/job.								
56	Claimant returned to work - any occupation/job.								
57	Lack of documentation.								
58	Non-participation in evaluation.								
59	Death of claimant.								
60	Failure to participate in rehabilitation.								
61	Misrepresentation.								
62	Claimant had offsetting compensation.								
63	Maximum benefit reached.								
64	Not disabled with respect to "own occupation" but *has not returned to work.*								
65	Not disabled with respect to "any occupation" but *has not returned to work.*								
66	Other closed after payment.								

Disability Income Underwriting Activity (Group & Individual)

		Individual Voluntary Short-Term	Individual Voluntary Long-Term	Individual Employer-Paid Short-Term	Individual Employer-Paid Long-Term	Group Voluntary Short-Term	Group Voluntary Long-Term	Group Employer-Paid Short-Term	Group Employer-Paid Long-Term
67	Number of policies in force at the beginning of the reporting period.								
68	Number of new policies issued during the reporting period.								
69	Dollar amount of direct written premium.								
70	Number of policyholder cancellations and non-renewals.								
71	Number of insurer non-renewals.								
72	Number of insurer cancellations.								
73	Number of rescissions within two years from policy issue.								
74	Number of rescissions after two years from policy issue.								
75	Number of policies in force at the end of the reporting period.								

Disability Income Covered Lives Related to Underwriting Activity (Group Only)

		Individual Voluntary Short-Term	Individual Voluntary Long-Term	Individual Employer-Paid Short-Term	Individual Employer-Paid Long-Term	Group Voluntary Short-Term	Group Voluntary Long-Term	Group Employer-Paid Short-Term	Group Employer-Paid Long-Term
76	Number of lives covered under policies in force at the beginning of the reporting period.	--	--	--	--				
77	Number of lives covered under new policies issued during the reporting period.	--	--	--	--				
78	Number of lives covered under policyholder cancellations and non-renewals.	--	--	--	--				
79	Number of lives covered under insurer non-renewals.	--	--	--	--				
80	Number of lives covered under insurer cancellations.	--	--	--	--				
81	Number of lives covered under rescinded policies.	--	--	--	--				
82	Number of lives covered under policies in force at the end of the reporting period.	--	--	--	--				

Disability Income (2026)

Disability Income Complaints and Lawsuits

		Individual Voluntary Short-Term	Individual Voluntary Long-Term	Individual Employer-Paid Short-Term	Individual Employer-Paid Long-Term	Group Voluntary Short-Term	Group Voluntary Long-Term	Group Employer-Paid Short-Term	Group Employer-Paid Long-Term
83	Number of complaints received directly from any person or entity other than the DOI.								
84	Number of lawsuits open as of the beginning of the reporting period.								
85	Number of new lawsuits opened during the reporting period.								
86	Number of lawsuits closed during the reporting period (total).								
87	Number of lawsuits closed during the reporting period with consideration for the consumer.								
88	Number of lawsuits open as of the end of the period.								

Disability Income Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
89	First Attestor Information						--
90	Second Attestor Information						--
91	Overall Comments for the Filing Period	--	--	--	--	--	

MCAS Market Conduct Annual Statement

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Line of Business: Disability Income Insurance
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

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	Response
1-01	Does the company have Individual Voluntary Short-Term coverage to report?	Yes/No
1-02	Does the company have Individual Voluntary Long-Term coverage to report?	Yes/No
1-03	Does the company have Individual Employer-Paid Short-Term coverage to report?	Yes/No
1-04	Does the company have Individual Employer-Paid Long-Term coverage to report?	Yes/No
1-05	Does the company have Group Voluntary Short-Term coverage to report?	Yes/No
1-06	Does the company have Group Voluntary Long-Term coverage to report?	Yes/No
1-07	Does the company have Group Employer-Paid Short-Term coverage to report?	Yes/No
1-08	Does the company have Group Employer-Paid Long-Term coverage to report?	Yes/No
1-09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-10	If Yes, explain:	Comment
1-11	Has all or part of the reporting entity's disability income protection business been sold, closed, or moved to another insurer during the reporting period?	Yes/No
1-12	If Yes, explain:	Comment

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

1-13	Number of class action lawsuits?	Number
1-14	Additional underwriting comments (optional):	Comment
1-15	Additional claims comments (optional):	Comment
1-16	Additional comments (optional):	Comment

Product Type Identifiers

Each product will represent a unique mix of three characteristics related to method of payment (voluntary v. employer-paid), duration of the benefit period (short term v. long term) and method of product marketing and sales (group v. individual). The mix of these three characteristics yields eight possible product types:

- Individual voluntary short-term
- Individual voluntary long-term
- Individual employer-paid short term
- Individual employer-paid long term
- Group voluntary short-term
- Group voluntary long-term
- Group employer-paid short-term
- Group employer-paid long-term

Schedule 2—Claims Information

ID	Description
2–17	Pending benefit determinations, beginning of reporting period.
2–18	Active paid claims, beginning of reporting period.
2–19	Claims received during reporting period.
2–20	New paid claim determinations during reporting period.
2–21	Claim denials during reporting period.
2–22	Paid claims closed during reporting period.
2–23	Pending benefit determinations, end of reporting period.
2–24	Active paid claims, end of reporting period.

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Disability Income Insurance Data Call & Definitions

Schedule 3—Claims Decisions Processed

ID	Description
3–25	Number of claims processed with initial claim decision within 1-14 days (Short term)
3–26	Number of claims processed with initial claim decision within 15-30 days (Short term)
3–27	Number of claims processed with initial claim decision within 31-45 days (Short term)
3–28	Number of claims processed with initial claim decision over 45 days (Short term)
3–29	Median Processing Time: The median processing time for claims resulting in payments reported in 3-25 through 3-28 (Short term)
3–30	Number of claims processed with initial claim decision within 1-30 days (Long term)
3–31	Number of claims processed with initial claim decision within 31-60 days (Long term)
3–32	Number of claims processed with initial claim decision within 61-90 days (Long term)
3–33	Number of claims processed with initial claim decision over 90 days (Long term)
3–34	Median Processing Time: The median processing time for claims resulting in payments reported in 3-30 through 3-33 (Long term)

Schedule 4—Resulting in Closed Without Payment

ID	Description
4–35	Number of claims closed without payment within 1-14 days (Short term)
4–36	Number of claims closed without payment within 15-30 days (Short term)
4–37	Number of claims closed without payment within 31-45 days (Short term)
4–38	Number of claims closed without payment over 45 days (Short term)
4–39	Median Processing Time: The median processing time for claims closed without payment reported in 4-35 through 4-38 (Short term)
4–40	Number of claims closed without payment within 1-30 days (Long term)
4–41	Number of claims closed without payment within 31-60 days (Long term)
4–42	Number of claims closed without payment within 61-90 days (Long term)
4–43	Number of claims closed without payment over 90 days (Long term)
4–44	Median Processing Time: The median processing time for claims closed without payment reported in 4-40 through 4-43 (Long term)

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 5—Claims Denied – Reasons

ID	Description
5–45	Claimant not covered under the policy as of date of disability onset.
5–46	Claimant returned to work during elimination period.
5–47	Pre-existing condition.
5–48	Claimant not disabled under the policy definition of disabled.
5–49	Lack of documentation.
5–50	Disability arising from diagnosis excluded under the policy.
5–51	Disability due to work-related injury or condition excluded under the policy.
5–52	Disability caused by excluded condition or circumstance other than a work-related injury.
5–53	Misrepresentation.
5–54	All other denials.

Schedule 6—Claims Closed After Initial Payment(s)

ID	Description
6–55	Claimant returned to work – own occupation/job.
6–56	Claimant returned to work – any occupation/job.
6–57	Lack of documentation.
6–58	Non-participation in evaluation.
6-59	Death of claimant.
6–60	Failure to participate in rehabilitation.
6–61	Misrepresentation.
6–62	Claimant had offsetting compensation.
6–63	Maximum benefit reached.
6–64	Not disabled with respect to "own occupation" but *has not returned to work.*
6–65	Not disabled with respect to "any occupation" but *has not returned to work.*
6–66	Other closed after payment.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 7—Disability Insurance Underwriting Activity (Group & Individual)

ID	Description
7–67	Number of policies in force at the beginning of the reporting period.
7–68	Number of new policies issued during the reporting period.
7–69	Dollar amount of direct written premium.
7–70	Number of policyholder cancellations and non-renewals.
7–71	Number of insurer non-renewals.
7–72	Number of insurer cancellations.
7–73	Number of rescissions within two years from policy issue.
7–74	Number of rescissions after two years from policy issue.
7–75	Number of policies in force at the end of the reporting period.

Schedule 8—Covered Lives Related to Underwriting Activity (Group Only)

ID	Description
8–76	Number of lives covered under policies in force at the beginning of the reporting period.
8–77	Number of lives covered under new policies issued during the reporting period.
8–78	Number of lives covered under policyholder cancellations and non-renewals.
8–79	Number of lives covered under insurer non-renewals.
8–80	Number of lives covered under insurer cancellations.
8–81	Number of lives covered under rescinded policies.
8–82	Number of lives covered under policies in force at the end of the reporting period.

Schedule 9—Complaints and Lawsuits

ID	Description
9–83	Number of complaints received directly from any person or entity other than the DOI.
9–84	Number of lawsuits open as of the beginning of the reporting period.
9–85	Number of new lawsuits opened during the reporting period.
9–86	Number of lawsuits closed during the reporting period (total).
9–87	Number of lawsuits closed during the reporting period with consideration for the consumer.
9–88	Number of lawsuits open as of the end of the period.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 10—Disability Income Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
10-89	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
10-90	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
10-91	Overall Comments for the Period

Disability Income Insurance (or Disability Income Protection)–Disability income (DI) insurance is insurance that provides payments when an insured is disabled or unable to work because of illness, disease or injury, including incidental benefits. Policies may provide monthly benefits for loss of income from disability, either on a short-term or a long-term basis. This does not include insurance policies specifically intended to satisfy an employer's obligations or liabilities arising from incidents covered under the various states' Worker's Compensation Acts, Jones Act, United States Longshoreman and Harbor Workers Act, and similar statutes.
Reporting entities are required to report data on all Disability Income Insurance Coverage issued by the reporting entity as set forth on the DI MCAS blank.

Participation Requirements: All companies licensed and reporting at least $50,000 of disability income written premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Terms defined within these DI MCAS INSTRUCTIONS are to be utilized in completing the DI MCAS report. Reporting entities are required to file DI MCAS data consistent with the definitions provided within these INSTRUCTIONS.

These instructions are organized by MCAS DI Schedule or Section. Line numbers correspond to the line numbers appearing on the MCAS blank.

Individual v. Group Policies—Individual policies are marketed to, or are purchased directly by, individuals. Group policies are sold and purchased by or through group sponsors such as associations, 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.

Short term v. Long-term DI— Short term DI policies offer benefit payments during a disability for no more than two years. Long term policies cover disability for a significantly longer period, often to the age of retirement.

Voluntary v. Employer Paid—Voluntary coverage is coverage for which an individual pays **all** of the premium, irrespective of whether the policy is a group or individual policy. Employer-paid policies are coverage for which an employer pays **any portion** of the premium, and may also be individual or group coverage.

NOTE: Contact the Department of Insurance for the relevant jurisdiction if you have any questions regarding how to categorize any such products or policies for any particular jurisdiction.

Contact Information

MCAS Administrator—The MCAS Administrator is the person responsible for preparing and filing the DI MCAS report.

MCAS Contact—The MCAS Contact is the primary company representative for DOI communications regarding the DI MCAS report; can be same as the MCAS Administrator.

MCAS Attestor—The person who attests to the completeness and accuracy of the MCAS data.

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

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

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Interrogatories

The Interrogatories Section is intended to allow reporting entities the opportunity to provide regulators with relevant contextual information that may help them interpret the data, and to afford a general overview of the nature of a company's book of business.

Significant events or change to business strategy—(1-09 and 1-10) If a reporting entity experienced a significant event or a business strategy change, describe the experience and explain the significance with respect to data filed in this report.

Sales, closures and movement of DI business—(1-11 and 1-12) Described instances in which portions of the reporting entity's DI business has been sold, closed or moved to another insurer, and describe what impact, if any, these activities have on the data reported herein.

Number of class action lawsuits—(1-13) Reporting entities should put the total class action lawsuits for DI business.

Underwriting information comments—(1-14) Reporting entities should provide any additional underwriting information that might assist insurance departmental personnel in interpreting specific data or in analyzing this MCAS report.

Claims information comments—(1-15) Reporting entities should provide any additional claims information that may assist insurance department personnel in interpreting specific data or in analyzing this MCAS report.

Additional Comments—(1-16) Reporting entities should provide any additional information related to features or characteristics of their DI business in a given state that would assist department personnel in interpreting specific data or in analyzing this MCAS report.

Schedule 2 – Claims.

A claim is a request or demand for payment of benefits under a disability income policy. For 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.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

In Schedule 2 and Schedule 3 "initial benefit determination" refers to a reporting entity's decision to pay benefits under the policy or to deny the claim – not to a reporting entity's decision to continue payment or to close a claim that has been in previous payment status. These latter decisions are to be reported on Schedule 6.

Pending benefit determinations, beginning of reporting period—(2-17) Report the number of open or pending claims for which no decision to pay or deny has been made as of the beginning of the reporting period (January 1).

Active paid claims, beginning of reporting period—(2-18) Report the number claims from the prior reporting period for which payment is continuing to be made at the beginning of the reporting period (January 1).

Claims received during reporting period—(2-19) The number of new claims received by the reporting entity during the reporting period (January 1)

New paid claim determinations during reporting period—(2-20) Report the number of claims for which a benefit determination has been made at any time during the reporting period that resulted in a decision to make a payment.

Claim denials during reporting period—(2-21) Report the number of initial benefit determinations made at any time during the reporting period that resulted in a decision to deny payment.

Paid claims closed during reporting period—(2-22) Report the number of claims with an initial benefit determination resulting in payment that are closed or are no longer receiving payments during the reporting period.

Pending benefit determinations, end of reporting period—(2-23) Report the number of open or pending claims for which no decision to pay or deny has been made as of the end of the reporting period (December 31).

Active paid claims, end of period—(2-24) Report the number of claims for which payment is continuing to be made at the end of the reporting period(December 31).

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 3 and Schedule 4

These schedules capture information about claims processing times. All processing times should be calculated as the number of days from the receipt of a claim in the mailroom or other claims intake unit, until the decision is made to either pay or deny the claim. Do not include any additional days until payment is actually made to, or received by, the claimant.

Median processing times—(3-29, 3-34; 4-39, 4-44)

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

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

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

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

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

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

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

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.

Schedule 5 Claim Denials – Reasons

Schedule 5 captures information about claims closed without payment. Categories are mutually exclusive such that each claim should be reported in **one and only one** category.

Claimant not covered under the policy—(5-45) A claim determination decision that the claimant is not insured or covered under the policy, against which a claim for benefits is made, as of the date of claimed disability onset.

Claimant returned to work during elimination period—(5-46) Many policies have an elimination period, which is defined as the time between the onset of a disability and benefit eligibility.

Pre-existing condition—(5-47) A medical condition of the insured that existed prior to eligibility for coverage under a disability income policy.

Claimant not disabled under the policy definition of disabled—(5-48) The claimant is not disabled as per policy definitions. Include in this line instances in which an individual is deemed physically capable of work as well as instances where the decline in income or wages is insufficient to trigger coverage.

Lack of documentation—(5-49) Instances in which a claimant fails to submit requested documentation sufficient to demonstrate disability.

> Exclude**:** cases where requested documentation has been submitted but still fails to establish sufficient evidence of a disability.

Disability arising from diagnosis excluded under the policy— (5-50) An injury or condition specifically identified in the policy as excluded from coverage. For example, some policies exclude

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

conditions whose diagnosis relies to a significant degree on the insured's subjective expressions of symptoms or for which there exists no objective lab, imaging or other medical test. Examples might include fibromyalgia or chronic fatigue syndrome. Other policies might exclude psychological conditions or substance abuse.

Disability due to work-related injury or condition excluded under the policy— (5-51) Claims denied under an exclusion or injuries or condition arising from paid employment.

Disability caused by excluded condition or circumstance other than a work-related injury— (5-52) A disability arising from circumstances or causes that are specifically excluded under the policy. Common examples might include disabilities arising in connection with the commission of a felony, and act of war, or an excluded activity such as non-commercial aviation.

Exclude: denials due to a work-related injury reported in 5-51.

Misrepresentation—(5-53) Claim denials due to false or incorrect information on an application for coverage or in the application for policy benefits.

Other denials—(5-54) All claim denials that are not reported in 5-45 through 5-52.

Schedule 6 – Claims closed after initial payments

Include claims closed, after initial payment, at any time during the reporting period regardless of the reporting year in which they were received. Categories are intended to be mutually exclusive, such that a claim should be reported in **one and only one** category.

Claimant returned to work – own occupation / job (6-55)

Claimant returned to work – any occupation / job (6-56)

The above two lines (6-55 and 6-56) should include claims for which payment has been terminated because an individual formerly considered disabled has returned to employment sufficient to end coverage. The own occupation/job (6-55) refers to those instances in which a claimant returns to previous employment or employment of the same class as is defined in the policy (usually under an "own occupation" definition of disability). The any occupation/job (6-56) should include instances in which a claimant returns to work, but at a materially different job class (usually defined in an "any occupation" definition of disability).

The remaining lines should only include benefit terminations under conditions in which the insured has not returned to employment of a kind necessary to end disability coverage.

Lack of documentation—(6-57) Include claims in which payment has been terminated due to a failure to obtain documentation pertaining to medical records, earnings loss, or any other evidence of continued disability.

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Disability Income Insurance Data Call & Definitions

Non-participation in evaluation—(6-58) Payment termination due to the failure to an insured to comply with a reporting entity's requirements for an independent medical, occupational or other similar evaluation.

Death of claimant—(6-59)

Failure to participate in rehabilitation—(6-60) Instances in which an insured refuses to comply with policy requirements pertaining to participation in rehabilitation, worksite accommodations, or other program designed to facilitate a return to employment.

Misrepresentation—(6-61) See definition under schedule 5 (5-52); **Misrepresentation** in the context of a claim denial.

Claimant had offsetting compensation—(6-62) Claims for which payment is terminated due to off-setting income available to an insured, such as social security benefits, workers compensation payments, or other source of income. This category may include instances in which an insured has not availed themselves available sources of income, depending on policy provisions.

Maximum benefit reached—(6-63) Claim payments terminated because the maximum level of benefits afforded by the policy has been reached. Include all claims terminated due to maximum payment amount, maximum benefit period, or other cap defined in the policy.

The next two lines (6-64 and 6-65) should include all other instances in which a claimant has not returned to work but is deemed capable of returning to work pursuant to policy provisions. *Exclude claims which are more appropriately reported in 6-57 through 6-63.* Use the same definitions of "own occupation" and "any occupation" as for 6-55 and 6-56.

Not disabled with respect to own occupation but has not returned to work—(6-64) Claimant has been deemed as not disabled with respect to "own occupation," but has not returned to work based on the company's records.

Not disabled with respect to any occupation but has not returned to work—(6-65) Claimant has been deemed as not disabled with respect to "any occupation," but has not returned to work based on the company's records.

Other closed after payment—(6-66) Include all claims which resulted in any payment, and for which payment has terminated during the reporting period, that are not reported in 6-55 through 6-65.

Schedule 7 – Disability Insurance Underwriting Activity (both Group and Individual DI)

The following definitions are referring to the number of policies in force.

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Policies in force at the beginning of reporting period—(7-67) The number of in force policies at the beginning of the reporting period (January 1).

Policies issued—(7-68) New policies issued at any time during the reporting period. Exclude policy renewals.

Direct written premium—(7-69)

Policyholder cancellations and non-renewals—(7-70) Policies cancelled or non-renewed at any point during the reporting period at the request of or in response to the policyholder. Include policies terminated for nonpayment of premium.

Insurer non-renewals—(7-71) 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 in 7-70).

Insurer cancellations—(7-72) A cancelation is the termination of an in-force policy during the policy contract period.

> Exclude: cancellations resulting from nonpayment of premium (these data are reported in 7-70).

Rescissions within two years—(7-73) A rescission is the termination of coverage by the reporting entity, retroactive to the beginning of the policy contract period. Include rescissions occurring within two years of the date the policy was first issued.

Rescissions after two years—(7-74) Rescissions occurring beyond two years after the date a policy was first issued.

Policies in force at the end of reporting period—(7-75) The number of in force polices at the end of the reporting period (December 31).

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Disability Income Insurance Data Call & Definitions

Schedule 8 –Covered Lives Related to Underwriting Activity (Group DI Only)

For group coverage, each line should record the number of lives covered under policies reported in Schedule 7.

Lives covered under policies in force beginning of period—(8-76) The number of lives covered under policies in force at the beginning of the reporting period (January 1). These are lives covered under the policies reported in 7-67.

Lives covered under new policies issued—(8-77) The number of lives covered under new policies issued at any time during the reporting period, corresponding to the policies reported in 7-68. *Report the number of covered lives on the effective date of the policy.*

Lives covered under policyholder cancellations and non-renewals—(8-78) The number of lives covered under policies that were terminated at the request of or in response to the policyholder. Include policies cancelled or non-renewed at any time during the reporting period. *Report the number of covered lives as of the date that coverage ended.* The lives reported here should correspond to the policy termination reported in 7-70

Lives covered under insurer non-renewals—(8-79) The number of lives covered under policies subject to non-renewals initiated by a reporting entity, *as of the date that coverage terminated.* A non-renewal is the termination of coverage at the end of the policy contract period. The lives reported correspond to the policies reported on 7-71. Exclude non-renewals resulting from a nonpayment of premium (these data are reported on 8-78).

Lives covered under insurer cancellations—(8-80) The number of lives on cancellations initiated by the reporting entity, *as of the date that coverage terminated.* A cancellation is the termination of an in-force policy during the policy contract period. The lives reported should correspond to policies reported on 7-72. Exclude cancellations resulting from non-payment of premiums, (these data are reported on 8-78).

Lives covered under rescinded policies—(8-81) A rescission is the termination of coverage by the reporting entity, retroactive to the beginning of the policy contract period. Report the number of lives *as of the date that the rescission occurred.* The lives reported here should correspond to the policies reported in 7-73 and 7-74.

Lives covered under policies in force at the end of the reporting period—(8-82) The number of lives covered by policies in force at the end of the reporting period (December 31). The lives reported here should correspond to the policies reported in 7-75.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Schedule 9 Complaints and Lawsuits

Use the following definitions of complaints and lawsuits for reporting the number of complaints/lawsuits for the items in Schedule 9.

Complaint—Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

> Report only complaints pertaining to or arising from insurance operations associated with Disability Income Insurance, such as marketing and sales, policy service, claims handling or any other operations directly related to a disability income insurance policy.

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 lawsuit in the Disability Income MCAS blank:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit 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 reside. Include an explanatory note in the Additional Comments field (1-16) with your submission stating the general cause of action.

Complaints received directly from any entity other than the DOI—(9-83) The number of complaints received directly by a reporting entity from any person or entity other than a department of insurance.

Lawsuits open —(9-84) The number of lawsuits in process that have not been resolved or closed at the beginning of the reporting period (January 1).

New lawsuits—(9-85) The number of new lawsuits filed against the reporting entity at any time during the data year.

Market Conduct Annual Statement
Disability Income Insurance Data Call & Definitions

Lawsuits closed—(9-86) Include all lawsuits closed at any time during the reporting period, regardless of the manner in which the lawsuit was resolved.

Lawsuits closed during the period with consideration for the consumer—(9-87) A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.

Lawsuits Open at the end of the period—(9-88) Total of lawsuits that remain open or active at the end of the reporting period (December 31).

MCAS Market Conduct Annual Statement

Long-Term Care (2026)

Long-Term Care Interrogatories

		Yes/No Response	Explanation
01	Does the company have data to report for Stand-Alone Long-Term Care?		--
02	Does the company have data to report for Life Long-Term Care Hybrid?		--
03	Does the company have data to report for Annuity Long-Term Care Hybrid?		--
04	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
05	If yes, add additional comments.	--	
06	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
07	If yes, add additional comments.	--	
08	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?		--
09	If yes, add additional comments.	--	
10	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
11	If yes, add additional comments.	--	
12	Life LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
13	If yes, add additional comments.	--	
14	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?		--
15	If yes, add additional comments.	--	
16	Additional state specific Stand-Alone Long-Term Care comments (optional).	--	
17	Additional state specific Life Long-Term Care Hybrid comments (optional).	--	
18	Additional state specific Annuity Long-Term Care Hybrid comments (optional).	--	

Long-Term Care General Information

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
19	Number of policies/contracts in-force as of the beginning of the reporting period.			
20	Number of new business policies/contracts issued during the period.			
21	Number of free look cancellations during the period.			
22	Number of lapses during the period.			
23	Number of rescissions during the period.			
24	Number of policies/contracts in-force as of the end of the reporting period.			
25	Number of internal replacements during the period.			
26	Number of external replacements during the period.	--		
27	Number of policies/contracts replaced where age of insured at replacement was < 65.	--		
28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.	--		
29	Number of policies/contracts replaced where age of insured at replacement was > 80.			
30	Number of complaints received directly from ~~consumers~~ any person or entity other than the DOI.			

Long-Term Care Claimants and Claimant Requests Activity

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
31	Number of claimants approved for benefits as of the beginning of the period.			
32	Number of claimants with pending claimant request determinations as of the beginning of the period.			
33	Number of new claimants during the period.			
34	Number of claimants with pending claimant request determinations as of the end of the period.			
35	Number of claimants approved for benefits as of the end of the period.			
36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).			
37	Number of claimant requests denied or not paid because of preexisting condition exclusion.			
38	Number of claimant requests denied or not paid because of elimination or waiting period not met.			

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Long-Term Care (2026)

Long-Term Care Claimants and Claimant Requests Activity Continued

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
39	Number of claimant requests denied or not paid because services provided not covered under the policy.			
40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.			
41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.			
42	All other claimant requests denied or closed without payment.			
43	Number of claim request determinations made within 0-30 days.			
44	Number of claim request determinations made within 31-60 days.			
45	Number of claim request determinations made within 61-90 days.			
46	Number of claim request determinations made beyond 90 days.			

Long-Term Care Benefit Payment Requests Activity

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
47	Number of benefit payment requests pending as of the beginning of the period.			
48	Number of benefit payment requests received during the period.			
49	Number of benefit payment requests denied or not paid during the period.			
50	Number of benefit payment requests pending as of the end of the period.			
51	Number of benefit payment requests paid within 0-30 days.			
52	Number of benefit payment requests paid within 31-60 days.			
53	Number of benefit payment requests paid within 61-90 days.			
54	Number of benefit payment requests paid beyond 90 days.			
55	Number of benefit payment requests denied or not paid within 0-30 days.			
56	Number of benefit payment requests denied or not paid within 31-60 days.			
57	Number of benefit payment requests denied or not paid within 61-90 days.			
58	Number of benefit payment requests denied or not paid beyond 90 days.			

Long-Term Care Lawsuit Activity

		Stand-Alone LTC	Life LTC Hybrid	Annuity LTC Hybrid
59	Number of lawsuits open as of the beginning of the period.			
60	Number of lawsuits opened during the period.			
61	Number of lawsuits closed during the period - total.			
62	Number of lawsuits closed during the reporting period with consideration for the consumer.			
63	Number of lawsuits open as of the end of the period.			

Long-Term Care Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
64	First Attestor Information.						--
65	Second Attestor Information.						--
66	Overall comments for the filing period.	--	--	--	--	--	

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Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

Line of Business: Individual Stand-Alone Long-Term Care
Individual Long-Term Care Hybrid Products
Life-LTC Hybrid Products
Annuity-LTC Hybrid Products
Reporting Period: January 1, 2026 through December 31, 2026
Filing Deadline: April 30, 2027

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.

Long-Term Care Product Types

Product Identifier	Explanation of Product Identifiers
SALTC	Stand-Alone – Long-Term Care Products
LifeLTC	Life – Long-Term Care Hybrid Products
AnnLTC	Annuity – Long-Term Care Hybrid Products

Schedule 1 - Interrogatories

ID	Description	Response
1-1	Does the company have data to report for Stand-Alone Long-Term Care?	Yes/No
1-2	Does the company have data to report for Life Long-Term Care Hybrid?	Yes/No
1-3	Does the company have data to report for Annuity Long-Term Care Hybrid?	Yes/No
1-4	Stand-Alone LTC - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-5	If yes, add additional comments.	Comment
1-6	Life LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-7	If yes, add additional comments.	Comment

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

1-8	Annuity LTC Hybrid - Has the company had a significant event or business strategy change that would affect the data for this reporting period?	Yes/No
1-9	If yes, add additional comments.	Comment
1-10	Stand-Alone LTC - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-11	If yes, add additional comments.	Comment
1-12	Life LTC Hybrid - Has all of 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	Annuity LTC Hybrid - Has all of part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-15	If yes, add additional comments.	Comment
1-16	Additional state specific Stand-Alone Long-Term Care comments (optional).	Comment
1-17	Additional state specific Life Long-Term Care Hybrid comments (optional).	Comment
1-18	Additional state specific Annuity Long-Term Care Hybrid comments (optional).	Comment

Schedule 2 - General Information

ID	Description
2-19	Number of policies/contracts in-force as of the beginning of the reporting period.
2-20	Number of new business policies/contracts issued during the period.
2-21	Number of free look cancellations during the period.
2-22	Number of lapses during the period.
2-23	Number of rescissions during the period.
2-24	Number of policies/contracts in-force as of the end of the reporting period.
2-25	Number of internal replacements during the period.
2-26	Number of external replacements during the period.
2-27	Number of policies/contracts replaced where age of insured at replacement was < 65.
2-28	Number of policies/contracts replaced where age of insured at replacement was between 65 and 80.
2-29	Number of policies/contracts replaced where age of insured at replacement was > 80.
2-30	Number of complaints received directly from ~~consumers~~ any person or entity other than the DOI.

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

Schedule 3 - Claimants

ID	Description
3-31	Number of claimants approved for benefits as of the beginning of the period.
3-32	Number of claimants with pending claimant request determinations as of the beginning of the period.
3-33	Number of new claimants during the period.
3-34	Number of claimants with pending claimant request determinations as of the end of the period.
3-35	Number of claimants approved for benefits as of the end of the period.

Schedule 4 - Claimant Requests Denied/Not Paid

ID	Description
4-36	Number of claimant requests denied or not paid because claimant did not pursue (inactivity or death).
4-37	Number of claimant requests denied or not paid because of preexisting condition exclusion.
4-38	Number of claimant requests denied or not paid because of elimination or waiting period not met.
4-39	Number of claimant requests denied or not paid because services provided not covered under the policy.
4-40	Number of claimant requests denied or not paid because provider or facility not qualified under the policy.
4-41	Number of claimant requests denied or not paid because benefits eligibility criteria not met.
4-42	All other claimant requests denied or closed without payment.

Schedule 5 - Claimant Request Determinations Timeliness

ID	Description
5-43	Number of claim request determinations made within 0-30 days.
5-44	Number of claim request determinations made within 31-60 days.
5-45	Number of claim request determinations made within 61-90 days.
5-46	Number of claim request determinations made beyond 90 days.

Schedule 6 - Benefit Payment Requests

ID	Description
6-47	Number of benefit payment requests pending as of the beginning of the period.
6-48	Number of benefit payment requests received during the period.
6-49	Number of benefit payment requests denied or not paid during the period.
6-50	Number of benefit payment requests pending as of the end of the period.

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

Schedule 7 - Benefit Payment Request Timeliness

ID	Description
7-51	Number of benefit payment requests paid within 0-30 days.
7-52	Number of benefit payment requests paid within 31-60 days.
7-53	Number of benefit payment requests paid within 61-90 days.
7-54	Number of benefit payment requests paid beyond 90 days.
7-55	Number of benefit payment requests denied or not paid within 0-30 days.
7-56	Number of benefit payment requests denied or not paid within 31-60 days
7-57	Number of benefit payment requests denied or not paid within 61-90 days.
7-58	Number of benefit payment requests denied or not paid beyond 90 days.

Schedule 8 - Lawsuit Activity

ID	Description
8-59	Number of lawsuits open as of the beginning of the period.
8-60	Number of lawsuits opened during the period.
8-61	Number of lawsuits closed during the period - total.
8-62	Number of lawsuits closed during the reporting period with consideration for the consumer.
8-63	Number of lawsuits open as of the end of the period.

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

Schedule 9 - Long-Term Care Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
9-64	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title).
9-65	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title).
9-66	Overall comments for the filing period.

General Instructions – All LTC Products:

For the purpose of the MCAS Long-term care insurance reporting blank:

1. "Long-term care insurance" means that as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), with the exception that long-term care insurance riders attached to a life insurance policy or an annuity contract, and group insurance plans are not included.
2. Schedules 3, 4 and 5 refer to claimants and claimant requests. A claimant request is the initial request for LTC benefits under the policy or contract. It is the determination by the insurer that the claimant is entitled to benefits under the policy or contract.
3. Reporting for schedules 3 through 5 is to be done on a "per claimant" basis (counts each individual who makes one or a series of requests or demands for payment of benefits under a policy) [Model #641, Appendix E]
4. Schedules 6 and 7 refer to individual benefit payment requests following the initial determination by the insurer that the claimant is entitled to benefits under the policy or contract. The purpose of the schedules is to differentiate between initial coverage request activities (Schedules 3, 4 and 5) and benefit payment request activities (Schedules 6 and 7) once the insurer has affirmed the initial coverage requests.
5. Reporting for schedules 6 and 7 is to be done on a "per transaction" basis (counts each benefit payment request pending and benefit payment made). [Model #641, Appendix E]

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

General Instructions – Life and Annuity Hybrid LTC

1. For purposes of the LTC Hybrid Product MCAS, "LTC Hybrid Product" means those products providing Long-Term Care insurance as defined in Section 4.A. of the NAIC Long-Term Care Insurance Model Act (#640), as part of a Life-LTC hybrid insurance policy or Annuity-LTC hybrid contract. Such LTC hybrid benefits may be built into the life policy or annuity contract, or may be attached to such policy or contract by a rider. Report experience for Life-LTC hybrid products separately from Annuity-LTC hybrid products in the schedules provided. Report experience on individual LTC hybrid policies and contracts only. Do not report experience on group policies and contracts.
2. For Schedule 2, report experience for all policies or contracts with LTC hybrid benefits. For all data elements in Schedule 2, report the number of policies or contracts with Life-LTC hybrid or Annuity-LTC hybrid benefits and which meet the definition of the specific data element. For example, for data element 2-19 in the Life-LTC hybrid schedules, report the number of life insurance policies with LTC benefits in force at the beginning of the reporting period. For data element 2-19 in the Annuity-LTC hybrid schedules, report the number of annuity contracts with LTC benefits in force at the beginning of the reporting period. For data element 2-20, report the number of new business policies or contracts with LTC hybrid benefits.
3. For Schedules 3 through 7, report the experience for those policies or contracts with LTC hybrid benefits and report experience only for the LTC benefit portion of the policy or contract. For example, report experience for claimants, claimant requests denied/not paid, claimant request determination timeliness, benefit payment requests, and benefit payment request timeliness only for the LTC benefit portion of the LTC hybrid product.
4. For Schedule 8, report experience for those policies or contracts with some form of LTC benefit. Report lawsuit experience for all lawsuits related to the LTC product, regardless of what aspect of the product, coverage or benefit the lawsuit is about.

Definitions:

Benefit Payment Request—A request for benefits after the insurer has determined the insured is entitled to benefits following the initial claimant request. (See Claimant Request and Claimant Request Determination, below.) Each request or demand for a benefit payment (after satisfaction of the waiting or elimination period, if any) is treated as a distinct benefit payment request, and continuing payments for the same service should each be treated as a distinct benefit payment request. The data elements in Schedule 4 capture the period of time between the company's receipt of a claim form, bill, invoice, or other satisfactory documentation to the date the company makes

payment for an approved claimant (after satisfaction of the waiting or elimination period, if any).

Claimant - An insured under an in-force policy or contract who the insurer has determined has met the benefit trigger of the policy or contract, or is in the process of making such determination, and such insured is, or may be, eligible to submit benefit payment requests.

Claimant Request - A request or demand for payment made by an insured, or a representative of the insured, for a loss that may be included within the terms of coverage of the LTC stand-alone or LTC hybrid policy or contract. It does not include events that were reported by the insured for "information only" or an inquiry of coverage when a claim has not actually been presented (opened) for payment. If a claim is re-opened, report the claim as a new claim and the claim determination time period should be measured from the date the claim was re-opened to the benefit trigger determination date.

Claimant Request Determination - A determination as to whether an insured has met a contractual provision of an LTC policy or contract that conditions the payment of benefits on the insured's ability to perform activities of daily living, cognitive impairment, or other loss of functional capacity. For purposes of this blank, the term applies to the initial claimant request, and captures the period of time from notice of claim to the benefit trigger/claimant request determination date. For claimant requests that are denied/not paid, report the period of time from the date of notice of claim to the date the claimant was notified of the determination to deny or not pay the claim.

Claimant Request Denied or Not Paid because Benefit Eligibility Criteria Not Met - A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract, that a benefit trigger has not been met, or a required certification by a licensed health care practitioner has not been provided, or a plan of care has not been provided.

Claimant Request Denied or Not Paid Because Claimant Did Not Pursue - A claimant or policyholder made a request or demand for payment for the purpose of receiving a benefit trigger/claimant request determination and/or benefit payment under the LTC benefit of a policy or contract, but did not provide the necessary documentation or contact the insurer again (inactivity could be the result of death.)

Claimant Request Denied or Not Paid Because Elimination or Waiting Period Not Met - A determination, following the initial claimant request for coverage under the LTC benefit of the policy or contract that the elimination/waiting period had not yet elapsed.

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

Claimant Request Denied or Not Paid Because Services Provided Not Covered - Expenses incurred for services and support which are not eligible for reimbursement under the LTC benefit of a policy or contract, such as an expense incurred for home health care when the policy or contract only provides benefits for nursing home confinements.

Claimant Request Denied or Not Paid Because of Preexisting Condition Exclusion - A denial of coverage because benefits for the medical advice or treatment recommended by, or received from a provider of health care services are subject to a restriction as a pre-existing condition for a period of time following the effective date of coverage of an insured person.

Claimant Request Denied or Not Paid Because Provider or Facility Not Qualified - A long-term care provider or facility does not meet the minimum level of requirements or licensing as outlined in the policy or contract.
Complaint—Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.

Denied or Not Paid - A request or demand for payment that is not paid for any reason.

- Under Schedule 4, if a denial could be reported under more than one of the categories, report the denial in the category that is most specific to the circumstances surrounding the denial. If a claimant's request was denied, the denial should not be counted more than once.
- Under Schedule 5, exclude denials for failure to meet the waiting or elimination period or because of an applicable preexisting condition.

The term does not include a request or demand for payment that is in excess of the applicable contractual limits.

Elimination Period - A period of time, as specified in the policy or contract, during which the insured incurs qualified long-term care services and support for which benefits are not payable until the end of such period.

Free Look - A set number of days provided in an insurance policy or contract that allows time for the owner/purchaser to review the policy or contract provisions with the right to return the policy or contract for a full refund of all monies paid. Report the number of policies that were returned by the owner under the free look provision.

Lapse - The termination of the entire policy or contract or the termination of the LTC benefit of the policy or contract due to nonpayment of premium.

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

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

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

Lawsuits Closed During the Period with Consideration for the Consumer - A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.
New Business Policy or Contract—A newly written agreement that puts insurance coverage into effect under a policy or contract during the reporting period

Pending Claim - A claim that has not yet been paid or denied.

Replacement - Replacement of any life policy, annuity contract or LTC policy already in force with a new policy or contract with LTC insurance coverage.

- External Replacement—If the policy or contract to be replaced was issued by another insurer.
- Internal Replacement—If the policy or contract to be replaced was issued by your company.

For Data Elements 2-25 (Number of Internal Replacements) and 2-26 (Number of External Replacements), report the number of policies included in data element 2-20 (Number of new business policies) which are replacements of any type of life, annuity or long-term care policies.

Rescission - Invalidation of a policy or contract or invalidation of the LTC coverage portion of a policy or contract by an insurer, in accordance with the guidelines provided in the NAIC Long-Term Care Insurance Model Act (#640).

Market Conduct Annual Statement Long-Term Care Stand-Alone and Hybrid Products Data Call & Definitions

Waiting Period - See definition of Elimination Period.

MCAS Market Conduct Annual Statement

Short-Term Limited Duration Insurance (2026)

Short-Term Limited Duration Insurance Interrogatories

		Yes No Response	Explanation
01	List the states where your STLD products are marketed.	---	
02	Does the company offer STLD policies/certificates with up to a 90-day duration?		---
03	Does the company offer STLD policies/certificates with 91- to 180-day duration?		---
04	Does the company offer STLD policies/certificates with 181- to 364-day duration?		---
05	Number of STLD forms offered to residents in this state.	---	
06	Number of STLD forms offered in all states.	---	
07	Number of STLD forms filed in this state.	---	
08	Number of STLD forms filed in all states.	---	
09	List the states where your STLD products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product and describe the basis for not filing.	---	
10	How many policy forms have waiting periods that apply to the entire policy/certificate?	---	
11	How many policy forms have waiting periods that apply per specific benefits?	---	
12	Do any waiting periods exceed the policy/certificate term?		---
13	If yes, please explain	---	
14	Does the company issue STLD products through associations?		---
15	If yes, list the associations.	---	
16	If yes, do you have a contractual relationship with each Association?		---
17	If yes, does the contract cover the marketing of your product?		---
18	If yes, does the contract cover the collection of dues and fees?		---
19	If yes, does the contract cover commissions?		---
20	If yes, what other operational areas are covered in the contract?	---	
21	Does the company issue STLD products through trusts?		---
22	If yes, how many?	---	
23	Does the company issue STLD products through administrators?		---
24	If yes, how many?	---	
25	Does the company contract with third-party administrators for administrative services related to STLD products?		---
26	If yes, does your delegation structure include claims related to STLD products?		---
27	If yes, does your delegation structure include complaints related to STLD products?		---
28	If yes, does your delegation structure include medical underwriting related to STLD products?		
29	If yes, does your delegation structure include pricing related to STLD products?		---
30	If yes, does your delegation structure include producer appointments related to STLD products?		---
31	If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLD products?		---

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Short-Term Limited Duration Insurance (2026)

Short-Term Limited Duration Insurance Interrogatories (Continued)

		Yes No Response	Explanation
32	Does your company audit Third parties to whom you have delegated responsibilities?		---
33	If yes, please provide frequency of audits.	---	
34	Does the company offer renewals/reissues?		---
35	Are any renewals/reissues subject to optional or mandatory underwriting?		---
36	If yes, identify the products or plans subject to underwriting upon renewal/reissue	---	
37	Are there limitations on the number renewals per individual?		---
38	Does your company offer renewal(s) without underwriting for an additional charge?		---
39	If yes, identify the products or plans subject to underwriting for an additional charge	---	
40	Are the limitations on renewals based on state, federal, or company rules?		---
41	Does your company distribute its product through independent agents?		---
42	Does your company distribute its products through captive agents?		---
43	Does your company distribute its products through its employees?		---
44	What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)	---	
45	Additional State Specific Comments (optional)	---	

Policy/Certificate Administration

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
46	Direct Written Premium.									
47	Earned premiums for Reporting Year.									
48	Number of Policies/Certificates in Force at the Beginning of the Period.									
49	Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period.									
50	Number of new policy/certificate applications received during the period.									
51	Number of new policy/certificates issued during the period.									
52	Number of new policies/certificates denied during the period.									
53	Number of Covered Lives on New Policies/Certificates Issued During the Period.									
54	Member months for policies/certificates newly issued during the period.									
55	Number of policy/certificate renewal/reissue applications received during the period.									
56	Number of policies/certificates renewed/reissued during the period.									
57	Number of policies/certificates non-renewed or denied at the option of insurer during the period.									
58	Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period.									
59	Number of renewals/reissues allowed.									
60	Member months for policies/certificates renewed/reissued during the period.									
61	Member months for policies/certificates renewed/reissued which had an option to renew/reissue									
62	Member months for other than new policies/certificates or renewal/reissued policies/certificates during the period									
63	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder									

Short-Term Limited Duration Insurance (2026)

Policy/Certificate Administration (Continued)

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
64	Number of policies/certificates cancelled during the free look period.									
65	Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period.									
66	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period.									
67	Number of policy/certificate terminations and cancellations due to non-payment of premium.									
68	Number of Policies/Certificates Cancelled by Insurer for Any Reason Other Than Non-Payment of Premium During the Period.									
69	Number of Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period.									
70	Number of Lives on Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period.									
71	Number of rescissions.									
72	Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificateholder.									
73	Number of insured lives impacted on terminations and cancellations due to nonpayment.									
74	Number of insured lives impacted by rescissions.									
75	Number of Policies/Certificates in Force at the End of the Period.									
76	Number of Covered Lives on Policies/Certificates in Force at the End of the Period.									

Prior Authorizations

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
77	Number of Prior Authorization Requests Pending at the Beginning of the Period.									
78	Number of prior authorizations requested during period.									
79	Number of prior authorizations approved during period.									
80	Number of prior authorizations denied during period.									
81	Number of claims where prior authorization penalties were assessed.									
82	Number of Prior Authorization Requests Pending at the End of the Period.									
83	Median Number of Days from Receipt of Prior Authorization Request to Decision.									
84	Average Number of Days from Receipt of Prior Authorization to Decision.									

Short-Term Limited Duration Insurance (2026)

Claims Administration (Including Pharmacy)

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
85	Number of Claims Pending at the Beginning of the Period.									
86	Number of claims received.									
87	Total number of claims denied, rejected or returned.									
88	Number of denied, rejected, or returned due to claims submission coding error(s).									
89	Number of denied, rejected, or returned for lack of Prior Authorization.									
90	Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation.									
91	Number of denied, rejected, or returned as Not medically necessary.									
92	Number of denied, rejected, or returned as Subject to pre-existing condition exclusion.									
93	Number denied, rejected, or returned due to failure to provide adequate documentation.									
94	Number denied, rejected, or returned due to being within the waiting period.									
95	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded.									
96	Number of denied, rejected, or returned for Out-of-Network provider.									
97	Number of Claims Pending at End of Period.									
98	Median Number of Days from Receipt of Claim to Decision for Denied Claims.									
99	Average Number of Days from Receipt of Claim to Decision for Denied Claims.									
100	Median Number of Days from Receipt of Claim to Decision for Approved Claims.									
101	Average Number of Days from Receipt of Claim to Decision for Approved Claims.									
102	Number of Claim Decisions Appeals Pending At Beginning of Period.									
103	Number of Claim Decision Appeals Received During the Period.									
104	Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period.									
105	Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period.									
106	Number of Claim Decision Appeals Rejected and Not Considered for Any Reason.									
107	Number of Claim Decision Appeals Pending at End of Period.									
108	Average Number of Days from Receipt of Appeal to Decision.									
109	Number of claims paid.									
110	Dollar Amount of Claims Paid During the Reporting Period									

Short-Term Limited Duration Insurance (2026)

Consumer Complaints and Lawsuits

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
111	Number of complaints received ~~by Company (other than through the DOI)~~ directly from any person or entity other than the DOI.									
112	Number of complaints received through DOI.									
113	Number of complaints resulting in claims reprocessing.									
114	Number of Lawsuits Open at Beginning of the Period.									
115	Number of Lawsuits Opened During the Period.									
116	Number of Lawsuits Closed During the Period.									
117	Number of Lawsuits Closed During the Period with Consideration for the Consumer.									
118	Number of Lawsuits Open at End of Period.									

Marketing and Sales

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
119	Number of Individual Applications Pending at the Beginning of the Period.									
120	Number of applications received.									
121	Number of Renewal/Reissue Individual Applications Received During the Period.									
122	Number of New Individual Applications Denied During the Period for Any Reason.									
123	Number of New Individual Applications Denied During the Period - Health Status or Condition.									
124	Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason.									
125	Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition.									
126	Number of New Individual Applications Approved During the Period.									
127	Number of Renewal/Reissue Individual Applications Approved During the Period.									
128	Number of Individual Applications Pending at the End of the Period.									
129	Number of applications initiated via phone.									
130	Number of applications completed via phone.									
131	Number of applications initiated face-to-face.									
132	Number of applications completed face-to-face.									
133	Number of applications initiated online (Electronically).									
134	Number of applications completed online (Electronically).									
135	Number of New Individual Applications initiated by Mail During the Period.									

Short-Term Limited Duration Insurance (2026)

Marketing and Sales (Continued)

		STLD <=90	STLD 91 - 180	STLD 181 - 364	STLD Not Sitused <=90	STLD Not Sitused 91 - 180	STLD Not Sitused 181 - 364	STLD Sitused <=90	STLD Sitused 91 - 180	STLD Sitused 181 - 364
136	Number of New Individual Applications completed by Mail During the Period.									
137	Number of New Individual Applications initiated by Any Other Method During the Period.									
138	Number of New Individual Applications completed by Any Other Method During the Period.									
139	Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period).									
140	Unearned Commissions returned to company on policies/certificates sold during the period?									
141	Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period).									

Short-Term Limited Duration Attestation

		First Name	Middle Name	Last Name	Suffix	Title	Comments
142	First Attestor Information						---
143	Second Attestor Information						---
144	Overall Comments for the Filing Period	---	---	---	---	---	

Market Conduct Annual Statement
Short-Term Limited Duration Insurance
Data Call & Definitions

Line of Business: Short-Term Limited Duration Insurance

Reporting Period: January 1, 2026 through December 31, 2026

Filing Deadline: May 31, 2027

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	Response
1-01	List the states where your STLD products are marketed	Comment
1-02	Does the company offer STLD policies/certificates with up to a 90-day duration?	Yes/No
1-03	Does the company offer STLD policies/certificates with 91- to 180-day duration?	Yes/No
1-04	Does the company offer STLD policies/certificates with 181- to 364-day duration?	Yes/No
1-05	Number of STLD forms offered to residents in this state	Comment
1-06	Number of STLD forms offered in all states	Comment
1-07	Number of STLD forms filed in this state	Comment
1-08	Number of STLD forms filed in all states	Comment
1-09	List the states where your STLD products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing	Comment

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

1-10	How many policy forms have waiting periods that apply to the entire policy/certificate?	Number
1-11	How many policy forms have waiting periods that apply per specific benefits?	Number
1-12	Do any waiting periods exceed the policy/certificate term?	Yes/No
1-13	If yes, please explain	Comment
1-14	Does the company issue STLD products through associations?	Yes/No
1-15	If yes, list the associations	Comment
1-16	If yes, do you have a contractual relationship with each Association?	Yes/No
1-17	If yes, does the contract cover the marketing of your product?	Yes/No
1-18	If yes, does the contract cover the collection of dues and fees?	Yes/No
1-19	If yes, does the contract cover commissions?	Yes/No
1-20	If yes, what other operational areas are covered in the contract?	Comment
1-21	Does the company issue STLD products through trusts?	Yes/No
1-22	If yes, how many?	Comment
1-23	Does the company issue STLD products through administrators?	Yes/No
1-24	If yes, how many?	Comment
1-25	Does the company contract with third-party administrators for administrative services related to STLD products?	Yes/No
1-26	If yes, does your delegation structure include claims related to STLD products?	Yes/No
1-27	If yes, does your delegation structure include complaints related to STLD products?	Yes/No
1-28	If yes, does your delegation structure include medical underwriting related to STLD products?	Yes/No
1-29	If yes, does your delegation structure include pricing related to STLD products?	Yes/No
1-30	If yes, does your delegation structure include producer appointments related to STLD products?	Yes/No
1-31	If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLD products?	Yes/No
1-32	Does your company audit Third parties to whom you have delegated responsibilities?	Yes/No
1-33	If yes, please provide frequency of audits	Comment

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

1-34	Does the company offer renewals/reissues?	Yes/No
1-35	Are any renewals/reissues subject to optional or mandatory underwriting?	Yes/No
1-36	If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue	Comment
1-37	Are there limitations on the number renewals per individual?	Yes/No
1-38	Does your company offer renewal(s) without underwriting for an additional charge?	Yes/No
1-39	If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge	Comment
1-40	Are the limitations on renewals based on state, federal, or company rules?	Yes/No
1-41	Does your company distribute its product through independent agents?	Yes/No
1-42	Does your company distribute its products through captive agents?	Yes/No
1-43	Does your company distribute its products through its employees?	Yes/No
1-44	What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)	Comment
1-45	Additional State Specific Comments (optional)	Comment

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

Products

Product Identifiers	Explanation of Product Identifiers
STLD <=90	Short-Term Limited Duration Insurance not sold through an Association with a term less than or equal to 90 days
STLD 91-180	Short-Term Limited Duration Insurance not sold through an Association with a term greater than 90 and less than or equal to 180 days
STLD 181 - 364	Short-Term Limited Duration Insurance not sold through an Association with a term greater than 180 days and less than 364 days
STLD Not Sitused <=90	Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term less than or equal to 90 days
STLD Not Sitused 91-180	Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 90 and less than or equal to 180 days
STLD Not Sitused 181 - 364	Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 180 days and less than 364 days
STLD Sitused <=90	Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term less than or equal to 90 days
STLD Sitused 91-180	Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 90 and less than or equal to 180 days
STLD Sitused >181 - 364	Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 180 days and less than 364 days

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

Schedule 2 – Policy/Certificate Administration

2-46	Direct Written Premium.
2-47	Earned premiums for Reporting Year
2-48	Number of Policies/Certificates in Force at the Beginning of the Period
2-49	Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period
2-50	Number of new policy/certificate applications received during the period
2-51	Number of new policy/certificates issued during the period
2-52	Number of new policies/certificates denied during the period
2-53	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-54	Member months for policies/certificates newly issued during the period
2-55	Number of policy/certificate renewal/reissue applications received during the period
2-56	Number of policies/certificates renewed/reissued during the period
2-57	Number of policies/certificates non-renewed or denied at the option of insurer during the period
2-58	Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period
2-59	Number of renewals/reissues allowed
2-60	Member months for policies/certificates renewed/reissued during the period
2-61	Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting
2-62	Member months for other than new policies/certificates or renewal/reissued policies/certificates during the period
2-63	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder
2-64	Number of policies/certificates cancelled during the free look period
2-65	Number of policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-66	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-67	Number of policy/certificate terminations and cancellations due to non-payment of premium
2-68	Number of policies/certificates cancelled by insurer for any reason other than non-payment of premium during the period

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

2-69	Number of policies/certificates cancelled by insurer following filing of a claim or prior authorization request by the policyholder/certificate holder during the period
2-70	Number of lives on policies/certificates cancelled by insurer following filing of a claim or prior authorization request by the policyholder/certificate holder during the period
2-71	Number of rescissions
2-72	Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificate holder
2-73	Number of insured lives impacted on termination and cancellations due to nonpayment
2-74	Number of insured lives impacted by rescissions
2-75	Number of Policies/Certificates in Force at the End of the Period
2-76	Number of Covered Lives on Policies/Certificates in Force at the End of the Period

Schedule 3 – Prior Authorizations

3-77	Number of Prior Authorization Requests Pending at the Beginning of the Period
3-78	Number of prior authorizations requested during period
3-79	Number of prior authorizations approved during period
3-80	Number of prior authorizations denied during period
3-81	Number of claims where prior authorization penalties were assessed
3-82	Number of Prior Authorization Requests Pending at the End of the Period
3-83	Median Number of Days from Receipt of Prior Authorization Request to Decision
3-84	Average Number of Days from Receipt of Prior Authorization to Decision

Schedule 4 – Claims Administration (Including Pharmacy)

4-85	Number of Claims Pending at the Beginning of the Period
4-86	Number of claims received
4-87	Total number of claims denied, rejected or returned
4-88	Number of denied, rejected, or returned due to claims submission coding error(s)
4-89	Number of denied, rejected, or returned for lack of Prior Authorization

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

4-90	Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation
4-91	Number of denied, rejected, or returned as Not medically necessary
4-92	Number of denied, rejected, or returned as Subject to pre-existing condition exclusion
4-93	Number denied, rejected, or returned due to failure to provide adequate documentation
4-94	Number denied, rejected, or returned due to being within the waiting period
4-95	Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded
4-96	Number of denied, rejected, or returned for Out-of-Network provider
4-97	Number of Claims Pending at End of Period
4-98	Median Number of Days from Receipt of Claim to Decision for Denied Claims
4-99	Average Number of Days from Receipt of Claim to Decision for Denied Claims
4-100	Median Number of Days from Receipt of Claim to Decision for Approved Claims
4-101	Average Number of Days from Receipt of Claim to Decision for Approved Claims
4-102	Number of Claim Decisions Appeals Pending At Beginning of Period
4-103	Number of Claim Decision Appeals Received During the Period
4-104	Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period
4-105	Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period
4-106	Number of Claim Decision Appeals Rejected and Not Considered for Any Reason
4-107	Number of Claim Decision Appeals Pending at End of Period
4-108	Average Number of Days from Receipt of Appeal to Decision
4-109	Number of claims paid
4-110	Dollar amount of claims paid during the period

Schedule 5 – Consumer Complaints and Lawsuits

5-111	Number of complaints received ~~by Company (other than through the DOI)~~ directly from any person or entity other than the DOI
5-112	Number of complaints received through DOI
5-113	Number of complaints resulting in claims reprocessing
5-114	Number of Lawsuits Open at Beginning of the Period
5-115	Number of Lawsuits Opened During the Period
5-116	Number of Lawsuits Closed During the Period

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

5-117	Number of Lawsuits Closed During the Period with Consideration for the Consumer
5-118	Number of Lawsuits Open at End of Period

Schedule 6 – Marketing and Sales

6-119	Number of Individual Applications Pending at the Beginning of the Period
6-120	Number of applications received
6-121	Number of Renewal/Reissue Individual Applications Received During the Period
6-122	Number of New Individual Applications Denied During the Period for Any Reason
6-123	Number of New Individual Applications Denied During the Period - Health Status or Condition
6-124	Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason
6-125	Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition
6-126	Number of New Individual Applications Approved During the Period
6-127	Number of Renewal/Reissue Individual Applications Approved During the Period
6-128	Number of Individual Applications Pending at the End of the Period
6-129	Number of applications initiated via phone
6-130	Number of applications completed via phone
6-131	Number of applications initiated face-to-face
6-132	Number of applications completed face-to-face
6-133	Number of applications initiated online (Electronically)
6-134	Number of applications completed online (Electronically)
6-135	Number of New Individual Applications initiated by Mail During the Period
6-136	Number of New Individual Applications completed by Mail During the Period
6-137	Number of New Individual Applications initiated by Any Other Method During the Period
6-138	Number of New Individual Applications completed by Any Other Method During the Period
6-139	Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period)
6-140	Unearned Commissions returned to company on policies/certificates sold during the period

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

6-141	Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period)

Schedule 7– Short-Term Limited Duration Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

7-142	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
7-143	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
7-144	Overall Comments for the Period

Participation Requirements: All companies licensed and reporting at least $50,000 of Short-Term Limited Duration Insurance (STLD) premium for all coverages reportable in

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

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 situsted.

General Definitions:

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

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

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

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

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

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

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

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

Certificateholder is the individual when purchased through an Association, which is the policyholder.

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

Schedule 2 Definitions (Policy/Certificate Administration):

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

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

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

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

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

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

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

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

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

Claim Clarifications:

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

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

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

Clarification:

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

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

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

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

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

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

For purposes of reporting lawsuits for Short-Term Limited Duration 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 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.

Market Conduct Annual Statement Short-Term Limited Duration Insurance Data Call & Definitions

Schedule 6 Definitions (Marketing and Sales)

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

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

Draft: 7/14/25

Market Analysis Procedures (D) Working Group
Virtual Meeting
June 23, 2025

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 23, 2025. The following Working Group members participated: Jo A. LeDuc, Chair (MO); Raymond A. Guzman, Vice Chair (MD); Molly Nollette (AK); Lori Plant (AR); Cheryl Hawley, Tolanda Coker, and Anthony Murdock (AZ); Don McKinley (CA); Tracy Garceau (CO); Steve DeAngelis (CT); Rachael Lozano (FL); Chris Heisler (IL); Lori Cunningham (KY); Connie Mayette (ME); Danielle Torres (MI); Robert McCullough (NE); Ralph Boeckman and Erin Porter (NJ); Jonathan Wycoff (NV); Ben Hauck (OH); Landon Hubbart (OK); August Hall (PA); Brett Bache (RI); Rachel Moore (SC); Shelley Wiseman (UT); Melissa Gerachis (VA); Karla Nuissl and Izzy Keiser (VT); Theresa Miller (WV); and Rebecca Rebholz and Darcy Paskey (WI). Also participating was: Shane Quinlan (NC).

1. Adopted its May 27 Minutes

The Working Group met May 27 and took the following action: 1) adopted its April 21 meeting minutes; 2) adopted a one-year Market Conduct Annual Statement (MCAS) filing extension for fraternals; 3) received a report from the Market Analysis Prioritization Tool (MAPT) Recommendations Ad Hoc Group; 3) discussed revisions to the MCAS private passenger auto (PPA) and homeowners ratio 7; 4) discussed possible new lines of business for the MCAS; and 5) discussed revisions to the Market Analysis Review System (MARS) Level 2 guidance in the *Market Regulation Handbook.*

Mayette made a motion, seconded by Wiseman, to adopt the Working Group's May 27 minutes (Attachment One -C1). The motion passed unanimously.

2. Received a Report from the MAPT Recommendation Group

LeDuc said the MAPT Recommendations Ad Hoc Group finished its review of both the financial and MCAS MAPT data elements for PPA and homeowners, as well as potential new data elements from sources outside of the two MAPTs. She said that in its final meeting on June 16, the Ad Hoc Group did not come up with any new recommendations beyond what was reported to the Working Group in April. She thanked the Ad Hoc Group members for their work and time commitment. LeDuc said the work was done as part of the following Working Group charge: "In accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data."

LeDuc said the Working Group needs to consider its next steps. She said Randy Helder (NAIC) will distribute a document to Working Group members, interested regulators, and the Market Analysis Chiefs (MACs) showing the current MAPT data elements and the recommended additional data elements. As some data elements are recommended for deletion, those will be redlined out. Some data elements were recommended to be revised, and those revisions will be noted. LeDuc said the document would only be sent to regulators. The Working Group will meet July 21 in regulator-to-regulator session to review the recommended changes, discuss how these recommendations, if implemented, affect market analysis, and consider the next steps. She said that in addition to the list of data elements Helder will send, she will provide a summary with an explanation of the sources the Ad Hoc Group looked at, what it chose, and some options for next steps.

LeDuc said the Working Group will meet July 21 in regulator-to-regulator session to allow the members and interested regulators to candidly discuss their internal analysis processes and thoughts on the recommendations and next steps.

3. Received a Report from the Market Regulation Certification (D) Working Group on a MARS Level 1 Requirement

Helder reported that the Market Regulation Certification (D) Working Group chair and vice chair drafted and distributed a proposed requirement to the Working Group members and interested regulators. Comments are being received and posted to the Working Group's web page. He said the proposal would require six MARS or Market Actions Tracking System (MATS) analyses per full-time market regulation department employee in each jurisdiction. This will be the starting point for discussions at the Working Group's next meeting.

4. Discussed PPA and Homeowners MCAS Ratio 7

LeDuc said that ratio 7 of the PPA and homeowners MCAS blanks compares the reported number of lawsuits to the reported claims closed without payment. She said that over the last few meetings, the Working Group has considered changes to the ratio's numerator and denominator. A consensus seemed to be forming around the denominator being a measure of exposure units, such as the number of dwellings/autos insured during the period. LeDuc said this denominator (number of exposure units) has the benefit of being consistently and accurately reported by companies, and because the proposed denominator would no longer be based on the number of claims, it would allow analysts to include the non-claims lawsuits that MCAS began collecting a couple of years ago.

Guzman said Maryland recommends changing the denominator to policies in force rather than exposure units. LeDuc said the policies in force may not be consistent because some companies may only write one auto/home per policy, while others may write multiple autos/homes per policy. Guzman said this was discussed with Commissioner Grant (MD), who said the number of policies in force is better as a denominator than closed without payment; trends can continue to be tracked with policies in force; and most companies will write multiple autos on one policy and one home per policy.

Guzman made a motion to revise the MCAS PPA and homeowners ratio 7 to the number of claims-related and non-claims-related lawsuits divided by the number of policies in force. The motion was not seconded. LeDuc said possible revisions to ratio 7 can be reconsidered if any member wishes to do so.

5. Discussed MCAS Ranks

Guzman said that North Carolina had concerns that while it is okay to assign an MCAS ratio a ranking of "0," a numerator of "0" in an MCAS ratio should still rank the company with a "1," in lieu of a "0," because a ratio of "0" tells the analyst something about the company. Guzman said that after reviewing the ratios and thinking through North Carolina's concerns, he thinks it would not make sense to rank a company based on a "0" value for any MCAS ratios. He said that if the numerator for any of these ratios is "0," then there is simply no concern to note for that company and, therefore, it would not make sense to assign it a rank. He said he favored keeping the rank calculation as it is currently.

Quinlan said the concern arose during a lunch-and-learn. He said North Carolina creates its own analysis reports and uses primarily ratios. He said North Carolina does not have an issue with leaving the ranks calculations as is.

6. Discussed the Possibility of Adding a New Line of Business to the MCAS

LeDuc said Interim Director Maria Ailor (AZ) suggested possibly adding service companies offering warranty contracts for homes and automobiles. LeDuc said there were some questions about how many state departments of insurance (DOIs) have the authority to regulate this business. She said she saw that Ailor posted the question on the NAIC Market Regulation Bulletin Board.

Coker said that the Arizona Department of Insurance and Financial Institutions (DIFI) is still reviewing the results from the bulletin board and asked to report back at the Working Group's next meeting. LeDuc agreed.

7. Discussed the Lunch-and-Learn Schedule

LeDuc said that the Working Group's June 9 lunch-and-learn was on the MCAS Tableau reports in i-Site+ and how they can be used to manage the MCAS data as it is being received from the companies. She thanked Jun Lian (NAIC) for doing a great job hosting the session and answering questions. She encouraged everyone to reach out to Lian and NAIC staff with any assistance they may need navigating through the MCAS reports in i-Site.

LeDuc said the next lunch-and-learn is scheduled for Sept. 8. She said Helder will send out an invitation to get the session on everyone's calendars. She said no topic has been decided yet and asked for requests for topics of interest dealing with market analysis, the use of any analysis tools, or market analysis information databases. She said Helder will find speakers to host the discussion when the topic is chosen.

8. Discussed Revisions to the MARS Level 2 Guidance

The following revisions were proposed for "Area of Review: Consumer Complaints": 1) the note regarding summary reports was deleted, and a note to hear from states regarding whether they create summary reports was added; and 2) additional areas of concern in the market were added under items to be considered.

LeDuc said that when the guidance was originally drafted, it was written with the assumption that some Level 2 reviews would be completed without a Level 1 analysis having been done, and each of the listed items to consider contained some cursory information in case a Level 1 analysis had not been completed. LeDuc suggested addressing this in one place near the top of the guidance or at the beginning of each area of review, since some analysts may just turn to the specific areas of concern rather than read the whole guidance document. Moore said it would be best at the beginning of each section.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

SharePoint/Member Meetings/D CMTE/2025 Summer National Meeting/MAPWG/0623/6-MAPWG T.docx

Draft: 6/23/25

Market Analysis Procedures (D) Working Group
Virtual Meeting
May 27, 2025

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 27, 2025. The following Working Group members participated: Jo A. LeDuc, Chair (MO); Raymond A. Guzman, Vice Chair (MD); Chelsy Maller (AK); Teri Ann Mecca (AR); Cheryl Hawley and Tolanda Coker (AZ); Don McKinley (CA); Tracy Garceau (CO); Steve DeAngelis (CT); Susan Jennette (DE); Christina Huff (FL); Chris Heisler (IL); Lori Cunningham (KY); Lisa Fullington and Joshua Guillory (LA); Timothy N. Schott (ME); Danielle Torres (MI); Ralph Boeckman and Erin Porter (NJ); Stacy Gaytan (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Shelley Wiseman (UT); Melissa Gerachis (VA); Karla Nuissl (VT); Theresa Miller (WV); and Rebecca Rebholz and Darcy Paskey (WI).

1. Adopted its April 21 Minutes

The Working Group met April 21 and took the following action: 1) adopted its March 3 meeting minutes; 2) heard a report from the Market Analysis Prioritization Tool (MAPT) Recommendations Ad Hoc Group; 3) referred the Market Analysis Review System (MARS) Level 1 requirements discussion to the Market Regulation Certification (D) Working Group; 4) discussed possible new lines of business for the Market Conduct Annual Statement (MCAS); 5) discussed an extension of the first MCAS filing date for fraternals; 6) discussed the April 14 lunch-and-learn; and 6) discussed revising MARS Level 2 guidance in the *Market Regulation Handbook.*

Veronikis made a motion, seconded by Wiseman, to adopt the Working Group's April 21 minutes (Attachment One-C1a). The motion passed unanimously.

2. Adopted One-Year MCAS Filing Extension for Fraternals

LeDuc said that during the Working Group's last meeting, Alison Koppel (American Fraternal Alliance—AFA) said the AFA's members are preparing for their first MCAS submission due in April 2026. It is proving to be a large task for many fraternals, and they requested an extension to submit either later in 2026 or in April 2027.

Gerachis asked how long of an extension the fraternals would need if the extension was only for a future date in 2026. LeDuc said there may be some system constraints if the extension were for a later date in 2026. Teresa Cooper (NAIC) said that because fraternals now report on the life annual statement blank, there may be some issues with having separate due dates for fraternals than for other life insurance companies. She noted that the life insurance ratios are posted on July 1, but would not include the fraternals if they had a later due date. Gerachis suggested keeping the filing due date of April 2026. Then, each company can separately request extensions if needed. She said fraternals also have long-term care (LTC) data. LeDuc said that since we have not had fraternal data since the inception of MCAS, one more year seems acceptable. Nuissl and Guzman agreed.

Christopher Nowotarski (Catholic Order of Foresters) said the reason fraternals are asking for an extension is that the industry training webinars provided by the NAIC were not available until late March.

Guzman made a motion, seconded by Veronikis, to provide a one-year extension for the initial filing by fraternals, which would be for 2026 data to be collected in 2027. The motion passed.

3. Received a Report from the MAPT Recommendation Group

LeDuc said the MAPT Recommendations Ad Hoc Group met May 12 to discuss data found in sources outside the NAIC databases. It looked at the reports available internally at the departments of insurance (DOIs) and began reviewing the statistical reports published through the NAIC.

LeDuc said a decision was made not to recommend using any DOI internal reports in the MAPT since they are only available per department and cannot be used on a national basis. She said there are 11 statistical reports. Each report has a lot of data to review, and the Ad Hoc Group decided to split the task among its members. The members have volunteered to review one or two reports each. On June 2, the members will share their findings and see if there is data in the reports that can be used for prioritization in the MAPT.

4. Received a Report from the Market Regulation Certification (D) Working Group on a MARS Level 1 Requirement

Randy Helder (NAIC) reported that the Market Regulation Certification (D) Working Group met May 21 and discussed adding the MARS Level 1 requirement to the Voluntary Market Regulation Certification Program. The chair, vice chair, and NAIC support staff will meet separately and draft a proposed requirement to be circulated to members and interested regulators. This will be the starting point for discussions at the Working Group's next meeting.

5. Discussed PPA and Homeowners MCAS Ratio 7

LeDuc said concerns about ratio 7 of the private passenger auto (PPA) and homeowners MCAS blanks have been expressed. Ratio 7 compares the reported number of lawsuits to the reported claims closed without payment. LeDuc said the discussion in prior meetings generated some suggestions for a new denominator. The denominator should be a data point that companies consistently and accurately report. Any denominator should also have some relationship with the number of lawsuits received. She said the Working Group heard suggestions to change the denominator to "claims closed with payment;" "policies in-force at the end of the period;" and "number of autos or homes insured."

LeDuc reminded the Working Group that if a change does not impact the data elements a company has to report, it could be effective immediately. She said that if the Working Group does adopt a change, any future trending on ratio 7 will need to be careful to note the change in the year it is adopted.

Guillory said he would prefer "total claims closed" instead of "claims closed without payment" or "claims closed with payment." Guzman agreed with Guillory and said the original intent was likely to compare lawsuits to adverse claims decisions, but lawsuits can be generated on any claim. LeDuc affirmed that was the original intent and suggested a new ratio that compares lawsuits to exposure units. Self agreed and said "closed without payment" can be driven by reserving practices rather than adverse claims decisions. He noted that "claims closed without payment" is consistently reported by companies. He said all companies consistently report exposure units and that they would not vary based on companies' operational practices. LeDuc said that if exposure units are used as the denominator, the numerator could also be changed to include the non-claims lawsuits that the MCAS has recently begun collecting.

Guzman asked for additional time to discuss the ratio options with others in his department. LeDuc said the Working Group would discuss this issue again at its next meeting and consider a revised ratio for adoption.

6. Discussed the Possibility of Adding a New Line of Business to the MCAS

LeDuc said that Maria Ailor (AZ) suggested possibly adding service companies offering warranty contracts for homes and automobiles. LeDuc said there were some questions about how many state DOIs have the authority to regulate this business. She saw that Ailor posted the question on the NAIC Market Regulation Bulletin Board.

Coker said that the Arizona Department of Insurance and Financial Institutions (DIFI) is still reviewing the results from the bulletin board and asked to report back at the Working Group's next meeting. LeDuc agreed.

7. Discussed the Lunch-and-Learn Schedule

LeDuc said the next lunch-and-learn is tentatively scheduled for June 9. She said the topic is not set yet. She said it could be a lunch-and-learn about the MCAS reports in Tableau or, if not, she will host a discussion on how to find Market Information Systems (MIS) data on the NAIC website. Jennette said a webinar on how to pull data from i-Site+ would be helpful for new analysts.

8. Discussed Revisions to the MARS Level 2 Guidance

LeDuc said that during the Working Group's last meeting, it was decided to address the Market Regulation Handbook's MARS Level 2 Guidance at the Working Group level. She said the Working Group will consider one or two sections at a time, beginning with the introduction and complaints section of the guidance. LeDuc said it is important that what is found in i-Site+ is in sync with what is found in the *Market Regulation Handbook*. She said Helder would keep the two in sync as the Working Group moves along. The Handbook guidance will be the final version of what will be seen in i-Site+, so if there is anything in the i-Site+ guidance that is not currently in the Handbook, but should be, the Working Group should make sure it gets into the Handbook.

The following revisions were proposed: 1) add an opening paragraph outlining best practices when completing a Level 2 analysis; 2) delete a paragraph referencing changes implemented in 2006; 3) add a clause that "a good business practice would be" to review each of the 6 core areas of view; and 4) add a sentence that the "consumer complaints" area must be completed on all analyses.

Jennette suggested adding producer licensing to the core areas of review. LeDuc said not all jurisdictions require agency appointments.

9. Discussed MCAS Ranks

Guzman summarized the North Carolina request to assign a rank to all companies and not use a rank of zero, since a zero rank will not be included in some reports. Guzman noted, however, that zero rank is generated when the ratio numerator is "0." That indicates that the company would not be a concern in that area and should not be ranked. He said that at the next Working Group meeting, he would like to discuss how jurisdictions use the ranks and how helpful they find them to be.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

SharePoint/Member Meetings/D CMTE/2025 Summer National Meeting/MAPWG/0421/5-MAPWG T.docx

Draft: 5/8/25

Market Analysis Procedures (D) Working Group
Virtual Meeting
April 21, 2025

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 21, 2025. The following Working Group members participated: Jo A. LeDuc, Chair (MO); Chelsy Maller (AK); Teri Ann Mecca (AR); Maria Ailor (AZ); Don McKinley (CA); Tracy Garceau (CO); Steve DeAngelis (CT); Susan Jennette (DE); Sheryl Parker (FL); Chris Heisler (IL); Lori Cunningham and Patrick Smith (KY); Mary Lou Moran (MA); Salama Karim-Camara (MD); Jeff Hayden and Danielle Torres (MI); Robert McCullough (NE); Melinda Stalter (NJ); Jon Wycoff (NV); Larry Wertel (NY); Guy Self (OH); Landon Hubbart (OK); Karen Veronikis (PA); Brett Bache (RI); Rachel Moore (SC); Shelley Wiseman (UT); Laura Klanian (VA); Karla Nuissl (VT); and Rebecca Rebholz and Darcy Paskey (WI). Also participating was: Bryan Stevens (WY).

1. Adopted its March 3 Minutes

The Working Group met March 3 and took the following action: 1) adopted its 2024 Fall National Meeting minutes; 2) discussed its 2025 charges; 3) heard a report from the Market Analysis Prioritization Tool (MAPT) Recommendation Group; 4) discussed Market Analysis Review System (MARS) Level 1 requirements; 5) discussed possible new lines of business for the Market Conduct Annual Statement (MCAS); 6) discussed the lunch-and-learn schedule for 2025; and 6) discussed revising MARS level 2 guidance in the *Market Regulation Handbook*.

Rebholz made a motion, seconded by Mecca, to adopt the Working Group's March 3 minutes (*see NAIC Proceedings – Spring 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Two*). The motion passed unanimously.

2. Received a Report from the MAPT Recommendation Group

LeDuc said the MAPT Recommendations Group meets bi-weekly and has begun looking into additional data sources available from the NAIC, such as the financial analysis databases, MARS, and the Market Actions Tracking System (MATS). When that review is complete, the group will review data sources external to the NAIC and the departments of insurance (DOIs). She said she expects that two or three more meetings are needed to wrap up this phase of identifying different data sources. Then, the group will begin discussions on how to use the data to prioritize companies.

3. Discussed the MARS Level 1 Requirements

LeDuc said that during the Working Group's last meeting, the Working Group decided that any requirement for jurisdictions to do a set number of MARS Level 1 reviews should be made at the Market Regulation Certification (D) Working Group.

Stevens said the Market Regulation Certification (D) Working Group discussed the requirement briefly at the Spring National Meeting, and it was clear that more discussion was needed. He said the Working Group will be dedicating its next meeting to considering a MARS Level 1 requirement and whether the requirement should be based on staff size, number of domestics, or some other factor.

Stevens said that he would be happy to begin the discussion of a new requirement at the Market Regulation Certification (D) Working Group.

4. Discussed the Possibility of Adding a New Line of Business to the MCAS

LeDuc said the Working Group has not received any suggestions for a new line of business to be added to the MCAS and opened up the discussion to the Working Group.

Ailor said that service companies offering warranty contracts for homes and automobiles in Arizona have been an issue for her state, but there is very little data available to monitor these companies. She said she did not know how many state insurance departments regulate these entities but wanted to raise the possibility. LeDuc suggested first trying to find out how many states regulate service warranties as insurance. Ailor said she could post a question to the Market Regulation Bulletin Board asking states whether their department regulates service warranties.

5. Discussed the Due Date for Inclusion of Fraternals in the MCAS

LeDuc said the Working Group voted to require fraternals to file the MCAS with participating states. The first filing would be due April 30, 2026, for the 2025 data. She said the Working Group has received a request from the American Fraternal Alliance (Alliance) to extend the due date.

Allison Koppel (Alliance) said members of the Alliance immediately began preparing for MCAS submissions when the Plenary adopted the proposal to remove the exemption of fraternals from filing the MCAS. She said a cohort of more than 20 of their member societies has uncovered a number of challenges to be prepared in time for the filing on April 30, 2026. Among the challenges are the different data formats requiring new queries to be written and determining who has and needs access to the data. She also said they are working through understanding the scope of the MCAS definitions. She asked for a one-year extension of the April 30, 2026, filing date to allow additional time to prepare.

LeDuc said she had a conversation with Koppel during the Spring National Meeting and is convinced fraternal societies are making a good-faith effort to prepare. Ailor asked if a one-year extension is necessary and whether additional time could be granted to submit the 2025 data. LeDuc said that because fraternals report on the life financial blank, it would be difficult to allow an extended due date in the same year for fraternals separate from life and annuity companies.

Chris Nowotarski (Catholic Order of Foresters—COF) said the NAIC's training for MCAS only began recently, which has delayed the COF's analysis of what data will be needed. Additionally, even though the premium threshold is $50,000, the data needs to be pulled for all states regardless of premium size because for some states with little premium, they will not know from year to year whether they have to report.

LeDuc said the Working Group will vote on the request to extend reporting for one year at its next meeting in May.

6. Discussed the Lunch-and-Learn Schedule

LeDuc said the April 14 lunch-and-learn hosted by Self and Tom Whitener (WY) was very good, and she thanked them. She said the next lunch-and-learn is scheduled for June 9 and asked the Working Group to provide suggestions for potential topics to Randy Helder (NAIC).

7. Discussed Revisions to the MARS Level 2 Guidance

LeDuc said the MARS Level 2 guidance in the *Market Regulation Handbook* has not been updated since it was added to the Handbook many years ago. She said it is a large document that goes into detail on areas to look at in a market analysis review. LeDuc said the guidance was written in the early days of market analysis and could benefit from the analysis experience gained over the years. She noted that no one volunteered to be part of a drafting group since this was raised at the last meeting.

Self said that during the lunch-and-learn, Whitener showed that there are not many Level 2 reviews in MARS and suggested there is not currently a need to revise the guidance. LeDuc said the Level 2 guidance is useful for market analysis even if the review is not recorded in MARS. LeDuc said Louisiana indicated they use the guidance for training. She said she also views the guidance as a helpful training tool and refresher for analysts. Ailor said Arizona uses the guidance as a training resource. Moran said her department uses the guidance to explain to auditors and other departments what is being done by their market analysts. Wycoff said he has only done market analysis for a couple of years, and he found the guidance very useful. He cautioned against removing anything unless it is no longer relevant.

Bache said it was noted during lunch-and-learn that there are also some differences between what is in the Handbook and what is in i-Site+. Self said it was primarily due to when the Market Initiatives Tracking System (MITS) and the Examination Tracking System (ETS) were combined into MATS. That change is reflected in the Handbook but not in i-Site+.

Helder suggested reviewing the guidance at the Working Group level. He said one or two sections could be worked on at a time. LeDuc agreed and said the Working Group could begin with the complaints section. Ailor asked for a Word version of the document. Helder agreed to circulate the Word version.

8. Discussed Other Matters

Karim-Camara said that when their analysts completed a review of individual and group analysis in MAPT, some companies were shown to have premium for individual and group accident and health, but in the Complaint Database System (CDS) and market share reports, they do not show any premium. She said this premium is also missing in MARS. She said in previous years that premium has been shown. Teresa Cooper (NAIC) asked for some screenshots and said she would look into this.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

SharePoint/Member Meetings/D CMTE/2025 Summer National Meeting/MAPWG/0421/4-MAPWG.docx

Draft: 7/31/25

Market Conduct Examination Guidelines (D) Working Group
Virtual Meeting
July 23, 2025

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 23, 2025. The following Working Group members participated: Matthew Tarpley, Chair, Thomas Morgan and Stacie Parker (TX); Brett Bache, Vice Chair, (RI); Chelsy Maller and Molly Nollette (AK); Lori Plant (AR); Tolanda Coker and Katherine Jessen (AZ); Nick Gill (CT); Simone Edmonson, Paula Shamburger and Tia Taylor (GA); Jack Engle and Chris Heisler (IL); Airic Boyce and Danielle Torres (MI); Julie Hesser, Teresa Kroll, Jo A. LeDuc and Win Nickens (MO); Tracy Biehn, Bill George and Teresa Knowles (NC); Ralph Boeckman and Erin Porter (NJ); Sylvia Lawson (NY); Rodney Beetch (OH); Landon Hubbart and Zach Palank (OK); Tashia Sizemore and Cassie Soucy (OR); Paul Towsen (PA); Andrea Baytop, Julie Fairbanks and Bryan Wachter (VA); Jared Holshouser and Isabelle Turpin Keiser (VT); Sandy Ray (WA); and Barbara Belling, Darcy Paskey, Rebecca Rebholz, Mary Kay Rodriguez, TerriJo Saarela and Jody Ullman (WI).

1. Discussed the July 17 Draft Revisions to Chapter 21A of the *Market Regulation Handbook*

Tarpley said a Feb. 11 exposure draft of Chapter 21A—Conducting the Property and Casualty Travel Insurance Examination of the *Market Regulation Handbook* (Handbook) was discussed at the Working Group's last meeting on March 13. During the meeting, a high-level summary of the comments received on March 12 from the American Property Casualty Insurance Association (APCIA) and the U.S. Travel Insurance Association (USTIA) was provided. Tarpley said the state insurance regulator subject matter experts (SMEs) who drafted the Feb. 11 revisions to the chapter reconvened after the Working Group's March 13 meeting and met five times from April to July to review the comments and make changes as necessary. A revised travel insurance chapter draft and combined APCIA/USTIA comment chart were distributed for the Working Group's review and posted to the Working Group's web page on July 17. The comments due date on the revised travel insurance chapter draft is Aug. 15.

Tarpley said the travel insurance chapter had been revised to provide a market conduct examiner with guidance that would prompt the examiner to review specific documents in the "Document to Be Reviewed" section and/or to perform specific review procedure/criteria, should the examiner deem them relevant. Prior to all changes, the travel insurance chapter was missing review procedures/criteria from marketing and sales exam standards 3, 4, 8, and 11, and from underwriting and rating exam standard 1.

Biehn said that the SMEs who drafted the July 17 changes to the travel insurance chapter exposure draft agreed to a number of revisions in consideration of the APCIA and USTIA comments received. Biehn also mentioned that the sentence, "If the examiner is unable to obtain the requested information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer," was removed from all occurrences in the exposure draft. The removal of the sentence was made not only in the areas specifically mentioned in the APCIA/USTIA comments (marketing and sales exam standards 3, 4, 8, 11, and underwriting and rating standard 1) but was also made in marketing and sales standards 1, 2, 6, and producer licensing standard 1.

Biehn said after the SMEs' consideration of the APCIA/USTIA comments, there were seven instances where language was deleted from the draft, twelve instances where a rationale was provided in the comment chart, and two instances where no change was made. Biehn asked the Working Group to focus on the two areas where no changes were made in response to the APCIA/USTIA comments, which were about rebating in marketing and sales

standard 1 and about compliance with 18 U.S.C. § 1033—Crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce in marketing and sales standard 4.

Lisa Brown (APCIA) and Michael Byrne (McDermott Will & Emery), who submitted the comments on behalf of the USTIA, both said they would submit comments on the revised travel insurance exposure draft by the comment due date of Aug. 15.

Tarpley reminded the Working Group, interested regulators, and interested parties of the Handbook's intended use, which is in the foreword of each volume of the Handbook, which states in part: "This handbook is only a guide and should be used by each jurisdiction as a tool for developing jurisdiction-specific procedures and guidelines. To effectively use this handbook, it is recommended that each jurisdiction closely review the handbook to determine those standards that reflect the statutes and regulations of the given jurisdiction and those that do not..."

Tarpley recognized the travel insurance SMEs who worked on the review of the APCIA/USTIA comments: Joshua Guillory (LA), Robert Barnes (LA), Kroll, Biehn, Bache, and Petra Wallace (NAIC staff).

2. Discussed the May 22 Draft of a New Chapter 21B for Inclusion in the Handbook

Bache said an exposure draft of a new pet insurance examination chapter, Chapter 21B—Conducting the Pet Insurance Examination, distributed May 22 for a 30-day public comment period. State insurance regulator pet insurance SMEs created the pet insurance chapter based upon the *Pet Insurance Model Act* (#633). Comments were received from Baytop on June 23.

Baytop said that marketing and sales examination standard 3 would be more appropriately placed in the underwriting and rating examination standards section of the chapter, and she noted a typographical error in marketing and sales standard 3. Baytop also suggested that a new paragraph be included in the relocated marketing and sales examination standard that addresses that the examiner should review and ascertain whether the pet insurer's policy form/endorsements are approved by the applicable department of insurance, pursuant to applicable state statutes.

The Working Group agreed to place the examination standard in the underwriting and rating section. Since the section will then need introductory paragraphs titled "Purpose," "Techniques," and "Tests and Standards" included—like other sections of the chapter where exam standards are located—the pet insurance SMEs will meet to develop that language, correct the typographical error, and renumber marketing and sales examination standard 4 to be marketing and sales examination standard 3. Bache said that the SMEs will consider placing a new paragraph in marketing and sales standard 3 regarding policy form/endorsement approval by a department of insurance. A revised pet insurance chapter exposure draft will be distributed for discussion at a future working group meeting.

Bache recognized the pet insurance SMEs who drafted the chapter: Ullman, Ellen Wilkins (NH), Tarpley, and Wallace.

3. Discussed Progress on its 2025 Charges and Work Plan

Tarpley said pet insurance standardized data requests (SDRs) addressing policies in force, claims, and complaints are currently being drafted. The pet insurance SMEs have met four times to date in drafting sessions, which started in May. Tarpley recognized the addition of Lori Cunningham (KY) to the pet insurance SDR SME group.

Tarpley said state insurance regulator accelerated underwriting SMEs have met five times to date since mid-April to develop market conduct examiner guidance for inclusion in the Handbook, based upon the Regulatory Guidance Document that the Accelerated Underwriting (A) Working Group adopted in August 2024. The Life Insurance and Annuities (A) Committee adopted the document at the 2024 Summer National Meeting. A formal accelerated underwriting exposure draft will be distributed to the Working Group, interested regulators, and interested parties upon the SMEs' completion. Tarpley recognized the accelerated underwriting SMEs: Sarah Gillaspey (MN), Lauren Van Buren (WI), Parker, and Bache.

Tarpley said the draft travel insurance chapter, as well as the new pet insurance draft chapter, the new pet insurance SDRs, and forthcoming accelerated underwriting market conduct examiner guidance, are subject to the Working Group's standard adoption process (exposure, comment period or periods, review and discussion at open Working Group meetings, and adoption).

Regarding the Working Group's charge to develop a collaborative space for the Working Group, Tarpley said the group's NAIC Connect page went live on Feb. 11. An invitation to join NAIC Connect was distributed at that time to the Working Group, interested regulators, and chief market conduct examiners. The Working Group is the first Working Group under the Market Regulation and Consumer Affairs (D) Committee to have a live page on NAIC Connect. Tarpley reminded regulators to join the Working Group Connect page. Tarpley said the Working Group anticipates that the NAIC Connect Working Group page will be a platform where regulator-only tools and related information can be shared. Tarpley said he and Bache are discussing the most appropriate way to accomplish this charge.

Regarding the Working Group's charge to coordinate with the Innovation, Cybersecurity, and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities' use of artificial intelligence (AI), the Big Data and Artificial Intelligence (H) Working Group has a formal exposure draft of an AI systems evaluation tool. The comment period for the tool ends Aug. 6.

Tarpley said that the Big Data and Artificial Intelligence (H) Working Group also had issued a formal request for information (RFI) regarding the proposal of an NAIC model law on the use of AI in the insurance industry. The Big Data and Artificial Intelligence (H) Working Group plans to discuss all comments received on the RFI at its upcoming meeting at the 2025 Summer National Meeting. Tarpley said the AI systems evaluation tool, when adopted by the NAIC, is a good example of a resource that can be provided as a link on the Working Group's collaborative space in NAIC Connect, for example, in a "to-be-created" AI-related section of the page. Tarpley said a link can also be provided on the NAIC Connect page to other AI-related resources, such as the NAIC *Model Bulletin on the Use of Artificial Intelligence Systems by Insurers*, adopted by the NAIC on Dec. 4, 2023. Tarpley said that when an NAIC AI-related model is eventually adopted, that will prompt the Working Group to begin developing an AI-related chapter in the Handbook. Tarpley said he and Bache are monitoring the work of the Innovation, Cybersecurity, and Technology (H) Committee.

4. Discussed Other Matters

Tarpley said a notice of the Working Group's next meeting will be distributed when a meeting date and time have been determined.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/Committee Folders/D CMTE/2025 Summer/MCEG/07-23.docx

Draft: 8/5/25

Speed to Market (D) Working Group
Virtual Meeting
June 24, 2025

The Speed to Market (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met June 24, 2025. The following Working Group members participated: Maureen A. Motter, Chair, and Lilane Fox (OH); Julie Fairbanks, Vice Chair, and Amanda McCauley (VA); Erick Wright (AL); Mary Grover (CO); Susan Jennette (DE); Spencer Hawkins (ID); Tammy Lohmann (MN); Camille Anderson-Weddle and Jo LeDuc (MO); Tracy Biehn and Ted Hamby (NC); Yuri Venjohn and Chrystal Bartuska (ND); LuAnne J. King (NH); Joshua Blakey and Lauren Bodine (OR); Marianne Baker, Angela McNeal, and Lynnette Bentley (TX); Kelly Christensen and Heidi Clausen (UT); Rob Lee and Gail Jones (WA). Also participating were Christina Huff (FL); Nina S. Hunter (LA); Nour Benchaaboun (MD); Audrey I. Wade (ME); and Mary V. Richter (VT).

1. Adopted its Spring National Meeting Minutes

Fairbanks made a motion, seconded by Wright, to adopt its March 4 (*see NAIC Proceedings – Spring 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Six*) minutes. The motion passed unanimously.

2. Discussed Suggestions Received on the PCM

Motter explained that the Working Group received seven suggestions for changes to the product coding matrix (PCM). Each suggestion was discussed in detail to reach a determination (Attachment One). The first suggestion was to add two new hospital indemnity types of insurance (TOIs): H14G.001 Health-Hospital Indemnity and H14I.001 Hospital Indemnity. These would describe a hospital indemnity contract that pays a fixed amount for a hospital confinement that is less than the minimum standards outlined in state law. The rationale behind this suggestion was to align the types with the limited benefit health coverage outlined in the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (Model #171). The Working Group considered several factors, including where states were currently filing such submissions and whether existing TOIs H15.G004 and H15.I002 could serve the same purpose. They also discussed whether to amend the descriptions of H14.G000, H14I.000, H15.G004, and H15.I002 to indicate which TOIs to use for products that do not meet state minimum standards, and if this could be a solution instead of adding additional sub-TOIs. Other considerations included the identification of such products through filing labels or state filing descriptions, the number of states that would use the new TOIs, and whether updates to the descriptions of H14.G000 and H14I.000 would be necessary.

Ultimately, the outcome was a lack of interest in the additions by other states, since Utah had adopted Model #171. The requesting state believed that a filing label could not be a long-term solution since it would not be available in the System for Electronic Rates & Forms Filing (SERFF) modernization project. However, NAIC SERFF staff confirmed that filing labels would continue to exist, so the state would likely use that solution. Motter concluded that the Working Group would not be able to add any new TOIs but could add two new filing labels to accommodate this suggestion. The NAIC SERFF team, including Renee Brownfield and Alex Rogers, would reach out to Clausen to try to get the filing labels added for hospital indemnity contracts that week. Rogers noted that for this change to be cost-effective, SERFF would need to be widely adopted and have high utilization.

The second suggestion was to add several sub-TOIs for limited long-term care coverage. These included LTC07G and LTC07I for limited long-term care services such as nursing home care, assisted living care, home health care, and adult day care, all providing reimbursement for periods of less than one year. Additional sub-TOIs included

LTC02G.005 and LTC02I.005 for home health care policies, LTC03G.005 and LTC03I.005 for long-term care policies, LTC04G.005 and LTC04I.005 for nursing home policies, LTC05G.005 and LTC05I.005 for nursing home and home health care policies, LTC05.1G.005 and LTC05.1I.005 for assisted living care policies, and LTC05.2G.005 and LTC05.2I.005 for adult day care policies, all providing reimbursement for periods of less than one year. Clausen and Bartuska highlighted the challenges faced by their states with limited long-term care product categorization. Utah was the only state using LTC06, and Clausen noted difficulties in pulling up the number of filings, possibly due to the H13s. North Dakota also had a less than 12-month LTC policy and used H13 for the short-term care piece due to the low number of filings. Motter emphasized the importance of uniformity and asked Clausen to revisit the issue with the Working Group.

The third suggestion was to add TOIs and sub-TOIs for behavioral health, specifically H27G and H27I, with potential sub-TOIs for various group sizes. The rationale was to add a new TOI instead of using existing Affordable Care Act (ACA)-eligible TOI codes. The Working Group considered where such submissions were currently filed, whether existing TOIs could serve the same purpose with a description update, the number of states that would use the new TOIs, and the fact that some states denied standalone behavioral health policies, preferring them as part of broader health benefits. The outcome was a lack of interest in pursuing additions by other states, as standalone behavioral health products were rarely submitted and often not permitted.

The fourth suggestion was to add a TOI for network adequacy, possibly NA02. This new TOI would be used for network adequacy form filings, including attestations, network access plans, and enrollment documents. The Working Group considered where such submissions were currently filed, whether a filing type for network adequacy could serve the purpose, the number of states that would use the new TOI, and the variation in network adequacy filings by state. Rogers planned to contact Colorado regarding the network adequacy forms to see if adding a filing type might assist them. The outcome was a lack of interest in the addition by other states, with most not receiving this type of filing submission.

The fifth suggestion was to add a TOI for occupational accident (Occ/Acc) coverage to differentiate it from other filings. The Working Group considered where such submissions were currently filed, whether submission requirements would differ from existing ones, and whether a filing label or description could serve the purpose. The outcome was a lack of interest in the addition by other states, with such filings currently received under H03. The requesting state was advised to consider using a filing label or description.

The sixth suggestion was to add sub-TOIs for HOrg 04 Group Health-Single Service Dental to differentiate by group size, possibly large group and small group. The rationale was to allow differentiation for reporting purposes. The Working Group considered whether submission requirements would differ for small and large dental, whether a filing label or description could serve the purpose, and whether the expansion should include H10G Group Dental. The outcome was a lack of interest in pursuing additions by other states and in group size differentiation. The requesting state was advised to consider using a filing label or description.

The seventh suggestion was to revise the description and/or add sub-TOIs for HOrg 04 and H10 to acknowledge ACA stand-alone dental plans that provide coverage beyond the pediatric age. The rationale was that current descriptions and sub-TOIs did not contemplate these plans. The Working Group considered where such submissions were currently filed, whether the description should be amended or additional sub-TOIs added, whether submission requirements would differ, and whether a filing label or description could serve the purpose. The outcome was that Utah had insurers using H10G.000 or H10I.000 when the product offering also provided coverage beyond the pediatric age, while Washington instructed insurers to use H10.G001 or H10.I001 in such situations. The Working Group discussed potential PCM TOI description revisions and sought feedback from all members before making changes.

3. Heard a Report on the SERFF Modernization Project and SERFF Product Steering Committee

Lauren Bandle (NAIC) said the SERFF modernization project was an overall success. However, she said there are still a few users who are unable to access the platform due to various issues, but they are being addressed as a top priority. Brandle said development teams refine issues and measure user satisfaction for early adopter feedback. She said 10 early adopters participated in a recent workshop to discuss intake and review processes. Bandle said the workshop included presentations on reporting capabilities and a hands-on artificial intelligence (AI) lab.

4. Discussed Other Matters

The discussion of the suggested changes received on the PCM caused a time constraint on the meeting, so the update on the Interstate Insurance Product Regulation Commission (Compact) was postponed until the Working Group's next meeting.

Motter said a survey will be sent to Working Group members and interested regulators to gather feedback on current internal reporting requirements and future needs related to SERFF data and filing-related data.

Having no further business, the Speed to Market (D) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/D CMTE/2025 Summer/S2M WG/June 24 2025

Draft: 8/20/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
August 7, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Aug. 7, 2025. The following Working Group members participated: Josh Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Rachael Lozano (FL); Chris Heisler (IL); Raymond A. Guzman (MD); Danielle Torres (MI); Jo A. LeDuc (MO); Robert McCullough (NE); Guy Self (OH); Karen Veronikis (PA); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Shelley Wiseman (UT); and Melissa Gerachis (VA).

1. Adopted its July 10 Minutes

The Working Group met July 10 and took the following action: 1) adopted its May 22 and May 1 minutes; 2) adopted a travel Market Conduct Annual Statement (MCAS) proposal received from the travel subject matter expert (SME) group; 3) discussed how to care for discretionary groups on other health MCAS; 4) discussed submitting a proposal form to address clarification of blanket policies reporting on the other health MCAS; 5) discussed the adjusted valuation calculation proposed by Rhode Island; 6) discussed the next line of business to review and the formation of an SME group; and 7) discussed other matters.

Wiseman made a motion, seconded by LeDuc, to adopt its July 10 minutes (Attachment Two-A). The motion passed unanimously.

2. Discussed How to Care for Discretionary Groups on the Other Health MCAS

Guillory referenced Attachment 2, which outlines current definitions for "report by residency," "other health," and "associations/trust." He noted that while exclusions for some definitions have been adopted, none currently exist for discretionary groups. He recapped SME concerns that discretionary group definitions vary by state, creating reporting inconsistencies. The following options were discussed: 1) make no changes and allow companies to continue current reporting practices; 2) add a separate column/bucket for discretionary group data (proposed by Mary Kay Rodriguez [WI]); 3) add an exclusion with examples of discretionary groups (proposed by the SME group); and 4) add an exclusion noting that definitions are determined by the reporting jurisdiction (proposed by Missouri).

No motion was made regarding discretionary group reporting. The topic was removed from the agenda, with the assumption that there is no interest in pursuing changes at this time.

3. Adopted the Proposal Form to Address Clarification of Blanket Policy Reporting on the Other Health MCAS

Guillory introduced the proposal forms submitted by Guzman regarding clarification of blanket policy reporting on the other health MCAS. The proposal would amend the definition of "other health" to specify that blanket policies for short-term events are excluded. No comments were raised after review and an opportunity for questions or discussion from Working Group members, state regulators, and interested parties. A motion was requested to adopt the proposal.

Guzman made a motion, seconded by Veronikis, to adopt the proposal. The motion passed unanimously.

4. Discussed the Handling of Expatriate Policies in the Health MCAS

Guillory introduced the discussion on expatriate policies in the health MCAS, a topic Mary Lou Moran (MA) raised at the Working Group's July 10 meeting. As Moran was not present, Guillory provided background, noting the lack of clear guidance on how states are handling expatriate policies.

LeDuc raised general questions regarding expatriate coverage, noting her understanding that it is intended for U.S. citizens living abroad. She questioned whether coverage would apply to U.S. services, the volume of such policies (e.g., limited versus large-scale), and how companies allocate premiums to state pages. Specifically, she asked how residency is determined for expatriates living overseas.

Guillory agreed with LeDuc's understanding of expatriate policies as U.S.-based policies covering U.S. citizens overseas. He noted that in Louisiana, volume appears to be very low or non-existent, with no complaints or company inquiries identified, though reporting gaps cannot be ruled out. He invited industry representatives and other regulators to provide input on expatriate policy volume and handling.

Guillory noted the continued uncertainty regarding expatriate policies and recommended keeping the item on the agenda for one more meeting. He said he would conduct further research and suggested reaching out to NAIC staff for additional information. It is anticipated that Moran will join the next meeting to provide input. The Working Group will then determine whether clarification is needed or if the issue should be dropped. No further comments were raised.

5. Discussed the Formation of an SME Group to Begin Work on the LTC MCAS

Guillory introduced the formation of an SME group to review the long-term care (LTC) MCAS reporting blank and data column definitions, which was in line with the Working Group's charge to review data elements in effect for more than three years. At this time, no volunteers from state regulators or industry have come forward. Guillory reminded participants that best practices call for at least five jurisdictions to participate. Without sufficient volunteers, the full Working Group will conduct the review during regular calls. Members were encouraged to contact Hal Marsh (NAIC) to volunteer.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 7/22/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
July 10, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 10, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Rachael Lozano (FL); Tia Taylor (GA); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Jeff Hayden (MI); Jo A. LeDuc (MO); Jonathan Wycoff (NV); Guy Self (OH); Karen Veronikis (PA); Rachel Moore (SC); Rhonda Bowling-Black (TN); Tracy Klausmeier (UT); Melissa Gerachis (VA); Mary Kay Rodriguez (WI); and Letha Tate (WV).

1. Adopted its May 22 and May 1 Minutes

The Working Group met May 22 and took the following action: 1) adopted the Market Conduct Annual Statement (MCAS) other health blank and data call definitions proposal; 2) adopted changes to the homeowners MCAS reporting; 3) considered adoption of the MCAS lender-placed insurance (LPI) proposal related to renewed coverage; 4) discussed the removal of the MCAS complaints data element for collecting the number of complaints received directly from a department of insurance; 5) motioned to update the definition of "partial payment"; 6) received an update and a proposal from the MCAS travel subject matter expert (SME) group; and 7) discussed and decided to address remaining minor concerns about LPI reporting issues and potential guidance updates in the next reporting cycle.

The Working Group also met May 1 and took the following action: 1) considered adoption of the MCAS other health blank and data call definitions proposal; 2) adopted the MCAS private passenger auto (PPA) blank and data call definitions proposal; 3) considered adoption of the MCAS LPI proposal; and 4) discussed the consistency of the MCAS' complaints data element wording.

Wycoff made a motion, seconded by Veronikis, to adopt its May 22 minutes (Attachment Two-A1). The motion passed unanimously.

Guzman made a motion, seconded by Gerachis, to adopt its May 1 minutes (Attachment Two-A2). The motion passed unanimously.

2. Adopted a Travel MCAS Proposal Received from the Travel SME Group

Guillory said the draft proposal was initially presented to the Working Group on May 22, and a comment period was opened. No comments have been received to date. The only recommended changes from the SME group were to merge interrogatory data elements 7, 9, and 11 into a single element and merge the corresponding follow-up questions 8, 10, and 12 into a single element. These questions address the involvement of third-party administrators (TPAs), managing general agents (MGAs), and travel administrators. He invited comments from Working Group members or other regulators on the proposed changes. No comments or questions arose.

Coker made a motion, seconded by Guzman, to adopt the proposed changes to the travel MCAS reporting. The motion passed unanimously.

3. Discussed How to Care for Discretionary Groups on Other Health MCAS

Guillory said that discretionary groups are not typically eligible to form for insurance but are allowed at a commissioner's discretion.

LeDuc expressed concern about excluding discretionary groups, as groups like labor unions and financial institutions are not considered discretionary in Missouri. She stated Missouri could go either way, but it opposes excluding groups based on a national definition. Missouri supports letting each state define discretionary groups and include them accordingly. LeDuc compared the inconsistency to similar issues in other MCAS lines and supports moving forward despite non-uniformity.

Rodriguez could not find a legal definition of discretionary groups in Wisconsin law. She suggested that discretionary groups could include unions and financial groups, but this was primarily industry input. Rodriguez proposed creating a separate reporting bucket or tab for discretionary groups to prevent data from being muddled. She supported defining discretionary groups as entities approved by a commissioner despite not meeting standard group criteria.

Guzman supported LeDuc's points and acknowledged the national analysis may be affected but said state-level trend analysis would remain viable. He leaned toward including discretionary groups based on how individual states define them. He suggested taking the issue back for further internal review before the next meeting.

Kirsten Wolfford (American Council of Life Insurers—ACLI) stated that the ACLI does not have a strong position on discretionary groups. She noted the ACLI's original concern was related to employer group data, not discretionary groups specifically. She acknowledged the variation in state treatment of discretionary groups.

Coker sought clarification on how to frame Arizona's comments. She confirmed understanding that Missouri's proposal to remove the discretionary group bullet was still under consideration. She asked about which edits (blue versus purple text) would be included with that proposal.

Guillory encouraged regulators to discuss the matter internally and submit comments to Hal Marsh (NAIC) by July 24. The group aims to reach a final decision at the next meeting, with the goal of avoiding another year of unclear guidance.

4. Discussed Submitting a Proposal Form to Address Clarification on Blanket Policies Reporting on Other Health MCAS

Guillory introduced the agenda item on whether blanket policies for short-term events should be reported in the MCAS other health blank. He noted that Guzman submitted a change proposal form (Attachment 6) to address this issue.

Guzman explained that while reviewing a waiver request, a company cited prior informal guidance that suggested blanket policies were excluded from MCAS other health reporting. After confirming this understanding with NAIC staff, he submitted a formal proposal to add language to the data call definitions explicitly excluding blanket policies. He noted that the goal is to clarify in writing what was already an established understanding so that companies and regulators have clear direction. Rodriguez supported the proposal, saying it is a good clarification to improve understanding of the data call.

The proposal was exposed for a 14-day public comment period ending July 24.

Guillory said the proposal could be considered for adoption at the Working Group meeting in August. He clarified that if adopted, the change could be implemented immediately, as it is a clarification rather than a policy shift.

5. Discussed the Adjusted Valuation Calculation Proposed by Rhode Island

Guillory stated that the purpose of this agenda item was to review necessary changes to the validation calculation logic for the MCAS LPI blank to prevent incorrect error code generation. He explained that at the Working Group's May 22 meeting, a vote was passed to add two new data elements to the MCAS LPI blank. These new elements affect the logic used to generate error/warning codes and must be included in validations that compare policies/certificates in force at the beginning and end of the reporting period. No vote was required for this item. The goal is to ensure consensus and understanding among all stakeholders.

Guillory had asked for comments or questions from Working Group members, state regulators, and interested parties, and none were received. The NAIC will implement these validation logic updates once the MCAS LPI blank and the data call definitions are formally adopted by the Market Regulation and Consumer Affairs (D) Committee and NAIC Plenary.

6. Discussed the Next Line of Business to Review and the Formation of an SME Group

Guillory introduced the discussion to identify the next MCAS line of business for review, as outlined in the Working Group's charges. Per those charges, lines of business in effect for over three years should be reviewed and updated as necessary. Guillory suggested long-term care (LTC) as a strong candidate for the next review. As done previously, he recommended forming an SME group to assess the MCAS blank and data call definitions for LTC and return with recommendations. No specific preferences were expressed by Working Group members, regulators, or interested parties. Guillory requested that regulators from participating jurisdictions interested in leading or joining the LTC SME group contact Marsh or Teresa Cooper (NAIC) within the next month.

7. Discussed Other Matters

Moran raised concern regarding a health insurer under examination that only writes expatriate policies and has not been filing an MCAS. The insurer is cooperative and above the $50,000 filing threshold, but there is confusion about whether expat-only writers are required to file. NAIC staff have had limited contact on the matter. Massachusetts is currently taking a neutral stance to avoid delaying the exam.

Rodriguez asked for feedback or clarification from other states and the NAIC on whether these companies should file an MCAS. Guillory acknowledged that this is a unique situation, and suggested members review statutes and MCAS definitions and revisit the issue in a future meeting. Coker asked if the plans were considered group health under the Affordable Care Act (ACA), and Rodriguez confirmed they were.

Randy Helder (NAIC) noted that reporting on the other health MCAS blank is typically based on residency, and expatriate policies may fall outside of that scope if policyholders reside abroad. The Working Group decided to further consider the issue and revisit it at a future meeting. Rodriguez said she appreciated the input and agreed that a delayed decision is appropriate to avoid holding up the exam

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 5/28/2025

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 22, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 22, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Rachael Lozano (FL); Chris Heisler (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Jo A. LeDuc, Julie Heser, and Teresa Kroll (MO); Robert McCullough (NE); Jonathan Wycoff (NV); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Laura Klanian and Melissa Gerachis (VA); Mary Kay Rodriguez (WI); and Letha Tate (WV). Also participating were: Zack Palank (OK); and Brian Werbeloff (RI).

1. Adopted the MCAS Other Health Blank and Data Call and Definitions Proposal

Guillory stated that during the Working Group's May 1 meeting, a motion was made to adopt the proposed revisions to the other health Market Conduct Annual Statement (MCAS). However, the motion did not receive a second and, therefore, did not move forward. The main area of concern appeared to be the reporting of discretionary groups. For the current meeting, the plan is to first consider all edits proposed by the health subject matter expert (SME) group and Missouri, excluding discretionary group reporting. The Working Group will then discuss and consider discretionary group reporting separately. Guillory opened the floor for questions, comments, or discussions from Working Group members, other state regulators, and interested parties regarding the proposed edits, excluding those related to discretionary groups. No comments were noted at that time.

Guillory asked for a motion to adopt all edits proposed by the other health SME group and Missouri, excluding those regarding discretionary group reporting.

Guzman made a motion, seconded by Gerachis, to adopt the proposed edits, excluding those regarding discretionary group reporting. The motion passed unanimously.

Guillory moved on to discuss the reporting of discretionary group data in the other health MCAS. He stated that the health SME group proposed adding an exclusion to eliminate the reporting of discretionary group data. Missouri did not oppose the exclusion but pointed out that discretionary groups are defined differently by each state. Guillory stated that Missouri recommended excluding groups as defined by the reporting jurisdiction, rather than using a fixed list of example groups.

Rodriguez confirmed that she had submitted comments regarding the discretionary group reporting issue. She expressed concern that allowing companies to report discretionary groups based on each state's definition would render national comparisons meaningless. She supported other recommendations that companies should not report discretionary groups as defined by each state. Rodriguez proposed two alternative approaches: 1) excluding all health insurance policies/certificates not considered association, trust, individual, or employer groups—limiting reporting to just those categories; or 2) creating an "Other" category to capture any groups outside of association, trust, individual, and employer group definitions if regulators still want some discretionary group information.

Guillory asked for a motion for the handling of discretionary group reporting in the other health MCAS.

Guillory noted that since no motion was made, the topic of discretionary group reporting will not be advanced to the larger committee or plenaries for the 2026/2027 reporting year. The Working Group will consider whether to

keep the item on the agenda for future discussion or take further action at a later date. The issue will be clarified and addressed later.

2. Adopted Changes to the Homeowners MCAS Reporting

Guillory stated that during its May 1 meeting, the Working Group approved rewording the non-standard interrogatory in the private passenger auto (PPA) MCAS question no. 8, "If Yes, what percentage of your business is non-standard?" to ask for the number of non-standard policies in force during the period rather than the percentage. The Working Group also moved question no. 8 to the underwriting section. For consistency, it was proposed that the same edits be applied to the homeowners MCAS.

Guzman expressed support for the proposed change to the homeowners MCAS for the sake of consistency. He noted that reporting an actual number rather than a percentage would provide additional value to regulators, particularly in prioritizing companies. He agreed that it would make sense to apply the same edit to the homeowners MCAS as was approved for the PPA MCAS.

Kroll shared that, based on a review of state records, only seven companies have reported non-standard homeowners business in Missouri over the past several years. She noted this indicates the non-standard homeowners market is much smaller than the PPA market. Kroll suggested that this difference may affect the value or relevance of making the same change for the homeowners MCAS and encouraged the Working Group to consider whether the update is truly beneficial.

Guillory asked for a motion to adopt the proposed changes to homeowners MCAS reporting.

Guzman made a motion, seconded by Moore, to adopt the proposed changes to homeowners MCAS reporting. The motion passed, with Missouri opposing.

3. Considered Adoption of the MCAS LPI Proposal Related to Coverage Renewed

Guillory noted that comments were received regarding the proposal form posted on the Working Group's web page. He reviewed items that were approved during the Working Group's May 1 meeting to address a validation issue and help insurers correctly identify policies and certificates where the term of coverage was completed during the period. Approved changes included: 1) a revised definition for "cancellations;" 2) a new definition for "term of coverage completed;" and 3) two new data elements: a) number of certificates for which coverage was completed during the period; and b) number of individual policies for which coverage was completed during the period. He stated that the three remaining items from the proposal are now under consideration: 1) new definitions for "coverage renewed," "individual policies written during the period," and "certificates written during the period;" 2) a new data element for the number of certificates issued for coverage renewed during the period; and 3) a new data element for the number of individual policies issued for coverage renewed during the period. He referenced the meeting materials, where approved and proposed items are clearly identified.

Birny Birnbaum (Center for Economic Justice—CEJ) offered a recap of the data edit issue raised by insurers. He said some insurers were unsure how to classify policies that reached the end of their term, leading to inconsistencies. He said some insurers treat them as cancellations, while others do not. The lack of appropriate data elements created challenges in completing the data validation edit. During its most recent meeting, the Working Group adopted several data elements to address this issue. Birnbaum reviewed the remaining items under consideration, which focused on identifying whether coverage under group policies or individual lender-placed insurance (LPI) policies was renewed. These additions would make the data edits more accurate and reliable. They would also help regulators better understand market trends, such as increases in LPI renewals,

which could signal inadequate consumer notification by insurers or market access problems for consumers seeking voluntary coverage.

Birnbaum cited the Wells Fargo/National General LPI case as an example where better data could have enabled insurance regulators to catch issues earlier than federal financial regulators. He emphasized that the proposed data elements would be extremely helpful to regulators and strongly encouraged their adoption. He also clarified that the proposed items labeled “individual policies written during the period” and “certificates written during the period” are not entirely new elements but enhanced definitions of existing elements already included in the MCAS.

Werbeloff acknowledged the usefulness of Birnbaum’s proposal, which was discussed at the prior meeting, but also noted industry concerns about adding new data elements. He presented an alternative approach aimed at addressing those concerns. Rather than adding new data elements, the Working Group could provide clarifying guidance regarding how to treat renewals/reissues with no gap in coverage. Specifically, guidance is needed on whether these should be counted as new policies or certificates issued. He explained that without this clarification, there's ambiguity in how insurers should interpret and report these transactions. He emphasized the need for clear instructions to ensure consistency in data reporting and error resolution, especially in the context of existing formulas (e.g., beginning number of certificates plus newly issued certificates minus cancellations equals ending number of certificates). He proposed the following one-line addition for clarity: "Note: Following the term of coverage completed, a reissue/renewal should be reported as a new policy or certificate issued.” Werbeloff said that while he was still supportive of Birnbaum’s proposal, this alternative minor clarification could help fix the data issue if the committee opts not to adopt the full set of proposed data elements.

Hesser stated that Missouri is not opposed to the proposed new data fields, but she expressed concern over the terminology used, specifically the use of the term "renewed." She noted that coverages are often described as expiring rather than renewing, which makes the term "renewed" potentially misleading. Missouri suggested using alternative terminology, such as "continued" or something else that would be more accurate.

Birnbaum responded by suggesting the term "coverage reissued" as a possible alternative. Hesser agreed that “reissued” would be preferable to "renewed" and would address Missouri's concern.

Birnbaum expressed appreciation for Werbeloff’s efforts and acknowledged his role in initiating the discussion. Birnbaum stated, however, that adding a single sentence of guidance under "term of coverage completed" would not sufficiently address the issue. Doing so places guidance in the wrong context, leading to potential confusion. He emphasized that the proposed data elements already include the precise, detailed guidance that the industry has requested. For example, the definition includes all individual policies issued, including those issued in error or reissued, before any cancellations. Birnbaum argued that including this guidance as a separate data element is critical to ensure clarity and consistent interpretation. Without a separate element, confusion may persist from having to embed the information in unrelated data fields. He concluded by urging regulators to adopt the full proposal, with the terminology changed from "coverage renewed" to "coverage reissued" in response to earlier feedback.

Guillory invited a motion regarding the proposed changes, reminding participants to clarify whether the motion included Werbeloff's suggested language and whether it used "reissued" instead of "renewed," as suggested by Hesser and Birnbaum.

No motion was made. Guillory indicated that the Working Group may try to hold one more meeting before the June 2 deadline to finalize a decision on the remaining items. He emphasized the need for a firm decision to avoid inconsistent or piecemeal implementation.

Werbeloff added a follow-up comment, noting that if no additional changes are finalized before the deadline, the Working Group should plan to discuss guidance for the NAIC in a future meeting. Specifically, the guidance would address error code handling related to whether certificates with completed coverage terms should be subtracted in the end-of-period calculation. This decision would influence whether reissued certificates are counted as newly issued. He stressed the importance of providing this clarity, either via guidance or system error logic.

4. Discussed the Removal of the MCAS Complaints Data Element for Collecting the Number of Complaints Received Directly from the DOI

Teresa Cooper (NAIC) confirmed that complaint data is available in Snowflake and will be accessible in ThoughtSpot soon. She stated that pulling accurate data depends on correctly using complaint coding structures.

Palank expressed concerns about other health coverage codes being incomplete (e.g., having no specific codes for specified disease, indemnity, or hospital surgical expenses). He said that there were discrepancies in complaint counts between the Complaints Database System (CDS) and MCAS for short-term, limited-duration (STLD) in 2023, as 61 companies reported STLD complaints through CDS but only 16 reported STLD complaints through the MCAS. Despite more companies reporting through the CDS, it had 14% fewer total complaints than the MCAS. Among those that did report in the MCAS, CDS reflected 38% fewer complaints. These differences raised concerns about data accuracy and consistency, reinforcing the need to continue collecting complaint data for LPI, STLD, and other health via the MCAS.

Guillory asked if there were any motions to: 1) remove the data element from all lines of business; 2) remove it from specific lines only; or 3) retain it but standardize the wording.

No motion was made, so the data elements will remain unchanged for now. Members were encouraged to send further comments to Hal Marsh (NAIC) for future discussion or updates.

5. Adopted a Motion to Update the Definition of “Partial Payment”

Guillory introduced an inconsistency in the pet MCAS reporting, specifically with question no. 109, which asks for the number of claims closed with partial payment due to maximum benefit limits. However, the current definition of "partial payment" excludes claims reduced for this reason, creating a contradiction. Regulators had originally added this data element to capture claims detail after pet insurers indicated they could not provide breakdowns by coverage type. The intent was to differentiate less concerning denial reasons (e.g., maximum benefit limits) from other claims-handling issues. Guillory proposed resolving the contradiction by striking the exclusion in the definition and aligning it with the data element language.

Cooper agreed that clarification was needed due to the conflicting language.

Lozano made a motion, seconded by Dorschner, to update the definition of “partial payment” by removing the exclusion for maximum benefit limit reductions, noting it could be revisited next year as this is a new data element. The motion passed. Missouri abstained, citing a lack of awareness that a vote would be taken.

6. Received an Update and Proposal from the MCAS Travel SME Group

Guzman provided an update on the travel MCAS SME group. The group met once in an open discussion format involving both regulators and industry representatives to address concerns raised, particularly by Caren Alvarado (Crum & Forster). The only recommended change from the SME group was to merge three interrogatory questions

related to entity types used in travel insurance (i.e., third-party administrators [TPAs], managing general agents [MGAs], and travel administrators), consolidating them into a single question. Guillory clarified that these proposed edits will be exposed at a later date and are not being considered for the 2026 data year.

No additional comments or questions were raised from Working Group members, other regulators, or interested parties. Stakeholders were encouraged to submit feedback during the future exposure period.

7. Discussed Other Matters

Cooper raised the final outstanding item of whether to schedule another call to address additional LPI items or defer the discussion to the next data year.

Guillory noted there is still confusion among Working Group members and that a meeting in the immediate future likely would not resolve the remaining issues. He opened the floor for feedback on scheduling.

Coker asked if the recently adopted changes addressed the original concern.

Guillory deferred to Birnbaum, who said the changes were partially helpful, but additional guidance is still needed.

Werbeloff, who raised the initial concern, clarified that the primary issue was mathematical, specifically related to inflated cancellation ratios, and has now been addressed. There is a secondary concern for potential inflation of policies issued, which he agreed could be addressed through future guidance and error code adjustments, possibly in the next data year cycle. He suggested refining the error code logic and offered to send a recommendation to Marsh.

Guillory and Werbeloff agreed that even if language changes do not happen before the June deadline, refining the error code logic will serve as a useful backup. Werbeloff said he would send proposed error code updates for consideration.

Birnbaum asked whether the newly approved data elements will ensure the edit check functions correctly. Cooper confirmed that the updated validations will include subtraction of the new data element and should resolve the error issue. She welcomed further guidance from Werbeloff.

The Working Group acknowledged significant progress in resolving LPI reporting issues and agreed to address remaining minor concerns and potential guidance updates in the next reporting cycle.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 5/16/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
May 1, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 1, 2025. The following Working Group members participated: Joshua Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Rachael Lozano (FL); Chris Heisler (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Raymond A. Guzman (MD); Jo A. LeDuc, Julie Hesser, and Teresa Kroll (MO); Robert McCullough (NE); Jon Wycoff (NV); Karen Veronikis (PA); Tony Dorschner (SD); Laura Klanian (VA); Mary Kay Rodriguez (WI); and Letha Tate (WV). Also participating was: Brian Werbeloff (RI).

1. Adopted its April 3 Minutes

The Working Group met April 3 and took the following action: 1) adopted its March 6 minutes; 2) reviewed the subject matter expert (SME) group's proposed draft other health MCAS revisions; 3) considered adoption of changes to the private passenger auto (PPA) Market Conduct Annual Statement (MCAS) blank; 4) discussed comments received regarding the travel MCAS Blank; 5) discussed the Center for Economic Justice (CEJ) proposal form on the lender-placed insurance (LPI) MCAS and the reporting of a subsequent individual policy or certificate following the expiration of the term of the previous individual policy or certificate; and 6) discussed other matters, including inconsistencies in the MCAS data elements.

Dorschner made a motion, seconded by Klanian, to adopt the Working Group's April 3 minutes (Attachment Two-A2a). The motion passed unanimously.

2. Considered Adoption of the MCAS Other Health Blank and Data Call and Definitions Proposal

Kirsten Wolfford (American Council of Life Insurers—ACLI) highlighted two main concerns with the latest edits to the MCAS other health blank and data call and definitions proposal: 1) collecting data on closed blocks of business may not significantly aid regulators and could impact overall data quality, given its limited relevance to current market activity; and 2) data related to employer groups may be less useful compared to data from individual and association markets, where stronger data quality is observed. Both comments aim to streamline data collection and improve MCAS data quality. Wolfford offered to answer any questions.

Amy Killelea (Individual Consumer Advocate) spoke on behalf of several health-focused consumer representatives and summarized their collective comments. Killelea said that she and Lucy Culp (The Leukemia & Lymphoma Society—LLA) participated in the SME group and supported the edits presented, particularly those proposed by Missouri. The consumer representatives believe the draft strikes an appropriate balance in handling the complex and new data requests and emphasize that collecting this data is important from a consumer perspective. Killelea reiterated her support for including the employer market in MCAS reporting, aligning with earlier comments. Killelea said the consumer representatives believe that the compromises in the draft adequately address concerns about data collection feasibility and strongly recommend keeping the employer market inclusion.

LeDuc noted that the SME group's submitted comments were detailed and largely self-explanatory. They highlighted suggestions for additional consistency edits, particularly to add "during the period" language after several data elements to maintain uniformity throughout the blank, in line with earlier SME recommendations. They also suggested improving the description of discretionary groups by deferring to the legal definition rather

than attempting to redefine it in the blank. This approach would provide clarity and meet states' needs without causing confusion.

Kroll addressed proposed changes to Schedule 3, supporting the removal of the "non-claim claim" terminology and rephrasing it to "total number of all claims received during the period." Kroll said Missouri believes this revision would clarify reporting for both the states and industry. She explained that the clean claim definition was more industry-driven and not reflective of actual market activity. Since clean claims can be delayed by industry practices, it was previously decided to remove the clean claim definition. The proposed language change would further clarify the data collection process and better align with earlier discussions.

Rodriguez, who led the SME group, raised a question regarding the treatment of discretionary groups. She noted that the industry had difficulty identifying these groups. She suggested clarifying the instructions by specifying associations, trusts, individual, and employer groups, and designating all others as discretionary groups, while also stating that data on discretionary groups would not be collected. This approach would help simplify and clarify reporting requirements.

LeDuc responded to Rodriguez, explaining that the original intent was to define discretionary groups based on the reporting jurisdiction's existing definitions. She emphasized that companies should be able to determine discretionary group status per state requirements, as some states require approval of such groups. Relying on state-specific definitions would provide clearer guidance and proper reporting, rather than attempting to create a new, uniform definition.

Guzman asked for clarification regarding the proposed edits from Missouri, specifically regarding what changes would be made to the definition sheet concerning discretionary groups under their proposed edits.

Hal Marsh (NAIC) noted that another option would be to remove the discretionary policy bullet point entirely and asked whether the Working Group intended to keep or remove it.

Guzman confirmed this was the source of his confusion.

LeDuc stated Missouri could accept either approach but noted that some items originally listed as discretionary policies were not considered discretionary in Missouri.

Rodriguez agreed, adding that excluding those items and defining discretionary groups according to each reporting jurisdiction would provide greater clarity.

Guzman proposed adopting the edits, including Missouri's changes, with the understanding that discretionary policies would still be excluded and that the definition would be based on the reporting jurisdiction. He indicated he had already discussed this with Commissioner Marie Grant (MD) and was prepared to make a motion to adopt.

Guillory asked for a second to the motion.

Since no second was received, the motion was tabled. Guillory asked all members to review the proposed changes and options before the next meeting, noting that a decision would need to be made at that time.

3. Adopted the MCAS PPA Blank and Data Call and Definitions Proposal

LeDuc explained that a clarification was proposed to align the new data element referring to enrollment in telematics products with the deck definition, as no standalone definition for telematics existed.

Guillory asked for comments and mentioned that an additional item to consider is whether the homeowners MCAS non-standard question should also be moved to the underwriting section for consistency, as it would allow for numerical percentage reporting.

LeDuc requested to table the homeowners issue until the Working Group's next meeting to review Missouri's homeowner data first. No objections were raised.

Guzman said he supported Missouri's edits, including the addition of "usage-based" alongside "telematics." He also pointed out a possible discrepancy regarding whether non-standard policies should be counted as issued or in force at the end of the period. Guillory and others discussed and agreed that counting the policies as "in force at the end of the period" was more consistent.

Guzman made a motion, seconded by Hesser, to adopt the private passenger auto (PPA) MCAS edits with Missouri's changes and to revise the language to reflect "policies in force at the end of the period" instead of "issued during the period." The motion passed unanimously, and the Working Group agreed to forward the edits with Guzman's amendment.

4. Considered the Adoption of the MCAS LPI Proposal

Guillory introduced Amendment Six of the MCAS LPI proposal, which addresses an issue where companies were incorrectly reporting policies expiring at the end of their term as cancellations to make data reconcile. The proposal includes: 1) clarifications to the definition of cancellations (e.g., coverage ending at term completion is not a cancellation); 2) new definitions for coverage renewed, term of coverage completed, individual policies written, and certificates written during the period; and 3) the addition of new data elements related to certificates and policies whose coverage terms were completed or renewed during the period. Guillory noted that comments on the proposal were posted on the Working Group's web page, with feedback received from Birny Birnbaum (Center for Economic Justice—CEJ) and LeDuc. Guillory said that since Birnbaum was not present on the call, only written comments would be considered. He invited LeDuc to discuss her feedback.

LeDuc summarized that Missouri had submitted detailed comments indicating both support and questions regarding the amendment. She noted that Birnbaum had provided additional information related to their remaining concerns about the benefits of tracking the number of certificates or policies renewed. However, Missouri had not yet had time to fully review this information. She suggested it might be helpful for Birnbaum to explain the benefits directly at a future meeting and welcomed input from other states or interested parties on the issue.

Werbeloff explained that the issue originated from a company's reporting practice in Rhode Island and acknowledged there may be inconsistencies across companies in how expirations and renewals are reported. He outlined Birnbaum's reasoning for tracking policies and certificates renewed to help regulators determine whether short-term products are being used as long-term coverage. Werbeloff said he supported Birnbaum's overall proposal but emphasized that the key priorities are clarifying the definition of cancellations to exclude expirations and adding elements to separately capture term completions.

Werbeloff suggested a compromise, including: 1) adopting clarifications on cancellations; 2) defining "term of coverage completed;" 3) adding a note to clarify that renewals should be reported as new policies/certificates; and 4) adding two new data points (for term completions). Werbeloff noted that while Birnbaum's full proposal is reasonable and useful, the renewal tracking component is nice to have but not essential for correcting current data inconsistencies.

Guillory proposed splitting the amendment into two parts for separate consideration. The first part to consider is adoption of the revised definition of cancellations, the new definition for "term of coverage completed," and the addition of two data elements to report the number of certificates and individual policies for which coverage is completed during the period. Guillory noted that these changes would resolve the validation issues and allow for correct reporting. The second part to consider is the addition of definitions for coverage renewed, individual policies written during the period, certificates written during the period, and related new data elements for reporting renewed coverage. Guillory asked if there were any concerns with this two-part approach.

Werbeloff agreed with Guillory's proposal to divide the amendment into two parts. He recommended that if the Working Group moves forward with only the smaller portion, then updating the definition of cancellations, defining "term of coverage completed," and adding two related data points, an additional clarification should be included. Specifically, he proposed adding a note under the term of coverage completed definition stating that a reissue or renewal should be reported as a new policy or certificate issued. Werbeloff explained that this clarification would help ensure consistent reporting if the broader set of changes related to coverage renewed is not adopted.

Guillory confirmed that it would be helpful to include the clarification suggested by Werbeloff and noted that any motion to adopt could include that edit. Guillory restated that the first group for consideration includes: 1) a revised definition of cancellations; 2) a new definition for "term of coverage completed;" 3) data elements for the number of certificates with term of coverage completed; and 4) data elements for the number of individual policies with term of coverage completed. Guillory asked if there were any additional comments or questions about these four items and then called for a motion to adopt them, either as originally written or with Werbeloff's proposed clarification.

Moran made a motion, seconded by LeDuc, to accept the four changes to the proposal. The motion passed unanimously.

Teresa Cooper (NAIC) clarified that the motion did not include Werbeloff's suggested additional clarification.

Guillory opened a discussion on the second set of proposed changes regarding definitions and data elements for coverage renewed. No motion was made.

Lisa Brown (American Property Casualty Insurance Association—APCIA) commented that defining renewals as new coverage could cause confusion. She said she preferred Werbeloff's earlier suggested clarification instead. LeDuc expressed concerns that the "renewed" coverage data would not add regulatory value given state-specific authority limitations. Guzman suggested forming an SME group to further discuss the second set of changes due to their complexity.

Werbeloff agreed to table the broader proposal and suggested that further discussions focus on additional clarifying language to avoid inconsistencies in reporting.

Cooper asked Werbeloff to send his suggested wording so it could be posted for review before the next meeting.

Guillory confirmed there were no objections to tabling the second set of changes for further consideration at the next meeting.

5. Discussed the Consistency of the MCAS Complaints Data Element Wording

Guillory stated that the Working Group discussed inconsistencies in the wording of the data element that asks for complaints not submitted through the department of insurance (DOI). He said the most common wording across MCAS lines (annuity, homeowners, LPI, life, pet, private flood, PPA, and travel) is: 1) “Number of complaints received directly from any person or entity other than the DOI;” 2) “Variations exist in other lines;” 3) "Number of complaints received directly from any entity other than the DOI” (for disability income); 4) “Number of complaints received directly from consumers” (for long-term care); and 5) "Number of complaints received by company other than through the DOI (Other Health and STLD Lines).” It was noted that the original intent was for these data elements to use consistent wording across all lines. Comments were received from LeDuc regarding understanding the variations.

Guillory opened the floor for comments regarding the wording of the data element for complaints not submitted through the DOI, noting that Birnbaum had submitted written comments.

Guzman expressed support for using consistent wording across all lines of business and agreed with Missouri's earlier comments. He emphasized that the intent has always been to capture complaints not reported through the DOI and recommended standardizing the wording.

Guzman made a motion, seconded by LeDuc, to adopt the most common existing wording, "Number of complaints received directly from any person or entity other than the DOI," across all relevant MCAS lines, including disability income, long-term care (LTC), other health, and short-term, limited duration (STLD). Clarifications were made to ensure the Working Group understood the change applied only to the wording for consistency, not removing any existing DOI complaint counts. The motion passed unanimously.

The change will referred to the Market Regulation and Consumer Affairs (D) Committee for final approval.

Discussed Other Matters

Guillory noted that, due to time constraints, discussion of the following items would be postponed to the next meeting: 1) pet MCAS reporting, including clarification on question no. 109 related to partial payments due to maximum benefit limits; and 2) an update from the SME group reviewing comments on MCAS travel reporting.

Guzman confirmed that the SME group completed its work, resulting in only one proposed change that can easily be addressed at the next meeting.

LeDuc requested that the next meeting also include a discussion on eliminating the requirement for companies to report non-consumer DOI complaints and DOI complaints generally. She said she will provide specific language for this discussion.

Guillory asked Marsh to add LeDuc’s request to the next meeting agenda.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 4/24/25

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 3, 2025

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 3, 2025. The following Working Group members participated: Josh Guillory, Chair (LA); Tolanda Coker, Vice Chair (AZ); Teri Ann Mecca (AR); Rachel Lozano (FL); Elizabeth Nunes and Tia Taylor (GA); Chris Heisler (IL); Lori Cunningham (KY); Joshua Guillory (LA); Mary Lou Morn (MA); Raymond A. Guzman (MD); Jeff Hayden (MI); Jo A. LeDuc (MO); Martin Swanson (NE); Guy Self (OH); Karen Veronikis (PA); Rachel Moore (SC); Tony Dorschner (SD); Rhonda Bowling-Black (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); and Letha Tate and Theresa Miller (WV). Also participating was: Brian Werbeloff (RI).

1. Adopted its March 6 Minutes

The Working Group met March 6 and took the following action: 1) adopted its Dec. 5, 2024, minutes; 2) received an update from the subject matter expert (SME) group reviewing the other health Market Conduct Annual Statement (MCAS) blank; 3) received recommendations from the SME group reviewing the MCAS private passenger auto (PPA) proposal; 4) discussed comments and questions regarding the travel MCAS blank; and 5) discussed comments received on the MCAS blanks proposal form for the definition of cancellations on the MCAS lender-placed insurance (LPI) blank.

Veronikis made a motion, seconded by Coker, to adopt the Working Group's March 6 minutes *(see NAIC Proceedings – Summer 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment Three)*. The motion passed unanimously.

2. Reviewed the SME Group's Proposed Draft Other Health MCAS Revisions

Hal Marsh (NAIC) read Mary Kay Rodriguez's (WI) comments, which gave an overview of the SME group. Rodriguez's comments stated regulators and industry representatives have updated the other health MCAS blank so that the data elements more precisely analyze the marketplace and help identify companies that may require additional review. The existing other health MCAS blank has 155 data elements. Most of the changes to the blank are to the interrogatories. The draft creates separate sections for individual products, association trust products, employer group products, third-party administrator vendors, and general elements to make it easier to report data. The current blank asks companies to report large blocks of data, which has proven difficult to submit in the MCAS system. The draft blank eliminates those questions and asks mostly for simple yes or no responses, with a few elements allowing for additional comments. These changes will make the other health MCAS blank more consistent with the reporting in other MCAS lines of business. Rodriguez's comments also noted that the SME group is presenting a draft data call and definitions. In reviewing the draft, it became apparent that additional definitions were needed to provide clarification. Those definitions are included in the draft, as well as changes to the data elements.

Guillory stated that the suggestions are substantial additions and changes to an existing line of business. The MCAS data element revision process will need to be considered. Barring any concerns, these suggestions are considered to have been received in time for consideration for the 2026 data year since they were provided to the Working Group by April 1. Guillory clarified that this does not mean the drafts will be approved, but they will be considered.

Guillory asked that any comments be sent to Marsh by April 17 to allow for inclusion in the 2026 data year reporting. The revisions must be approved by June 1.

3. Considered Adoption of Changes to the PPA MCAS Blank

Guillory stated that no comments were received on the proposed edits to the PPA MCAS blank. He reminded the Working Group of the edits made, including moving data element no. 12, "If yes, what percentage of your business is nonstandard?" to the underwriting section and rewording it as "Number of nonstandard policies issued during the period." Thus, the data will be a numeric value rather than text in a field. He also stated nine additional data elements were added to the underwriting section for the total number of policies enforced at the end of the year with blank coverage. A data element to report the number of policies enforced at the end of the period enrolled through telematics products was also added to the end of the underwriting section.

Guillory also mentioned that the homeowners MCAS interrogatories contain the same nonstandard question being changed in the auto group, moving it to the underwriting section for consistency. He asked if there was any interest in also moving the homeowners nonstandard question to the underwriting section. Moore and Guzman agreed for consistency's sake.

Leduc asked what "enrolled through" means. She stated "enrolled" is not typically a term in property/casualty (P/C) or auto insurance. She stated that it sounds like a process one would go through to get coverage, as opposed to how coverage is being rated. Leduc said she feels wording it as "enrolled in a telematics product" is better than "enrolled through." Guillory explained that there could be two of the same auto policies, but one is enrolled in a telematics program where they agree to connect a device to their car to track data, and the other one opts out of that enrollment and just has a standard auto policy. He said that is why the word enrolled is used. Guillory said the language Leduc suggested could be taken into consideration.

Guzman added that in a large part of the industry, whether a person wants to enroll in a telematics product is voluntary and has no effect on their policy; it is simply something they would like to participate in.

Guillory asked for a motion to adopt the proposed changes to the MCAS blank and the additional homeowners changes, including moving PPA data element no. 12 to the underwriting section and the homeowners data element from the interrogatories to the underwriting section with the same wording, adding the nine data elements of policies enforced with certain coverages and the elements related to telematics.

Leduc stated that the Spring National Meeting interrupted workflow and suggested that additional time to think about these items would be helpful.

Guillory agreed and asked that comments be sent to Marsh by April 17.

4. Discussed Comments Received Regarding the Travel MCAS Blank

Guillory stated there is still a need for Working Group members to volunteer to form an SME group focused on travel MCAS blank revisions.

Guzman gave a travel insurance data reporting discussion summary following a meeting with Cumming Foster's team at the Spring National Meeting. Key points discussed include:

- Claims received date: The current definition of the claims received date for travel insurance may be misleading, as claims often are not ready for processing when first reported. It was suggested that the

definition be updated to reflect when the claim is perfected and ready for review, like the concept of a "clean claim" in health insurance.

- Role of producers: Insurance producers play a major role in travel insurance, not just managing general agents (MGAs) or third-party administrators (TPAs). A recommendation was made to revise the blank to include a question about whether producers are used in the travel insurance business.
- Policyholder-level data: Travel insurance policies may cover multiple individuals, but loss data is not always captured at the individual level. Discussion is needed to determine the value and feasibility of collecting individual-level data.
- Lawsuit data: There was mention of potential confusion in current reporting, which may capture lawsuits by individuals rather than policies. This was identified as another area for clarification.

Guzman emphasized that addressing these items would not require extensive SME involvement. He said these changes could enhance data quality and consistency.

Birny Birnbaum (Center for Economic Justice—CEJ) expressed opposition to changing the definition of the claim start date from the date the company receives the claim to the date it becomes a "clean claim." He emphasized two main concerns: 1) claim initiation misunderstanding; and 2) issues with the “clean claim” standard. Birnbaum clarified that in travel insurance, a claim is not initiated by a simple inquiry; rather, formal submission of documentation or a claim form is required. He also shared a personal experience where a travel insurer repeatedly requested the same documentation despite it already being submitted. He argued that using the insurer's acknowledgment of a "clean claim" as the start date could misrepresent prompt claim handling and undermine the purpose of the MCAS data, making it appear as though all claims are handled efficiently regardless of actual delays. He concluded that both the interpretation of when a claim begins and the use of the “clean claim” standard are problematic from a consumer perspective.

Guillory asked Guzman if he would lead the SME group on this topic. Guzman agreed.

Guillory then reminded the group that the MCAS data elements revision process document suggests a best practice of having a minimum of five Working Group jurisdictions volunteer to participate in SME group meetings when creating either a new MCAS line of business or blank changes for an existing line of business.

5. Discussed the CEJ Proposal Form on LPI MCAS and the Reporting of a Subsequent Individual Policy or Certificate Following the Expiration of the Term of the Previous Individual Policy or Certificate

Guillory led the discussion on the reporting of subsequent individual policies or certificates. The Working Group reviewed the proposal concerning the reporting of subsequent individual policies or certificates following the expiration of prior ones. This proposal was initially presented during the Working Group’s March 6 meeting and was followed by a comment period. Additional comments from Birnbaum, submitted after the agenda was published, are available on the Working Group’s web page. Guillory invited John Euwema (Consumer Credit Industry Association—CCIA) and Lisa Brown (American Property Casualty Insurance Association—APCIA) to summarize their submitted comments.

Euwema gave a summary of the comments on proposed data elements. The comments expressed a desire for more clarity on the need for additional data elements to capture expiring and renewing policies and certificates. The discussion stemmed from a company encountering error messages when attempting to report expired certificates as canceled within the MCAS system. The comments indicated a preference for amending MCAS instructions to prevent such error messages when expired policies are reported as canceled. While open to the addition of data elements, the comments emphasized the need to understand how these elements would enhance regulatory oversight. They noted that these policies often remain in place as long as necessary,

depending on loan agreements, and are not typically categorized as short- or long-term. Greater clarity is requested on how the new elements would support effective regulation of this product.

Brown echoed previous concerns, emphasizing that if the core issue is system error messages, the simplest and most immediate solution would be a programming change to eliminate the error. They cautioned that pursuing additional data elements could delay resolution, potentially resulting in continued error messages and related issues for at least another year or two.

Birnbaum emphasized the significant benefits of the proposed MCAS changes, noting that they would improve data reliability for market analysis and reduce the likelihood of outlier ratios due to incorrect reporting. He stressed that inconsistent or misunderstood reporting by insurers undermines the purpose of MCAS. He also highlighted that the benefits go beyond improved market analysis of individual insurers, extending to regulators' ability to identify broader market availability and affordability issues. Birnbaum referenced a trade letter that questioned the usefulness of segmenting renewals of placed coverage but noted that the letter itself illustrates the need for change. He pointed out that if insurers interpret and report canceled or expired LPI policies differently, the data becomes unreliable, supporting the case for standardized reporting.

Werbeloff stated that Rhode Island originally raised the issue, which centers on avoiding the misclassification of expirations as cancellations. Werbeloff clarified that the company involved did not view expirations as cancellations but had reported them as such due to MCAS error messages. He outlined three possible solutions: 1) removing the error message and clarifying that expirations are not cancellations in the MCAS instructions, which is an approach that seems acceptable to industry representatives; 2) adding a new data element for expirations, assuming companies can distinguish these from cancellations; and 3) creating a sub-element under "certificates issued" to account for reissued certificates with no gap in coverage to help determine the long-term use of these products. Werbeloff acknowledged that removing the error message alone may not fully resolve the issue, as the math behind the MCAS calculations (ending count is calculated by subtracting cancellations from the beginning count) may still not balance without treating expirations distinctly. He noted that Birnbaum's more comprehensive proposal—covering both certificates and individual policies—would provide regulators with the most useful data. However, if industry prefers a simpler approach, clarifying definitions and removing the error message could address much of the concern.

Guillory asked that comments be sent to Marsh by April 17.

6. Discussed Other Matters

Guillory stated that the Working Group discussed inconsistencies in the MCAS data elements related to complaints across different lines of business. It was noted that the question asking for the number of complaints received directly from the department of insurance (DOI) still appears on the LPI, short-term, limited-duration (STLD), and travel MCAS blanks but has been removed from other lines. If approved, this question will also be removed from the remaining health blank. The Working Group was invited to provide any comments or questions regarding the removal of this question from all MCAS lines of business.

Birnbaum said that this was included for some lines because there was no breakout for some of these complaints. He then asked if there are any breakouts for all of the complaints. Brown replied that she was told there is a breakout for LPI.

Guillory added another matter for discussion. The Working Group addressed inconsistencies in the question's wording regarding the number of complaints received from parties other than the DOI. The most common version reads: "number of complaints received directly from any person or entity other than the DOI." To standardize this

across all MCAS lines of business, wording changes would need to be made to the LTC, other health, and STLD blanks. This change does not involve removing the question, only aligning the language. Guillory stated that this is a matter of making the language consistent across all blanks rather than having inconsistent wording from one blank to another.

Birnbaum stated he thinks there is a huge distinction between a complaint received directly from a consumer and a complaint received from another entity. He also noted that while standardizing terminology may make sense across multiple lines of business, it may not be appropriate for all lines due to inherent differences. Examples cited included the uniqueness of travel insurance and differences between health and P/C lines. He emphasized the importance of allowing time for proper review, considering that previous differences in wording may have been intentional and appropriate.

Guillory asked that comments on this topic be sent to Marsh by April 17.

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

SharePoint/NAIC Support Staff Hub/D Working Groups/MCAS Blanks WG (TES)/2025 MCAS Blanks WG

Draft: 8/18/25

Market Regulation Certification (D) Working Group
Virtual Meeting
August 6, 2025

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Aug. 6, 2025. The following Working Group members participated: Bryan Stevens, Chair (WY); T.J. Patton, Vice Chair (MN); Chelsy Maller and Molly Nollette (AK); Chris Heisler (IL); Mary Lou Moran (MA); Mary Kwei (MD); Jo A. LeDuc (MO); Shane Quinlan and Tracy Biehn (NC); Ralph Boeckman and Erin Porter (NJ); Don Layson (OH); Landon Hubbart (OK); Gary Jones (PA); Rachel Moore (SC); Tracy Klausmeier and Kelly Christensen (UT); Andrea Baytop (VA); Karla Nuissl (VT); and Allan L. McVey (WV). Also participating were: Pam O'Connell and Don McKinley (CA); Victoria Hastings (IN); Lori Cunningham and Patrick Smith (KY); Danielle Torres (MI); and Brett Bache (RI).

1. Adopted its May 21 Minutes

The Working Group met May 21 and took the following action: 1) discussed its Spring National Meeting session; and 2) discussed drafting a market analysis certification requirement.

Patton made a motion, seconded by Moran, to adopt the Working Group's May 21 minutes (Attachment Three-A). The motion passed unanimously.

2. Discussed Drafting a New Market Analysis Certification Requirement

Stevens said that he and Patton drafted a market analysis certification requirement proposal that was circulated at the beginning of June. He reminded the Working Group that the request for a market analysis requirement came from the Market Analysis Procedures (D) Working Group during its discussions of the minimum requirements for the number of Market Analysis Review System (MARS) Level 1 reviews that all jurisdictions should complete annually.

Stevens said the proposal considers different types of market analysis in addition to MARS reviews and the value of shared analyses to all jurisdictions. He said the Working Group received 10 comments on the proposal.

Quinlan asked if the six reviews per market regulation employee proposal considers all market regulation employees or just market analysts. Stevens said it was all employees in the market conduct department. He said that in his state, he is the only one in the market conduct department. Quinlan said there is a hard line between examiners and analysts in North Carolina. He said that analysts do not do exams, and examiners do not do analysis.

McKinley said the California department has 35 examiners and analysts, and as written in the proposal, California would be required to do over 200 market analyses. He suggested a cap on the number of market analysis reviews required. Stevens said the Working Group should consider whether the requirement should be analyses per number of market analysts. LeDuc said Missouri would support that. She said the proposal should be number of analyses per full-time equivalent, not full-time employee. Patton supported the use of full-time equivalent.

Nuissl asked whether only MARS Level 1 analyses would be counted toward meeting the requirement if the language changes to "full-time equivalent" market analysts. LeDuc said the current requirement counts both Level 1 and Level 2 reviews toward completion of the requirement. She said Level 2 reviews should be included in the benchmark.

Bache said Rhode Island uses Level 2 reviews to input results from interrogatories and data calls. He said Rhode Island does not make entries into the Market Action Tracking System (MATS). He said Rhode Island's Level 1 reviews do full complaint analyses that do not need to be repeated in the Level 2 review. Quinlan said North Carolina inputs its continuum actions into State Based Systems (SBS). He said there is an NAIC initiative to link MATS and SBS.

Cunningham asked whether a state with no full-time equivalent analysts would have a market analysis requirement. Stevens said that if an examiner does market analysis, that examiner's percentage of time doing analysis would count toward the full-time equivalent. He said, for example, that five examiners who each spend 20% of their time doing analysis would count as one full-time equivalent, and the requirement would then be six shared analyses for that state. Stevens asked Cunningham if Kentucky follows up its baseline analyses with Level 1 or Level 2 analyses. She said they do not because the baseline gives them enough information, and doing Level 1 and Level 2 analyses in addition to the baseline would be a large undertaking for her state. Stevens said a state with zero full-time equivalent market analysts would be required to do zero analyses. Patton said the certification program has to be flexible.

LeDuc said that "full-time equivalent" should be defined in the certification program. She said it is about how many people are doing market analysis in the state. If the state has half of a full-time equivalent employee doing market analysis, then three market analyses would be required. Baytop noted that the term "full-time equivalent" is already used in the program on page 8.

Hastings asked if the requirement is just for market analysis and not for examinations. Stevens said it was just for market analysis. Hastings said that Indiana does data calls, but the results are not uploaded. LeDuc said the requirement's original intent was for a minimum amount of market analysis so that states were not just being reactive to market conduct issues as they arose.

Quinlan asked if investigations and examinations are the same. LeDuc said they are not and that contact with companies should be entered in MATS. Quinlan said that would be a duplicative effort for states that input their contacts in SBS. Torres said Michigan uses MATS for any additional investigation after a Level 1 analysis.

LeDuc said the question to be answered is the purpose of the requirement. She asked whether it is meant to capture just analyses or if all market conduct actions need to be included. Stevens said the proposal uses "actions," but it was geared toward market analysis. LeDuc said, however, that actions are intended for companies that do certain things that are not analyses. She asked if there should be a minimum level of analysis across all states. She said the original intent of the requirement was to get states to be more proactive and not just concentrate on the same large companies. Stevens said it is sometimes difficult to draw a line between analyses, actions, and investigations. LeDuc suggested describing the distinction in the certification program for the purposes of this requirement. Hastings said that for Indiana, data calls often follow up on complaints received. Stevens said it was the same for Wyoming. He also said he agreed with the need to be proactive. Quinlan said baseline prioritization was also meant to avoid focusing on the same large companies.

Baytop agreed with LeDuc that the Working Group needs to answer the question of the purpose of the requirement. If the purpose is to just be sure each certified state is doing market analysis, then the Working Group should just set a number of analyses to be done. O'Connell said the proposal includes the requirement in the examination section of the certification program. She said if the purpose is to ensure market analyses are done, then it should be in the market analysis section of the program, and the examination section should remain as it is.

Baytop said that if there is a disagreement on the appropriate number of market analyses, then perhaps it should not be a mandatory "red" requirement, but an aspirational "yellow" requirement. She said a number of states seem to be unable to comply with the requirement of 30 analyses. Stevens agreed and said Wyoming cannot reach 30.

Stevens raised the question of whether the requirement is appropriate for the market regulation certification program. Cunningham asked if there was a market analysis requirement prior to the Working Group considering this one. Stevens said there was, and it was forwarded to the Working Group because it seemed appropriate for the certification program. Cunningham asked if the market analysis has to be a MARS Level 1 review. Kentucky does market analysis, just not in MARS.

Stevens said the Working Group will put together an independent ad hoc group to consider the proposal and make revisions. LeDuc, Smith, O'Connell, Hastings, Patton, and Baytop volunteered to join the group.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

SharePoint/Member Meetings/D CMTE/2025 Summer National Meeting/MRCWG/August 6/8-MRCWG T.docx

Draft: 6/30/25

Market Regulation Certification (D) Working Group
Virtual Meeting
May 21, 2025

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met May 21, 2025. The following Working Group members participated: Bryan Stevens, Chair (WY); T.J. Patton, Vice Chair (MN); Chelsy Maller, Sarah Bailey, and Molly Nollette (AK); Lori Plant (AR); Will Speicher (IA); Mary Lou Moran (MA); Mary Kwei (MD); Teresa Kroll (MO); Robert Croom and Shane Quinlan (NC); Erin Porter (NJ); Cassie Soucy (OR); Gary Jones (PA); Rachel Moore (SC); Traci Klausmeier (UT); and Andrea Baytop (VA). Also participating were: Lisa Fullington and Joshua Guillory (LA); and Brett Bache and Matthew Gendron (RI).

1. Discussed its Spring National Meeting Session

Stevens said the Working Group met in regulator-to-regulator session at the Spring National Meeting and considered three main topics:

- The Working Group discussed the formation of a peer review group and considered the group's composition and responsibilities. Stevens said he was pleased to report that the following regulators have volunteered to be on the group: Jo A. LeDuc (MO); Baytop; Soucy; and Jones. Stevens said that along with Patton and him, the peer review group incorporates seasoned market regulators from a cross-section of large and small states from the Western, Midwest, Northeast, and Southeast Zones. The peer review group members are making themselves available to any jurisdictions that would like assistance and advice in reviewing their compliance with the certification program requirements.
- The Working Group started reviewing the self-certification applications submitted to the Working Group. He said this proved to be difficult to do during a formal Working Group meeting, so he asked the peer review group to review the self-certification applications. The peer review group will provide constructive feedback to the applicants.
- The Working Group discussed a certification requirement for Market Analysis Review System (MARS) Level 1 reviews. He said this discussion would continue during this meeting.

2. Discussed Drafting a New Market Analysis Certification Requirement

Stevens said the request for a new requirement comes to the Working Group from the Market Analysis Procedures (D) Working Group. The Market Analysis Procedures (D) Working Group began a discussion of the minimum requirements for the number of MARS Level 1 reviews that all jurisdictions should complete annually. He said the discussion ranged from the current requirement of 30 analyses per jurisdiction to a requirement that could vary for each state, depending on the department size or number of domestic companies. There was also some thought given to the fact that some jurisdictions rely more on interrogatories and other continuum actions to achieve the same results as a MARS Level 1 analysis. He said that toward the end of the Market Analysis Procedures (D) Working Group discussion, the chair, LeDuc, said that since this issue relates to a market analysis requirement for jurisdictions, it should be referred to this Working Group for consideration of either creating a new requirement or incorporating a MARS Level 1 section into a current requirement.

Stevens said that MARS Level 1 reviews have interdepartmental importance. When a Level 1 analysis is completed and approved by the analyst's supervisor, the analysis is available to any analyst in any NAIC jurisdiction. The analyses become a valuable resource for other states analyzing the same company. In effect, multiple perspectives on a company and its market conduct are available in MARS. Stevens said that because of this, a requirement to

complete a minimum number of MARS Level 1 analyses benefits every jurisdiction, and it seems appropriate to include in the certification program.

Guillory said that using the number of domestics to determine the number of Level 1 analyses to be completed would be difficult for smaller departments of insurance (DOIs). He said Louisiana does about 40 Level 1 analyses per year, or 10 per quarter, which seems to work well. The analyses are usually done on non-domestics because the Louisiana domestics tend to be small and specialized. He said he has a staff of three analysts, himself and his manager. Patton said using the number of domestics would create a burden for small DOIs with many domestics.

Quinlan said the original requirement was based on the state's premium size, and North Carolina is a fairly large market. He said North Carolina does the currently required 30 analyses per year, but he would not want to see his staff just doing Level 1 analyses to meet a requirement. He said that in addition to the 30 Level 1 analyses, North Carolina does about 100 continuum actions. The Level 1 analyses are based on prioritization using the Market Analysis Prioritization Tools (MAPT). He said performing more Level 1 analyses, just because they are a larger state, does not make much sense. Quinlan said they are only now fully staffed. He questioned whether there is a need to increase the requirement. He said he does not think it is good to only do Level 1 analyses to meet a requirement.

Stevens said that when they become aware of an issue in Wyoming, they address it immediately, and a Level 1 analysis is not necessarily needed. He suggested that it may be better to have a requirement that includes continuum actions. Quinlan said some continuum actions are closed quickly while others take a long time. He said he would not want his analysts doing something just for the sake of doing it. Stevens said having a baseline number of reviews and actions would ensure that analyses are available for collaboration with other jurisdictions.

Gendron said that Rhode Island does a lot of MARS reviews. He said that many of its continuum actions result in more information input as Level 2 reviews in MARS, just so the communication with the company can be recorded somewhere. It may be put into the Market Actions Tracking System (MATS) if the issue is problematic. Quinlan said North Carolina's continuum actions are tracked in State Based Systems (SBS), and he understands that other states cannot view them in SBS. He said Rhode Island will share the information with NAIC member jurisdictions.

Nollette said Alaska has no staff dedicated to market conduct. She said Alaska has a small population and a small overall premium, so it would need flexibility in the standards. She said she liked the idea of counting continuum actions. She said Alaska's staff members have multiple responsibilities in the department and need flexibility in the requirements. Moore said South Carolina only has one person dedicated to market conduct. Stevens said Wyoming is in the same situation. He said the question is whether states feel a requirement is needed so there is a base number of analyses in MARS, or if it is inappropriate because some states just do not have the staff.

Soucy said the discussion makes it clear that different states approach MARS analyses differently, and it would help states to meet specific metrics if there were examples of how a level analysis is completed and recorded among small and larger states, and how much time is needed to do a review. She said it helps to determine the resources needed to meet a requirement of "X" number of reviews.

Bache said that when Rhode Island completes a Level 2 review, it is not usually a comprehensive review; rather, it is often just adding more information in the market analysis section so the information is available for other regulators. Bache asked if a market analysis requirement is to make sure states are doing some sort of analysis in their states, or if it is to make sure states are getting a good overview of the market in their state. He said some states may be doing something other than MARS reviews to get a good overview of their markets. He suggested that if the goal is only to be sure states know how to do a MARS review, then a smaller required number would be enough.

Baytop said she believed the purpose of having a requirement is to be sure every state is doing some type of analysis. She said if that is the purpose, then maybe the requirement could be variable; for example, a set number of analyses per analyst, a Level 2 review for every examination done, or evidence of data calls and continuum actions. She said each state could show some evidence of analysis, regardless of the number of staff it has for market analysis. Baytop also suggested that the requirement should be an even number if it is measured per employee, because some employees have multiple roles, and the count of analysts may include half of an employee.

Fullington said Louisiana does at least 40 Level 1 reviews per year with three staff members. She said there is an amazing amount of information in the MARS Level 1 reviews, which drives their investigations. She said industry should know that these reviews are being used and analyzed, and it is critical that they report accurate numbers to the states. She said that when Louisiana is planning an investigation, it will do a Level 1 review as part of its market conduct work prior to the investigation. She said she has used the MARS Level 1 reviews to train new employees with little or no insurance background.

Patton said it is important that the criteria are flexible enough so all jurisdictions can qualify. He agreed with Baytop about having various criteria to measure compliance. He noted that Minnesota has not done MARS reviews in a couple of years but has done other market analyses that he thinks should be included in the requirement.

Stevens said it seems that everyone agrees that a requirement is needed. He said that he, Patton, and NAIC staff will draft and distribute a proposed requirement for comment.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

SharePoint/Member Meetings/D CMTE/2025 Summer National Meeting/MRCWG/0521/5-MRCWG T.docx

Draft: 8/15/25

Pharmacy Benefit Management (D) Working Group
Minneapolis, Minnesota
August 11, 2025

The Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Minneapolis, MN, Aug. 11, 2025. The following Working Group members participated: Joylynn Fix, Chair, and Allan L. McVey (WV); Susan Jennette, Co-Vice Chair (DE); Ashley Scott, Co-Vice Chair (OK); Sarah S. Bailey (AK); Erica Bowsher (AZ); Kurt Swan (CT); Sheryl Parker (FL); Paula Shamburger (GA); Andria Seip (IA); Shannon Hohl (ID); Matthew Pickett (IL); Grant Lindman (IN); Isaac Henson and Kenneth Scott (KS); Shaun Orme (KY); Nina Hunter (LA); Mary Lou Moran (MA); Michele Riddering (MI); Norman Barrett (MN); Robert Croom and Tracy Biehn (NC); John Arnold (ND); Michael Muldoon and Margaret Otto (NE); Ralph Boeckman (NJ); Jonathan Wycoff (NV); Tony Bonofiglio (OH); Numi Griffith (OR); Gary Jones (PA); Jud Jones (TN); Shelley Wiseman and Ryan Jubber (UT); Sebastian Arduengo and Karla Nuissl (VT); Andrew Davis (WA); Darcy Paskey (WI); and Lauren White (WY). Also participating was: Howard Liebers (DC).

1. Adopted its Spring National Meeting Minutes

Swan made a motion, seconded by Seip, to adopt the Working Group's March 25 minutes (*see NAIC Proceedings – Spring 2025, Market Regulation and Consumer Affairs (D) Committee, Attachment Five*). The motion passed unanimously.

2. Heard a Presentation from URAC on Pharmacy Benefit Management and Pharmacy Accreditation

Heather Bonome (URAC) discussed URAC's pharmacy benefit management accreditation and specialty pharmacy accreditation programs. She said URAC's pharmacy benefit management accreditation program was launched in 2007. Currently, approximately 25 pharmacy benefit managers (PBMs) are accredited under the program. Bonome discussed the program's scope, which is designed to emphasize transparency, continuous quality improvement, and regulatory compliance. She detailed the requirements PBMs must satisfy to achieve URAC accreditation, including requirements concerning: 1) pricing transparency; 2) clinical decision disclosures; and 3) member support. Bonome discussed URAC's 2025 revisions to the accreditation standards designed to: 1) promote best practices and solid foundational principles; 2) update format to match updated scoring; 3) align PBM and other pharmacy programs; and 4) ensure the program accurately reflects industry standards. She also discussed URAC's accreditation review process.

Bonome discussed URAC's specialty pharmacy accreditation program, including the requirements specialty pharmacies must satisfy to receive URAC accreditation. URAC launched the program in 2008. Currently, over 600 specialty pharmacies are accredited. Requirements include those related to pharmacy operations, medication distribution, patient services and communications, and patient management. She also discussed recent updates to the standards.

Seip asked how URAC monitors PBM price transparency with their clients. She said that Iowa and other states are struggling to obtain such information from PBMs. Bonome said URAC's pharmacy benefit management accreditation standards do not require a PBM to have a specific pricing structure. The standard requires a PBM to have a mechanism for communicating its pricing structure to its clients, so that clients have a clear expectation and understanding of the pricing structure.

Kenneth Scott asked what results URAC is finding with respect to complaints, complaint tracking, and response to those complaints during its accreditation process. He also asked how URAC validates the information PBMs provide about such complaints. Bonome said the pharmacy benefit management accreditation standard for complaints requires the PBM to have a process for handling complaints, as well as a requirement that the PBM sets the turnaround time as a goal for how they resolve complaints. She said that during its desktop review process, URAC looks to understand the process and the PBM's turnaround time for resolving complaints. Following this, URAC conducts a validation review. It requests that the PBM provide a list of all its complaints from which URAC pulls a sample, looking for documentation that the PBM has a process for handling complaints and that those complaints are resolved in accordance with its established turnaround time.

Arduengo asked how URAC developed specialty pharmacy accreditation standards without a clear definition of "specialty drug." Bonome agreed that there is no universal definition of "specialty drug." She explained that despite the lack of such a definition, many categories are typically considered specialty pharmacy. She said URAC has a broad definition of "specialty drug." It defines a "specialty drug" as a drug that requires additional clinical services. It may require additional special handling. Bonome said URAC has structured its accreditation program less around dispensing a specific drug and more around specific services, such as patient management and additional clinical services, that the pharmacy is providing.

Pickett asked about URAC's pricing structure for pharmacy benefit management program accreditation. Bonome explained that URAC has a tiered pricing structure based on the number of lives. She said that for PBMs in the tier one category, accreditation costs between $35,000 and $40,000. Pickett asked about the pricing structure for specialty pharmacy program accreditation. Bonome said URAC's tiered pricing structure is based on the number of scripts. She noted that URAC makes accommodations in pricing for independent and smaller pharmacies.

Jones asked about the structure and role of URAC's board of directors in reviewing and approving new accreditation standards and revisions to existing accreditation standards. Bonome said URAC is a unique independent third-party accrediting organization where patients, providers, and payers all have a seat at the table on establishing what constitutes best practice. She said URAC's board of directors reflects this melding of stakeholders and approves the creation of all its programs. Bonome said its board of directors also oversees the direction of the accreditation programs URAC offers. She said it also serves as the final approval of all URAC standards, whether it is a new accreditation program or a revision to existing accreditation program standards. Bonome said the board of directors is the last step in the review and approval process to ensure the standards are relevant and apply to the industry.

3. Received an Update on the Work to Develop the PBM Examination Chapter

Fix said the Working Group's PBM Examination Chapter Drafting Group has completed work on two sections of the draft PBM examination chapter and plans to complete the remaining sections soon after the Summer National Meeting. She said that after the Working Group receives all the sections and completes its own review, it plans to distribute the initial draft of the PBM examination chapter for public comment. Fix said that after the Working Group finishes its work, the Working Group will forward the draft PBM examination chapter to the Market Conduct Examination Guidelines (D) Working Group for its consideration. She also said that at the request of the Market Conduct Examination Guidelines (D) Working Group, as the subject matter experts on PBMs, a few of the Working Group members plan to participate in the Market Conduct Examination Guidelines (D) Working Group's discussions on the draft PBM examination chapter.

4. Received an Update on the Work to Develop PBM Licensing and Registration Standards

Ashley Scott said the Working Group established a drafting group after the Spring National Meeting to develop an initial draft of the PBM licensing and registration standards. She said the drafting group recently finished its work and forwarded the draft to the full Working Group for its review. She said that following the completion of this review, the Working Group plans to distribute the draft for public comment.

5. Discussed Necessary Changes to SBS to Better Handle PBM Complaints

Fix said she has heard from many states about the need for changes to the State Based Systems (SBS) to better handle PBM complaints. She said she recently reached out to SBS staff to discuss the issue and the best path for moving forward with potential SBS changes. Fix said that after talking to the Working Group's co-vice chairs, Jennette volunteered to spearhead this project and work with any other Working Group members or interested regulator volunteers to develop recommendations for the Working Group's consideration during a future meeting. Jennette said she has some ideas for potential changes and would welcome input from other states to increase the prospect of achieving uniformity across the states in addressing this issue. She asked that anyone interested in volunteering reach out to her.

Having no further business, the Pharmacy Benefit Management (D) Working Group adjourned.

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