MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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The Market Regulation and Consumer Affairs (D) Committee met via conference call Aug. 11, 2020. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Trinidad Navarro (DE); Dean L. Cameron (ID); Robert H. Muriel (IL); Chlora Lindley-Myers and Cindy Amann (MO); Matthew Rosendale represented by Jeannie Keller (MT); Russell Toal represented by Robert Doucette (NM); Kent Sullivan represented by Ignatius Wheeler (TX); Michael S. Pieciak represented by Kevin Gaffney and Phil Keller (VT); and Mark Afable and Rebecca Rebholz (WI). Also participating were: Doug Ommen (IA); Bruce R. Ramage and Laura Arp (NE); Larry D. Deiter (SD); and John Haworth (WA).

1. **Adopted its July 27 Minutes**

Commissioner Richardson said the Committee met July 27 and took the following action: 1) adopted its 2019 Fall National Meeting minutes; 2) adopted standardized data requests (SDRs) for farmowners claims and farmowners policy in force; and 3) adopted revised Market Conduct Annual Statement (MCAS) data call and definitions for life and annuities, homeowners, private passenger auto, and lender-placed auto and homeowners. Mr. Doucette made a motion, seconded by Ms. Biehn, to adopt the Committee’s July 27 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its Task Force and Working Group Reports**

   **a. Antifraud (D) Task Force**

Commissioner Navarro said the Antifraud (D) Task Force met Aug. 3 and adopted its May 20 minutes. He said the Task Force continues to collaborate with the states, industry and antifraud organizations monitoring insurance fraud directly related to the COVID-19 pandemic. He said the Task Force received updates from California, Florida and Texas.

Commissioner Navarro said the Task Force received updates from the Coalition Against Insurance Fraud (CAIF) and the National Insurance Crime Bureau (NICB). He said the Task Force advised it will continue monitoring the pandemic and conference calls will be scheduled as necessary to continue its discussions and bring awareness to the public.

Commissioner Navarro said the Task Force received an update from the Antifraud Education Enhancement Working Group. He said the Working Group updated the “Safety Training for Private Sector Field Employees” course (EDU 330-130) to include COVID-19 safety precautions. He a webinar for the private sector will be held Aug. 26. In addition, the Working Group worked with fraud directors to finalize the content of the NAIC Investigator Safety Training Program. He said the program was initially offered several years ago and the was incorporated into the “Basic Fraud Investigations” course (EDU 330-107). This training will be held Sept. 30. He said the Working Group is also planning to present additional webinars to benefit both the state and private industry investigators.

Commissioner Navarro said the Task Force also received an update from the Antifraud Technology (D) Working Group. He said the Working Group has two projects it is working on or monitoring. The first project is the Online Fraud Reporting System (OFRS) redesign, which is being worked on by NAIC staff. They are finalizing the conversion of the existing system over to the new platform and are planning a demonstration of the new platform during the NAIC Insurance Summit in September. He said the second project is the creation of a single-point online repository for insurers to file their antifraud plans. He said the Working Group is in the initial stages of this process and currently revising the 2011 *Antifraud Plan Guideline (#1690)* before proceeding with the creation of the repository. He said the Working Group will be distributing a new draft of Guideline #1690 for a public comment period ending Aug. 28.

   **b. Market Information Systems (D) Task Force**

Director Wing-Heier said the Market Information Systems (D) Task Force met Aug. 4. She said that during the meeting, the Task Force heard a report from the Market Information Systems Research and Development (D) Working Group concerning its work during its July 8 and July 22 meetings. She said the Task Force adopted the Working Group’s approval of two Uniform System Enhancement Request (USER) forms to add additional codes to the NAIC’s Complaints Database System (CDS). The codes to be added are a new subject code for “pandemic” and three new coverages codes for “business interruption,” “lender-
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placed insurance” and “pet insurance.” Director Wing-Heier said the Task Force also heard a presentation from Birny Birnbaum (Center for Economic Justice—CEJ) regarding the use of artificial intelligence (AI) in market analysis and market regulation.

c. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force met Aug. 3 and adopted its May 6 minutes. Director Deiter said the Task Force discussed producer licensing issues arising from COVID-19. He said the Task Force continues to focus on access to producer licensing examinations. He noted that while 30 states issued bulletins offering temporary licensing, 15 states reported the implementation of online, proctored examinations and that increased to 20 states since Aug. 3. He said for those states offering online examinations, approximately 50%–60% of all examinations have been taken online. He said for the latest information on state bulletins, he encourages everyone to visit the NIPR’s COVID-19 message center. Director Deiter said examination vendors (PSI, Pearson Vue and Prometric) all reported they can implement online examinations for a state in less than 60 days, but it could be as quick as one week. Director Deiter also said the Task Force will have additional discussions on licensing uniformity and reciprocity for independent adjuster licensing in the coming months.

d. Market Conduct Examination Standards (D) Working Group

Director Ramge said the Market Conduct Examination Standards (D) Working Group met July 23, 2020; March 4, 2020; and Dec. 18, 2019.

Director Ramge said that during its July 23 meeting, the Working Group welcomed Illinois as a new member state, and new regulator representation for New Mexico and Ohio. The Working Group also adopted new examination standards addressing limited long-term care insurance for inclusion in the Market Regulation Handbook. He said the new examiner guidance is based on the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643). He said the Working Group also adopted a new inland marine in-force policies SDR and a new inland marine claims SDR for inclusion in the reference documents of the Market Regulation Handbook.

Director Ramge said that during its March 4 meeting, the Working Group welcomed North Carolina as a new member state, and new regulator representation for Nevada, Oklahoma and Oregon. The Working Group also discussed its 2020 charges and potential tasks. He said the Working Group also continued its discussion of limited long-term care insurance draft examination standards.

Director Ramge said that during its Dec.18, 2019, meeting the Working Group adopted a new farmowners policy in force SDR and a new farmowners claims SDR. He said the Working Group also reviewed and discussed comments received on draft examination standards addressing limited long-term care insurance.

e. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met July 30 and adopted its March 23 minutes, which included the adoption of travel insurance as the next line of business in MCAS. He said also during its March 23 meeting, the Working Group agreed to a 60-day extension of the 2020 MCAS due date to allow companies to address COVID-19-related issues. Because of the extension, most lines of business were due June 30 and the health and disability lines of business are due at the end of August. Mr. Haworth said that during its July 30 meeting, the Working Group adopted scorecard ratios for the private flood MCAS blank. He noted that the MCAS will require companies to file private flood data for the first time on the next MCAS due date in April 2021.

f. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met July 31. During this meeting, the Working Group adopted its June 24 minutes. Ms. Rebholz said the Working Group discussed homeowners MCAS clarifications related to newly added underwriting data elements; life and annuity MCAS reporting of national producer numbers (NPNs) for third party administrators (TPAs) within the interrogatories; and homeowners and private passenger automobile MCAS reporting of NPNs for TPAs and managing general agents (MGAs) within the interrogatories. Additionally, the Working Group discussed possible reporting of accelerated underwriting within the life MCAS; placement options for the complaints and lawsuit data elements within the homeowners and private passenger automobile MCAS; and possible homeowner MCAS claims reporting of digital claims settlements and other than digital claims settlements in the dwelling and personal property coverage types. Ms. Rebholz said the Working Group also heard and discussed industry concerns about the addition of a newly adopted data element to collect claims closed without payment below the deductible for the private passenger automobile MCAS.
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g. Market Regulation Certification (D) Working Group

Mr. Haworth said the Market Regulation Certification (D) Working Group has not met since February because of the need to address the COVID-19 crisis. He said that during the Working Group’s Feb. 20 and Jan. 30 meetings, the Working Group considered suggestions submitted by interested parties and interested insurance regulators. Mr. Haworth said the Working Group also began discussions on the pass/fail metrics for the Market Regulation Certification Program. He said the Working Group is still planning to provide its draft revisions to the Committee during the Fall National Meeting.

h. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group met July 30 and adopted its May 5 minutes. Ms. Amann said the Working Group received updates on data privacy legislation by NAIC Legal Division staff, which included federal privacy legislation and state data privacy legislation. Ms. Amann said the Working Group also heard a presentation that included a comparative analysis and comments from the Blue Cross and Blue Shield Association (BCBSA) and Arbor Strategies LLC, representing a coalition of several insurers. Ms. Amann said the Working Group also reviewed plans to begin a gap analysis discussion by Working Group members, interested state insurance regulators and interested parties using the Privacy of Consumer Financial and Health Information Regulation (#672) as a baseline model.

i. Market Actions (D) Working Group

Commissioner Richardson thanked Mr. Wheeler for his leadership as chair of the Market Actions (D) Working Group in 2020, as well as his long-term service to state insurance regulation. She congratulated him on his retirement at the end of August. Commissioner Richardson said Matt Gendron (RI), the current vice chair of the Working Group, will assume the role of chair, and Ms. Biehn will serve as the new vice chair for the rest of this year.

j. Advisory Organization Examination Oversight (D) Working Group

Commissioner Ommen said the Advisory Organization Examination Oversight (D) Working Group was appointed to coordinate and provide oversight of the examinations of multistate advisory organizations, which includes rating organizations and statistical agents. He said the goal is to be more efficient than having multiple single-state exams of advisory organizations and leverage the collective expertise of the Working Group members.

Commissioner Ommen said the Working Group met July 28 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. He said that during the meeting, the Working Group agreed to ask three companies to complete a Comprehensive Annual Audit (CAA) form seeking more information about their operations. He noted the Working Group is considering adding these three advisory organizations to the Working Group’s current list of companies that the Working Group members regularly examine. Additionally, he said the Working Group heard a final update on the conclusion of one examination and discussed the planning of the next examination to begin in about a month.

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the following reports: 1) Antifraud (D) Task Force; 2) Market Information Systems (D) Task Force, including its recommendation to add a “pandemic” subject code and the coverage codes for “business interruptions,” “lender-placed insurance” and “pet insurance” to the CDS; 3) Producer Licensing (D) Task Force; 4) Market Analysis Procedures (D) Working Group, including its July 30 minutes (Attachment Two) and its recommendation to add travel insurance as the next line of business for MCAS and implement new scorecard ratios for the private flood MCAS blank; 5) Market Conduct Annual Statement Blanks (D) Working Group, including its July 31 minutes (Attachment Three) and its recommended clarification to the definition of “individual indexed variable annuity” for the MCAS blank; 6) Market Conduct Examination Standards (D) Working Group, including its July 23 minutes (Attachment Four); 7) Privacy Protections (D) Working Group, including its July 30 minutes (Attachment Five); 8) Market Regulation Certification (D) Working Group, including its Feb. 20 minutes (Attachment Six); 9) Market Actions (D) Working Group; and 10) Advisory Organization Examination Oversight (D) Working Group. The motion passed unanimously.

3. Heard Presentation from Alliance Health Care Sharing Ministries

Katy Talento (Alliance of Health Care Sharing Ministries—Alliance) provided background on what health care sharing ministries (HCSMs) are and noted they are defined in and exempted from the federal Affordable Care Act (ACA). She said Alliance is a nonprofit, nonpartisan coordinating body of seven HCSMs. Alliance provides issue advocacy and public relations on behalf of its member HCSMs. She said the member HCSMs must be certified by the federal Centers for Medicare &
Medicaid Services (CMS) and adhere to Alliance’s standards. Additionally, she said Alliance is moving toward developing accreditation requirements to be an Alliance member.

Ms. Talento said the U.S. Department of Health and Human Services (HHS) has certified that 108 HCSMs meet the federal definition of “health care sharing ministry.” She said 1.5 million Americans are active members of an HCSM and reside in all 50 states. She said HCSM are not insurance. She noted that HCSMs share 100% of eligible medical bills and, in 2019, there were $1.3 billion in shared medical expenses.

Ms. Keller said the use of the term “accreditation” can create confusion. This term is used by the state departments of insurance (DOIs) to demonstrate that a DOI has met certain NAIC requirements in its conduct of financial analysis and regulations and their financial regulation activities can be relied on by other DOIs. Commissioner Clark agreed with Ms. Keller. Ms. Talento acknowledged their concerns and noted that many different entities outside the field of insurance use the term “accreditation.” Commissioner Clark asked who would conduct the accreditation audits. Ms. Talento said it would be an outside vendor.

Director Cameron asked if Alliance is opposed to the DOIs doing the accreditation audits. Ms. Talento said the concern would be that Alliance HCSMs want to be treated as religious organizations, not insurers. She suggested maybe the state attorneys general offices could do the audits. Director Cameron said he understood the concern but noted that DOIs regulate multiple types of organization and have the resources and experience. He said he believes audits could be done by the DOIs without indicating an HCSM is an insurer.

Superintendent Toal questioned the figure that 100% of eligible expenses have been shared. He said it implies that all medical bills are paid when they are, in fact, not all paid. Ms. Talento said each HCSM has guidelines that explain what types of medical bills are eligible and paid, and which are not eligible. She appreciated the feedback and said Alliance strives to be clear about eligible and non-eligible expenses. Commissioner Clark asked what percentage of the total submitted eligible expenses the $1.3 billion in shared expenses represent. Ms. Talento said she would have to get back with that information. Ms. Arp asked if Alliance could provide a list of the 108 HHS-certified HCSMs.

Commissioner Ommen asked if Alliance is concerned that if the definition of HCSM is little more than an ethical or shared belief in human health, then this will collapse the concept as an exclusion from insurance. Ms. Talento said she could only speak on behalf of the Alliance members that require common religious, biblical beliefs. She said the ACA definition requires a common ethical or religious belief, but Alliance members are strictly biblically based religious HCSMs.

Ms. Biehn asked if the Alliance HCSM could share the eligibility guidelines used by its members. Ms. Talento said she believes each HCSM has its guidelines posted online. She said she would provide links. Mr. Keller asked whether any non-religious HCSMs have wanted to be an Alliance member. Ms. Talento said all of Alliance’s HCSMs have religious affiliations. She said Alliance believes that makes for the clearest distinction.

4. **Discussed Template for Waiver of On-Site Reviews**

Commissioner Richardson said the American Property Casualty Insurance Association (APCIA) produced a template for a state bulletin on the waiver of on-site reviews requirements during a public health emergency. She said this is not a bulletin developed by the Committee or any of its working groups. She said the APCIA raised this issue with NAIC staff and, in response, NAIC staff worked with the APCIA to draft the bulletin template. Commissioner Richardson said this is an important enough issue to provide Lisa Brown (APCIA) an opportunity to make some comments on the topic and briefly review the template for state use in the event a state would like to issue such a bulletin.

Tim Mullen (NAIC) said Ms. Brown reached out to him to discuss what the states were doing about waiving on-site reviews of MGAs and TPAs during the current COVID-19 crisis. He said the APCIA suggested the use of its state bulletin template. He said NAIC staff provided information on the model laws related to on-site reviews for reference in the template. He said similar templates have been used for producer licensing. He said this is an informational document for members to consider for use.

Ms. Brown said the APCIA worked with NAIC leadership regarding regulatory relaxations during the early stages of the crisis. She said on-site reviews were overlooked and she asked the Committee to please consider this bulletin template to waive on-site reviews until the end of the COVID-19 crisis.
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5. Adopted New Examination Standards and SDRs

Director Ramge said that on July 23 the Market Conduct Examination Standards (D) Working Group adopted new examination standards addressing limited long-term care; a new inland marine policy in force SDR; and a new inland marine claims SDR. Director Ramge said the limited long-term care examination standards are based on Model #642 and Model #643 and will be included in the Market Regulation Handbook. Director Ramge said the inland marine SDRs will be incorporated in the Market Regulation Handbook reference documents. Director Cameron made a motion, seconded by Commissioner Afable, to adopt the limited long-term care examination standards (Attachment Seven) and the two inland marine SDRs (Attachment Eight and Attachment Nine). The motion passed unanimously.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
The Market Regulation and Consumer Affairs (D) Committee met via conference call July 27, 2020. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClaim represented by Jimmy Harris (AR); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron (ID); Robert H. Muriel represented by Erica Weyhenmeyer (IL); Anita G. Fox represented by Michele Riddering (MI); Chloris Lindley-Myers represented by Cynthia Amann (MO); Russell Toal represented by represented by Robert Doucette (NM); Mike Causey represented by Tracy Biehn (NC); Kent Sullivan represented by Doug Slape, Matthew Tarpley, Jamie Walker and Ignatius Wheeler (TX); Michael S. Pieciak represented by Christina Rouleau (VT); and Mark Afable represented by Jo LeDuc and Rebecca Rebholz (WI). Also participating was: Bruce R. Ramge (NE).

1. **Adopted its 2019 Fall National Meeting Minutes**

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the Committee’s Dec. 19, 2019, minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee). The motion passed unanimously.

2. **Adopted Farmowners SDRs**

Director Ramge said the Market Conduct Examination Standards (D) Working Group adopted on Dec. 18, 2019, a farmowners claims standardized data request (SDR) (Attachment One-A) and a farmowners policy in-force SDR (Attachment One-B). There were no questions or comments on the SDRs.

Commissioner Clark made a motion, seconded by Ms. Biehn, to adopt the farmowners claims SDR and the farmowners policy in-force SDR. The motion passed unanimously.

3. **Adopted Revised Market Conduct Annual Statement Blanks**

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met May 28, May 27, May 21 and May 20 and adopted edits to existing Market Conduct Annual Statement (MCAS) lines of business. The Working Group also met June 24 and adopted instructional clarifications needed that related to changes adopted in May. Ms. Rebholz provided the following summary of changes:

a. **Life and Annuities Data Call and Definitions**

   Two data elements were added that related to policy surrenders. An interrogatory was added to identify third-party administrators (TPAs) used by the company along with their function. Reporting was added for external replacements of unaffiliated company policies and external replacements of affiliated company policies. Lawsuits data elements were added for consistency across the MCAS lines of business. Reporting for Individual Fixed Annuities was broken out into Individual Indexed Fixed Annuities and Individual Other Fixed Annuities. Reporting for Individual Variable Annuities was broken out into Individual Indexed Variable Annuities and Individual Other Variable Annuities (Attachment One-C).

b. **Homeowners Data Call and Definitions**

   Wording for interrogatories related to the explanation of company changes was updated for clarity. Interrogatories were added to report managing general agents (MGAs) and TPAs used by the company. Lawsuits data elements and definitions were updated to be consistent across MCAS lines of business. Policy count data elements were added to the underwriting for the reporting of: 1) dwelling fire policies; 2) homeowner policies; 3) tenant/renter/condo policies; and 4) all other residential property policies (Attachment One-D).

c. **Private Passenger Auto Data Call and Definitions**

   Wording for interrogatories related to the explanation of company changes was updated for clarity. Interrogatories were added to report MGAs and TPAs used by the company. Lawsuits data elements and definitions were updated to be consistent across...
MCAS lines of business. An interrogatory was added to report the use of telematics or usage-based data. A data element was added for “claims closed without payment because the amount claimed is below the insured’s deductible.” (Attachment One-E)

d. **Lender-Placed Data Call and Definitions**

Separate reporting of Blanket Vendor Single Interest Auto and Blanket Vendor Single Interest Home was added.

Ms. Rebholz said interrogatories I-28 and I-20, which ask for the percentage of lender-placed coverage, were inadvertently included and should be deleted from the Interrogatories for Lender-Placed Auto Insurance and Lender-Place Homeowners Insurance (Attachment One-F).

Commissioner Clark made a motion, seconded by Mr. Doucette, to adopt the four revised MCAS blanks, with the note deletion from Mr. Rebholz to the Lender-Placed interrogatories. The motion passed unanimously.

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

Property & Casualty Line of Business
Farmowners

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of Farmowners claims within the scope of the examination.

- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted;
- Cross-reference with the company’s in force data file to ensure completeness of exam data submitted; and
- Cross-reference to state(s) licensing information to ensure proper adjuster licensure.

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<td>Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded</td>
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POLICY IN FORCE STANDARDIZED DATA REQUEST

Property & Casualty Line of Business
Farmowners

Contents: This file should be downloaded from company system(s) and contain one record for each property insured under a Farmowners policy issued in [applicable state] which was in force at any time during the examination period.

For multiple dwellings, non-dwelling structures, and scheduled farm property, please repeat records as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of Farmowners policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state (s) licensing information to ensure proper producer licensure.

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<tr>
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<td>RfndDt</td>
<td>914</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date premium refund mailed [MM/DD/YYYY]</td>
</tr>
<tr>
<td>RefMthd</td>
<td>924</td>
<td>25</td>
<td>A</td>
<td></td>
<td>Refund method (i.e., 90%, pro rata, etc.) If codes are used, provide a list of codes along with their meanings</td>
</tr>
<tr>
<td>EndRec</td>
<td>949</td>
<td>1</td>
<td>A</td>
<td></td>
<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
</tr>
</tbody>
</table>

W:\National Meetings\2020\Spring\Cmte\D\FO In Force 12-18-19.docx
MCAS Blanks (D) Working Group Approved  
Changes May20 and May 21, 2020 and Additional Clarifications June 24, 2020

Market Conduct Annual Statement 
Life & Annuities Data Call & Definitions

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

Reporting Period: January 1, 2021 through December 31, 2021
Filing Deadline: April 30, 2022

Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

Life and Annuity Product Types

<table>
<thead>
<tr>
<th>Product Identifiers</th>
<th>Explanation of Product Identifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICVP</td>
<td>Individual Life Cash Value Products (Includes Variable Life, Universal Life, Variable Universal Life, Term Life with Cash Value, Whole Life, &amp; Equity Index Life)</td>
</tr>
<tr>
<td>INCVP</td>
<td>Individual Life Non-Cash Value Products (Any life insurance policy that does not contain a cash value element)</td>
</tr>
<tr>
<td>IFA</td>
<td>Individual Fixed Annuities (Includes Equity Index Annuity Products)</td>
</tr>
<tr>
<td>IIFA</td>
<td>Individual Indexed Fixed Annuities</td>
</tr>
<tr>
<td>IOFA</td>
<td>Individual Other Fixed Annuities</td>
</tr>
<tr>
<td>IVA</td>
<td>Individual Variable Annuities</td>
</tr>
<tr>
<td>IIVA</td>
<td>Individual Indexed Variable Annuities</td>
</tr>
<tr>
<td>IOVA</td>
<td>Individual Other Variable Annuities</td>
</tr>
</tbody>
</table>
## Market Conduct Annual Statement

### Life & Annuities Data Call & Definitions

#### Schedule 1A– Life Interrogatories

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A-01</td>
<td>Individual Life Cash Value – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-02</td>
<td>Individual Life Non-Cash Value – Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-03</td>
<td>Is there a reason that the reported Individual Life Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-04</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-05</td>
<td>Is there a reason that the reported Individual Life Non-Cash Value information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-06</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-07</td>
<td>Does the company use third party administrators (TPAs) for purposes of supporting the individual life business being reported?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1A-08</td>
<td>If yes, provide the names and functions of each TPA.</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-09</td>
<td>Individual Life Cash Value comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1A-10</td>
<td>Individual Life Non-Cash Value comments</td>
<td>Comment</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B-11</td>
<td>Number of New Replacement Policies Issued During the Period (Include only the number of replacement insurance policies issued)</td>
</tr>
<tr>
<td>1B-12</td>
<td>Number of Internal Replacements Issued During the Period</td>
</tr>
<tr>
<td>1B-13</td>
<td>Number of External Replacements of Unaffiliated Company Policies Issued During the Period.</td>
</tr>
</tbody>
</table>
## Market Conduct Annual Statement

### Life & Annuities Data Call & Definitions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B-14</td>
<td>Number of External Replacements of Affiliated Company Policies Issued During the Period.</td>
</tr>
<tr>
<td>1B-15</td>
<td>Number of Policies Replaced Where Age of Insured at Replacement was &lt;65 (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-16</td>
<td>Number of Policies Replaced Where Age of Insured at Replacement was Age 65 and Over (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-17</td>
<td>Number of Policies Surrendered Under 2 Years from Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-18</td>
<td>Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-19</td>
<td>Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-20</td>
<td>Number of Policies Surrendered More Than 10 Years from Policy Issue (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-21</td>
<td>Total Number of Policies Surrendered During the Period (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-22</td>
<td>Number of Policies Surrendered with a Surrender Fee (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-23</td>
<td>Number of Policies Issued During the Period where age of insured at issue was &lt;65 (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-24</td>
<td>Number of Policies Issued During the Period where age of insured at issue was Age 65 and over (Only applies to ICVP)</td>
</tr>
<tr>
<td>1B-25</td>
<td>Total Number of New Policies Issued by the Company During the Period</td>
</tr>
<tr>
<td>1B-26</td>
<td>Number of Policies Applied for During the Period</td>
</tr>
<tr>
<td>1B-27</td>
<td>Number of Free Looks During the Period</td>
</tr>
<tr>
<td>1B-28</td>
<td>Number of Policies In-Force at the End of the Period (The number of active policies that the company has outstanding at the end of the reporting period)</td>
</tr>
<tr>
<td>1B-29</td>
<td>Dollar Amount of Direct Premium During the Period</td>
</tr>
<tr>
<td>1B-30</td>
<td>Dollar Amount of Insurance Issued During the Period (Face Amount)</td>
</tr>
<tr>
<td>1B-31</td>
<td>Dollar Amount of Insurance In-Force at the End of the Period (Face Amount)</td>
</tr>
<tr>
<td>1B-32</td>
<td>Number of Complaints Received Directly from Any Person or Entity Other than the DOI</td>
</tr>
<tr>
<td>1B-33</td>
<td>Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the claim was received)</td>
</tr>
<tr>
<td>1B-34</td>
<td>Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the claim was received)</td>
</tr>
<tr>
<td>1B-35</td>
<td>Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date the Claim was Received (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the claim was received)</td>
</tr>
</tbody>
</table>
### Market Conduct Annual Statement

**Life & Annuities Data Call & Definitions**

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B-36</td>
<td>Number of Death Claims Closed With Payment, During the Period, Within 30 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 30 days from when the date of due proof of loss occurred)</td>
<td></td>
</tr>
<tr>
<td>1B-37</td>
<td>Number of Death Claims Closed With Payment, During the Period, Within 31-60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was made within 31-60 days from when the date of due proof of loss occurred)</td>
<td></td>
</tr>
<tr>
<td>1B-38</td>
<td>Number of Death Claims Closed With Payment, During the Period, Beyond 60 Days From the Date of Due Proof of Loss (Include claims where the final decision was payment in full, and full payment was NOT made within 60 days from when the date of due proof of loss occurred)</td>
<td></td>
</tr>
<tr>
<td>1B-39</td>
<td>Number Of Death Claims Denied, Resisted or Compromised During The Period</td>
<td></td>
</tr>
<tr>
<td>1B-40</td>
<td>Number of Death Claims Closed With Payment During the Period, Which Occurred Within the Contestability Period</td>
<td></td>
</tr>
<tr>
<td>1B-41</td>
<td>Number of Death Claims Denied During the Period, Which Occurred Within the Contestability Period</td>
<td></td>
</tr>
<tr>
<td>1B-42</td>
<td>Total Number of Death Claims Received During the Period (Include any claim received during the period as determined by the first date the claim was opened on the company system)</td>
<td></td>
</tr>
<tr>
<td>1B-43</td>
<td>Number of Lawsuits Open At the Beginning of the Period</td>
<td></td>
</tr>
<tr>
<td>1B-44</td>
<td>Number of Lawsuits Opened During the Period</td>
<td></td>
</tr>
<tr>
<td>1B-45</td>
<td>Number of Lawsuits Closed During the Period</td>
<td></td>
</tr>
<tr>
<td>1B-46</td>
<td>Number of Lawsuits Closed During the Period with Consideration for the Customer</td>
<td></td>
</tr>
<tr>
<td>1B-47</td>
<td>Number of Lawsuits Open at the End of the Period</td>
<td></td>
</tr>
</tbody>
</table>

#### Schedule 2A – Annuity Interrogatories

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A-01</td>
<td>Individual Fixed Annuities — Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-02</td>
<td>Individual Indexed Fixed Annuities — Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-03</td>
<td>Individual Other Fixed Annuities — Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-04</td>
<td>Individual Variable Annuities — Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-05</td>
<td>Individual Indexed Variable Annuities — Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2A-06</td>
<td>Individual Other Variable Annuities — Does the company have data to report for this product type?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
## Market Conduct Annual Statement

### Life & Annuities Data Call & Definitions

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A-05</td>
<td>Is there a reason that the reported Individual (Indexed or Other) Fixed Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)? Yes/No</td>
</tr>
<tr>
<td>2A-06</td>
<td>If yes, add additional comments</td>
</tr>
<tr>
<td>2A-07</td>
<td>Is there a reason that the reported Individual (Indexed or Other) Variable Annuities information may identify the company as an outlier or be substantially different from previously reported data (such as assuming, selling or closing blocks of business; shifting market strategies; underwriting changes, etc.)? Yes/No</td>
</tr>
<tr>
<td>2A-08</td>
<td>If yes, add additional comments</td>
</tr>
<tr>
<td>2A-09</td>
<td>Does the company use third party administrators (TPAs) for purposes of supporting the individual annuity business being reported? Yes/No</td>
</tr>
<tr>
<td>2A-10</td>
<td>If yes, provide the names and functions of each TPA.</td>
</tr>
<tr>
<td>2A-11</td>
<td>Individual Fixed Annuities comments</td>
</tr>
<tr>
<td>2A-12</td>
<td>Individual Variable Annuities comments</td>
</tr>
</tbody>
</table>

### Schedule 2B—Individual Fixed Annuity (IFA) and Individual Variable Annuity (IVA) Products—Individual Indexed Fixed Annuities (IIFA), Individual Other Fixed Annuities (IOFA), Individual Indexed Variable Annuities (IIVA), and Individual Other Variable Annuities (IOVA)

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2B-13</td>
<td>Number of New Replacement Contracts Issued During the Period (Include only the number of replacement annuity contracts issued)</td>
</tr>
<tr>
<td>2B-14</td>
<td>Number of Internal Replacement Contracts Issued During the Period</td>
</tr>
<tr>
<td>2B-15</td>
<td>Number of External Replacements of Unaffiliated Company Contracts Issued During the Period.</td>
</tr>
<tr>
<td>2B-16</td>
<td>Number of External Replacements of Affiliated Company Contracts Issued During the Period.</td>
</tr>
<tr>
<td>2B-17</td>
<td>Number of Contracts Replaced Where Age of Annuitant at Replacement was &lt; 65</td>
</tr>
<tr>
<td>2B-18</td>
<td>Number of Contracts Replaced Where Age of Annuitant at Replacement was 65 to 80</td>
</tr>
<tr>
<td>2B-19</td>
<td>Number of Contracts Replaced Where Age of Annuitant at Replacement was &gt; 80</td>
</tr>
<tr>
<td>2B-20</td>
<td>Number of New Immediate Contracts Issued During the Period</td>
</tr>
<tr>
<td>2B-21</td>
<td>Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was &lt; 65</td>
</tr>
</tbody>
</table>
Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

<table>
<thead>
<tr>
<th>2B-22</th>
<th>Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80</th>
</tr>
</thead>
<tbody>
<tr>
<td>2B-23</td>
<td>Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was &gt; 80</td>
</tr>
<tr>
<td>2B-24</td>
<td>Total Number of New Deferred Contracts Issued By the Company During the Period</td>
</tr>
<tr>
<td>2B-25</td>
<td>Number of Contracts Surrendered Under 2 Years from Issuance</td>
</tr>
<tr>
<td>2B-26</td>
<td>Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance</td>
</tr>
<tr>
<td>2B-27</td>
<td>Number of Contracts Surrendered Between 6 years and 10 Years of Issuance</td>
</tr>
<tr>
<td>2B-28</td>
<td>Number of Contracts Surrendered Over 10 Years from Issuance</td>
</tr>
<tr>
<td>2B-29</td>
<td>Total Number of Contracts Surrendered During the Period</td>
</tr>
<tr>
<td>2B-30</td>
<td>Total Number of Contracts Surrendered with a Surrender Fee</td>
</tr>
<tr>
<td>2B-31</td>
<td>Number of Contracts Applied for During the Period</td>
</tr>
<tr>
<td>2B-32</td>
<td>Number of Free Looks During the Period</td>
</tr>
<tr>
<td>2B-33</td>
<td>Number of Contracts In-Force at the End of the Period (The number of active contracts that the company has outstanding at the end of the reporting period)</td>
</tr>
<tr>
<td>2B-34</td>
<td>Dollar Amount of Annuity Considerations During the Period</td>
</tr>
<tr>
<td>2B-35</td>
<td>Number of Complaints Received Directly From Any Person or Entity Other than the DOI</td>
</tr>
<tr>
<td>2B-36</td>
<td>Number of Lawsuits Open At the Beginning of the Period</td>
</tr>
<tr>
<td>2B-37</td>
<td>Number of Lawsuits Opened During the Period</td>
</tr>
<tr>
<td>2B-38</td>
<td>Number of Lawsuits Closed During the Period</td>
</tr>
<tr>
<td>2B-39</td>
<td>Number of Lawsuits Closed During the Period with Consideration for the Customer</td>
</tr>
<tr>
<td>2B-40</td>
<td>Number of Lawsuits Open at the End of the Period</td>
</tr>
</tbody>
</table>

In determining what business to report for a particular state, all 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.

Definitions:

**Annuity** - A contract under which an insurance company promises to make a series of periodic payments to a named individual in exchange for a premium or a series of premiums. Data is being requested for individual annuities only; data for group annuity contracts are not being requested.

**Annuity Considerations** - Funds deposited to or used to purchase annuity contracts issued by the company. For the purpose of this statement, annuity considerations should be determined in the same manner used for the state pages of the company's financial annual statement. Do not report "Other Considerations" or "Deposit-Type Contract" considerations. MCAS requires that you report only allocated considerations on contracts that have a mortality or morbidity risk.

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Version 2021.0.0
Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Cash Value Product - A life insurance policy that generates a cash value element. Term life policies with cash value are considered cash value products.

Claim - A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Claims with multiple beneficiaries should be counted as one claim. If a single insured dies and has multiple policies (for individual life products), a claim should be reported for each of the insured’s policies (for example, if an insured had 3 individual life policies (2 cash value products and one non-cash value product), 3 claims would be reported (2 claims under schedule 1B ICVP and 1 claim under schedule 1B INCVP.)

It does not include events that were reported for “information only” or an inquiry of coverage since a claim has not actually been presented (opened) for payment.

Claim Closed with Payment - A claim where the final decision was payment of the claim.

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

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

Contestability Period - The period of time before a policy's incontestability clause becomes effective. During this period, a company may contest a claim based upon material misrepresentation or concealment during the policy application process. The contestability period is usually 2 years.
  - Do not report claims on guaranteed issue life policies
  - Do not report claims that are contested after the incontestability clause is in effect.

Conversion - The process by which a policyholder exercises his/her right under the policy contract to exchange a policy without submitting evidence of insurability. In most cases this involves exchanging a term policy for a permanent policy (e.g., whole life insurance, universal life, variable.)

Corporate Owned Life Insurance - Insurance on the life of an individual, paid for by the company, with the company being a beneficiary under the policy. Corporate Owned Life Insurance policies are included in the scope of this statement and should be reported in the applicable schedule.
Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

**Date Claim Received** - The date the company, or a third party acting on the company’s behalf, is notified of the claim.

**Date of Due Proof of Loss** - The date the company received the necessary proof of loss on which to base a claim determination.

**Denied Claim** - A claim where a demand for payment was made but payment was not made under the contract.

**Direct Written Premium** - The actual amount of direct premiums written during the reporting period and should be determined in the same manner used for the financial annual statement. Data for subject business reported by the company on the financial annual statement should be reported for the purposes of this project regardless of any 1) reinsurance agreements or 2) arrangements to administer the business that may exist with another insurer. (See also: “Life Insurance Premium” and “Annuity Considerations”)

**External Replacement** - An external replacement is when the policy and/or annuity to be replaced was issued by another company.

**External Replacement of Affiliated Company Policies** - An external replacement of an affiliated company policy is when the policy and/or annuity to be replaced was issued by a company affiliated to the MCAS reporting company.

**External Replacement of Unaffiliated Company Policies** - An external replacement of an unaffiliated company policy is when the policy and/or annuity to be replaced was issued by a company not affiliated to the MCAS reporting company.

**Face Amount** - Sum of insurance provided by a policy at death or maturity. In determining the face amount to be reported, companies should follow the same methodology/definitions used to file the financial annual statement and its corresponding state pages. For example, the face amount would include the basic policy plus any riders or amounts for policies with increasing death benefits if these amounts in addition to the basic policy are reported on the company’s financial annual statement.

**Fixed Annuity** - An annuity under which the insurer guarantees that at least a defined amount of monthly annuity benefit will be provided for each dollar applied to purchasing the annuity.

**Free Look** - A set number of days provided in an insurance or annuity contract that allows time for the purchaser to review the contract provisions with the right to return the contract for a full refund of all monies paid. Report the number of policies or contracts that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.
**Immediate Annuity** - An annuity (either fixed or variable) that begins its payment stream to the policyholder within 12 months after a single premium is paid. Immediate annuities are included within the scope of this statement and should be reported as a new immediate contract issued when issued during the reporting period. In addition, immediate annuities still in force at the end of the period should be included as well.

**Individual Indexed Fixed Annuity** - A fixed annuity whose accumulation or policy value is, in whole or in part, linked to an index or indices and offers principal protection. Indexed fixed annuities include equity indexed annuities or fixed indexed annuities that offer principal protection through a 0% floor feature.

**Individual Indexed Variable Annuity** - A variable annuity whose accumulation or policy value is, in whole or in part, linked to an index or indices and may offer some principal protection. Variable indexed annuities include buffer annuities or registered index-linked annuity that offer some principal protection but do not provide a guaranty against loss of principal.

**Internal Replacement** - An internal replacement is when the policy and/or annuity to be replaced was also issued by your company.

**Issued During the Period** - Report the number of policies that have an issue date within the reporting period.

- When reporting the policies/contracts that are broken out by the age of the insured or annuitant
  - for joint policies/contracts, use the age of the oldest insured or annuitant for determining the age category
- Internal and external replacements should be reported as new policies or contracts issued during the reporting period as well as reported in the number of internal and external replacements.

**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 Life & Annuities 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 seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
Market Conduct Annual Statement

Life & Annuities Data Call & Definitions

- 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.

Life Insurance Premiums – Funds used to purchase life insurance products issued by the company. Exclude Group Life and Credit Life premiums. For the purpose of this statement, life insurance premiums should be determined in the same manner used for the state pages of the company's financial annual statement.

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which file 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 an insurance holding company.

Non-Cash Value Product – A life insurance policy that does not contain a cash value element. Do not include life insurance covering only Accidental Death and Dismemberment (AD&D.)

Policies/Contracts Applied For – Applications for life insurance or annuities that are submitted to the company which have or will result in a formal offer of an insurance or annuity contract or a formal declination of the application by the company. Applications that are declined by a broker-dealer or producer and never reviewed by the company are not included in this count.

Replacement Policy – A policy and/or annuity contract application received by your company that is intended to replace an existing policy and/or annuity contract according to each state's definition of a replacement. This may include both external and internal replacements according to each state's replacement law.
Market Conduct Annual Statement
Life & Annuities Data Call & Definitions

Include:
- loan purchases, if the original policy is surrendered,
- surrenders, if a replacement policy is issued in conjunction with the surrender
- 1035 exchanges

Do not include:
- policy conversions
- exchanges of a group policy for an individual policy

Resisted Claim – A claim is considered resisted when it is in dispute and not resolved on the financial statement date for the reporting period. Where the company is holding up payment for sufficient evidence or where a beneficiary has made a claim and then withdraws it, such items should be considered as in the course of settlement.

Surrendered Policy/Contract – A life insurance policy or annuity contract terminated at the request of the policy owner. It does not include life insurance policies or annuity contracts not taken or cancelled during the free look period. For annuities, systematic withdrawals (the withdrawal of a certain amount on a predetermined periodic basis for deferred annuities) and partial withdrawals should not be reported as “surrenders” for this statement.

Term Life Insurance – Life insurance that provides a death benefit if the insured dies during the specified period.

Universal Life Insurance – A form of whole life insurance that is characterized by flexible premiums, flexible face amounts and flexible death benefit amounts and its unbundling of the pricing factor.

Variable Annuity – An annuity under which the amount of the contract’s accumulated value and the amount of the monthly annuity benefit payment fluctuate in accordance with the performance of a separate account.

Variable Life Insurance – A form of whole life insurance under which the death benefit and the cash value of the policy fluctuate according to the investment performance of a separate account.

Variable Universal Life Insurance – A form of whole life insurance that combines the premium and death benefit flexibility of universal life insurance with the investment flexibility and risk of variable life insurance.

Withdrawal – For annuity contracts, see Surrendered Policy/Contract.

Whole Life Insurance – Life insurance that provides lifetime insurance coverage. Whole life insurance policies generally build cash value and cover a person for as long as he or she lives if
premiums are paid as required. It would include life insurance policies that start accumulating cash value once the insured reaches a certain age as specified in the terms of the policy.
Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

**Line of Business:** Homeowners

**Reporting Period:** January 1, 2021 through December 31, 2021

**Filing Deadline:** April 30, 2022

**Contact Information**

<table>
<thead>
<tr>
<th>MCAS Administrator</th>
<th>The person responsible for assigning who may view and input company data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

**Schedule 1 – Interrogatories**

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies in-force during the reporting period that provided Dwelling coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>Were there policies in-force during the reporting period that provided Personal Property coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies in-force during the reporting period that provided Liability coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>Were there policies in-force during the reporting period that provided Medical Payments coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies in-force during the reporting period that provided Loss of Use coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>Was the Company still actively writing policies in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-07</td>
<td>Does the Company write in the non-standard market?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-08</td>
<td>If yes, what percentage of your business is non-standard?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-09</td>
<td>If yes, how is non-standard defined?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-10</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-11</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-12</td>
<td>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</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-13</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-14</td>
<td>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</td>
<td>Comment</td>
</tr>
<tr>
<td>1-15</td>
<td>Does the company use Managing General Agents (MGAs)?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-16</td>
<td>If yes, list the names of the MGAs.</td>
</tr>
<tr>
<td>1-17</td>
<td>Does the company use Third Party Administrators (TPAs)? Yes/No</td>
</tr>
<tr>
<td>1-18</td>
<td>If yes, list the names of the TPAs.</td>
</tr>
<tr>
<td>1-19</td>
<td>Claims Comments</td>
</tr>
<tr>
<td>1-20</td>
<td>Underwriting Comments</td>
</tr>
</tbody>
</table>

Coverages

Dwelling (includes - Other Structures)

Personal Property

Liability

Medical Payments

Loss of Use

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

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

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-21</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-22</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-23</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-24</td>
<td>Number of claims closed during the period, without payment</td>
</tr>
<tr>
<td>2-25</td>
<td>Number of claims open at the end of the period</td>
</tr>
<tr>
<td>2-26</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of claims closed with payment within 31-60 days</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of claims closed with payment within 61-90 days</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of claims closed with payment within 91-180 days</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of claims closed with payment within 181-365 days</td>
</tr>
<tr>
<td>2-32</td>
<td>Number of claims closed with payment beyond 365 days</td>
</tr>
</tbody>
</table>
### Property & Casualty Market Conduct Annual Statement

#### Homeowner Data Call & Definitions

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-33</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-34</td>
<td>Number of claims closed without payment within 31-60 days</td>
</tr>
<tr>
<td>2-35</td>
<td>Number of claims closed without payment within 61-90 days</td>
</tr>
<tr>
<td>2-36</td>
<td>Number of claims closed without payment within 91-180 days</td>
</tr>
<tr>
<td>2-37</td>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>2-38</td>
<td>Number of claims closed without payment beyond 365 days</td>
</tr>
<tr>
<td>2-39</td>
<td>Number of lawsuits open at beginning of the period</td>
</tr>
<tr>
<td>2-40</td>
<td>Number of lawsuits opened during the period</td>
</tr>
<tr>
<td>2-41</td>
<td>Number of lawsuits closed during the period</td>
</tr>
<tr>
<td>2-42</td>
<td>Number of lawsuits open at end of period</td>
</tr>
<tr>
<td>2-43</td>
<td>Number of lawsuits closed with consideration for the consumer.</td>
</tr>
</tbody>
</table>

#### Schedule 3 - Homeowners Underwriting Activity

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

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.
Property & Casualty Market Conduct Annual Statement

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- 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.

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

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

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

**Claims Closed Without Payment** - 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.
**Property & Casualty Market Conduct Annual Statement**

**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.

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

Include:

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

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

Include:

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

For purposes of reporting lawsuits for Homeowners products:
Property & Casualty Market Conduct Annual Statement
Homeowner Data Call & Definitions

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

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

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:

<table>
<thead>
<tr>
<th>Claim Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Claim Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

**Median Days to Final Payment** = \( \frac{5 + 6}{2} = 5.5 \)

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**

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
</tbody>
</table>
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.
**Property & Casualty Market Conduct Annual Statement**

**Homeowner Data Call & Definitions**

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

**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.
Private Passenger Auto Data Call & Definitions

**Line of Business:** Private Passenger Auto

**Reporting Period:** January 1, 2021 through December 31, 2021

**Filing Deadline:** April 30, 2022

**Contact Information**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

**Schedule 1 -- Interrogatories**

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies in-force during the reporting period that provided Collision coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>Were there policies in-force during the reporting period that provided Comprehensive/Other Than Collision coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies in-force during the reporting period that provided Bodily Injury coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>Were there policies in-force during the reporting period that provided Property Damage coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-07</td>
<td>Were there policies in-force during the reporting period that provided Medical Payments coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-08</td>
<td>Were there policies in-force during the reporting period that provided Combined Single Limits coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-09</td>
<td>Were there policies in-force during the reporting period that provided Personal Injury Protection coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-10</td>
<td>Was the Company still actively writing policies in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-11</td>
<td>Does the Company write in the non-standard market?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
### Property & Casualty Market Conduct Annual Statement

**Private Passenger Auto Data Call & Definitions**

<table>
<thead>
<tr>
<th>1-12</th>
<th>If yes, what percentage of your business is non-standard?</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-13</td>
<td>If yes, how is non-standard defined?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-14</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-15</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-16</td>
<td>Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-17</td>
<td>If yes, add additional comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-18</td>
<td>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</td>
<td>Comment</td>
</tr>
<tr>
<td>1-19</td>
<td>Does the company use Managing General Agents (MGAs)?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-20</td>
<td>If yes, list the names of the MGAs.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-21</td>
<td>Does the company use Third Party Administrators (TPAs)?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-22</td>
<td>If yes, list the names of the TPAs.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-23</td>
<td>Does the company use telematics or usage-based data?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-24</td>
<td>Claims Comments</td>
<td>Comment</td>
</tr>
<tr>
<td>1-25</td>
<td>Underwriting Comments</td>
<td>Comment</td>
</tr>
</tbody>
</table>

### Coverages

<table>
<thead>
<tr>
<th>Collision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive/ Other Than Collision</td>
</tr>
<tr>
<td>Bodily Injury</td>
</tr>
<tr>
<td>Property Damage</td>
</tr>
<tr>
<td>Uninsured Motorists and Underinsured Motorists (UMBI)</td>
</tr>
<tr>
<td>Uninsured Motorists and Underinsured Motorists (UMPD)</td>
</tr>
<tr>
<td>Medical Payments</td>
</tr>
<tr>
<td>Combined Single Limits</td>
</tr>
<tr>
<td>Personal Injury Protection</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-26</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of claims closed during the period, without payment.</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of claims remaining open at the end of the period</td>
</tr>
<tr>
<td>2-32</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-33</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-34</td>
<td>Number of claims closed with payment within 31-60 days</td>
</tr>
<tr>
<td>2-35</td>
<td>Number of claims closed with payment within 61-90 days</td>
</tr>
<tr>
<td>2-36</td>
<td>Number of claims closed with payment within 91-180 days</td>
</tr>
<tr>
<td>2-37</td>
<td>Number of claims closed with payment within 181-365 days</td>
</tr>
<tr>
<td>2-38</td>
<td>Number of claims closed with payment beyond 365 days</td>
</tr>
<tr>
<td>2-39</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-40</td>
<td>Number of claims closed without payment within 31-60 days</td>
</tr>
<tr>
<td>2-41</td>
<td>Number of claims closed without payment within 61-90 days</td>
</tr>
<tr>
<td>2-42</td>
<td>Number of claims closed without payment within 91-180 days</td>
</tr>
<tr>
<td>2-43</td>
<td>Number of claims closed without payment within 181-365 days</td>
</tr>
<tr>
<td>2-44</td>
<td>Number of claims closed without payment beyond 365 days</td>
</tr>
<tr>
<td>2-45</td>
<td>Number of lawsuits open at beginning of the period</td>
</tr>
<tr>
<td>2-46</td>
<td>Number of lawsuits opened during the period</td>
</tr>
<tr>
<td>2-47</td>
<td>Number of lawsuits closed during the period</td>
</tr>
<tr>
<td>2-48</td>
<td>Number of lawsuits open at end of period</td>
</tr>
<tr>
<td>2-49</td>
<td>Number of lawsuits closed with consideration for the consumer.</td>
</tr>
</tbody>
</table>
Schedule 3 - Private Passenger Auto Underwriting

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-50</td>
<td>Number of autos which have policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-51</td>
<td>Number of policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-52</td>
<td>Number of new business policies written during the period</td>
</tr>
<tr>
<td>3-53</td>
<td>Dollar amount of direct premium written during the period</td>
</tr>
<tr>
<td>3-54</td>
<td>Number of Company-Initiated non-renewals during the period</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of cancellations for non-pay or non-sufficient funds</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of cancellations at the insured's request</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of Company-Initiated cancellations that occur in the first 59 days</td>
</tr>
<tr>
<td></td>
<td>after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-58</td>
<td>Number of Company-Initiated cancellations that occur 60 to 90 days after</td>
</tr>
<tr>
<td></td>
<td>effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-59</td>
<td>Number of Company-Initiated cancellations that occur greater than 90 days</td>
</tr>
<tr>
<td></td>
<td>after effective date, excluding rewrites to an affiliated company</td>
</tr>
<tr>
<td>3-60</td>
<td>Number of complaints received directly from any person or entity other than</td>
</tr>
<tr>
<td></td>
<td>the DOI</td>
</tr>
</tbody>
</table>

Definitions:

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

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

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

Report cancellations separately for:
- Policies cancelled for non-payment of premium or non-sufficient funds
Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

- 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.

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

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:
- 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:
- 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.
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Private Passenger Auto Data Call & Definitions

- **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.

**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.
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Private Passenger Auto Data Call & Definitions

- 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.

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.

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

**Lawsuits Closed During the Period with Consideration for the Consumer**—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary 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:
- 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:

<table>
<thead>
<tr>
<th>Nbr</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Nbr</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
</tbody>
</table>
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.
**Property & Casualty Market Conduct Annual Statement**

**Private Passenger Auto Data Call & Definitions**

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

**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.
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, 2021 through December 31, 2021

Filing Deadline: April 30, 2022

Contact Information

<table>
<thead>
<tr>
<th>MCAS Administrator</th>
<th>The person responsible for assigning who may view and input company data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestors</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

Schedule 1 – Interrogatories

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed auto coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-02</td>
<td>If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were single-interest lender-placed auto.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-03</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed auto coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>If Yes, enter the percentage of all lender-placed auto policies/certificates issued during the period which were dual-interest lender-placed auto.</td>
<td>Comment</td>
</tr>
<tr>
<td>1-05</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners hazard coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-06</td>
<td>If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were single-interest lender-placed homeowners hazard.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-07</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners hazard.</td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Answer Type</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1-08</td>
<td>If Yes, enter the percentage of all lender-placed homeowners hazard policies/certificates issued during the period which were dual-interest lender-placed homeowners hazard.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-09</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners flood coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-10</td>
<td>If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were single-interest lender-placed homeowners flood.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-11</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners flood coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-12</td>
<td>If Yes, enter the percentage of all lender-placed homeowners flood policies/certificates issued during the period which were single-interest lender-placed homeowners flood.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-13</td>
<td>Were there policies/certificates in-force during the reporting period that provided single-interest lender-placed homeowners wind-only coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-14</td>
<td>If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were single-interest lender-placed homeowners wind-only.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-15</td>
<td>Were there policies/certificates in-force during the reporting period that provided dual-interest lender-placed homeowners wind-only coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-16</td>
<td>If Yes, enter the percentage of all lender-placed homeowners wind-only policies/certificates issued during the period which were dual-interest lender-placed homeowners wind-only.</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-17</td>
<td>Were there policies-in-force during the reporting period that provided blanket vendor single interest auto (vehicle) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-18</td>
<td>Were there policies-in-force during the reporting period that provided blanket vendor single interest home (residential property) coverage?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-19</td>
<td>Was the company still actively writing policies/certificates in the state at year end?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-20</td>
<td>Has the company had a significant event/business strategy that would affect data for this reporting period?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
1-21 | If yes, add additional comments | Comment |
1-22 | Has this block of business or part of this block of business been sold, closed or moved to another company during the year? | Yes/No |
1-23 | If yes, add additional comments | Comment |
1-24 | How does the company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? For example: Re-open original claim/open new claim | Comment |
1-25 | 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? | Yes/No |
1-26 | Add additional comment if desired | Comment |
1-27 | Does the company monitor third parties it contracts with to ensure insurance complaints are forwarded to the company? | 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)**

**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

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

### Schedule 3 -- Lender-Placed Auto and Home Underwriting Elements

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-54</td>
<td>Number of master policies in-force at beginning of the period</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of master policies added during the period</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of master policies canceled for any reason during the period</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of master policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-58</td>
<td>Number of certificates in-force at the beginning of the period</td>
</tr>
<tr>
<td>3-59</td>
<td>Number of certificates written during the period</td>
</tr>
<tr>
<td>3-60</td>
<td>Number of certificates in-force at the end of the period</td>
</tr>
</tbody>
</table>
### Schedule 3 – Blanket Vendor Single-Interest Auto and Home Underwriting Elements

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-54</td>
<td>Number of master policies in-force at beginning of the period</td>
</tr>
<tr>
<td>3-55</td>
<td>Number of master policies added during the period</td>
</tr>
<tr>
<td>3-56</td>
<td>Number of master policies canceled for any reason during the period</td>
</tr>
<tr>
<td>3-57</td>
<td>Number of master policies in-force at the end of the period</td>
</tr>
<tr>
<td>3-75</td>
<td>Dollar amount of gross written premium during the period</td>
</tr>
<tr>
<td>3-76</td>
<td>Dollar amount of net written premium during the period</td>
</tr>
<tr>
<td>3-77</td>
<td>Net written premium during period for policies/certificates for which no separate charge is made to the borrower</td>
</tr>
<tr>
<td>3-78</td>
<td>Dollar amount of premium earned during the period</td>
</tr>
</tbody>
</table>
### 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 meaning 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;
- 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. 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.

**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.
  o 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;
- 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 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.

Consider the following simple example of the number of days it took to settle each of the following seven claims:
<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Settle</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

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.

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 to the borrower.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 30, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Robin David (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Russell Hamblen (KY); Nathan Strebeck (LA); Dawna Kokosinski (MD); Timothy Schott (ME); Michele Riddering (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandeveroode (NE); Edwin Pugsley (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Peggy Willard-Ross (NV); Larry Wertel (NY); Todd Oberholtzer (OH); Landon Hubbart (OK); Gary Jones (PA); Matt Gendron (RI); Michael Bailes (SC); Tanji Northrup (UT); Melissa Gerachis (VA); and Christine Rouleau (VT). Also participating was: Paul Yuen (HI).

1. **Adopted its March 23 Minutes**

   Mr. Haworth said the Working Group met March 23 and took the following action: 1) extend the Market Conduct Annual Statement (MCAS) filing due dates by 60 days due to the COVID-19 crisis; and 2) adopt travel insurance as the next line of business for MCAS.

   Ms. Rouleau made a motion, seconded by Mr. Hamblen, to adopt the Working Group’s March 23 minutes (Attachment Two-A). The motion passed unanimously.

2. **Discussed Revisions to the MCAS Best Practices Guide**

   Ms. Rebholz said the work on the *MCAS Best Practices Guide* was put on hold while the state departments of insurance (DOIs) and the NAIC concentrated on critical work that was either related to COVID-19 or time sensitive. She said beginning with the Summer National Meeting, the drafting group will re-start the work on editing the *MCAS Best Practices Guide* and other MCAS documents.

   Ms. Rebholz said much of the work on the *MCAS Best Practices Guide* was to bring it up to date with the changes to the MCAS since 2014. These changes include new lines of business and changed web page links. The drafting group also created two new appendices to highlight the best practices and provide a list of resources for analysts. Ms. Rebholz said the drafting group expects to finish the edits to the *MCAS Best Practices Guide* during its next meeting.

   Ms. Rebholz said editing the *MCAS Best Practices Guide* is only the first piece of a larger project to update all MCAS reference documents with the goal of: 1) identifying “threshold” issues, such as the number of extension requests that a company has made in recent years and the reasons the company cites; 2) specifying the length of the extensions allowed in order to try to bring consistency in the states’ responses to company extension requests; 3) mapping out a generic process the states can use as a template; and 4) developing templates for extension request response letters and orders to be available to the states.

   Ms. Rebholz said the materials that the drafting group will be reviewing are: 1) the *MCAS Best Practice Guide*; 2) the MCAS web page; 3) the MCAS Frequently Asked Questions (FAQ); 4) the MCAS Industry User Guide; 5) the MCAS data call letters; and 6) all MCAS training materials.

   Ms. Rebholz said the drafting group will also explore what type of extension request report the NAIC can provide on an annual basis to help us determine where threshold issues are triggered. As part of the *State Ahead* strategic plan, the NAIC market regulation staff will be developing a Tableau report that will be able to track historical extension and waiver requests. Our work on the drafting group will provide input into what should be included in this tool and its design.
3. **Discussed the Market Analysis Framework**

Mr. Haworth said during the Working Group’s March 23 conference call, he asked for volunteers to help draft the revisions to the market analysis chapters. He said Ms. Rebholz, Sarah Crittenden (GA) and Rob McCullough (NE) volunteered, but because of the hiatus on Working Group activities, this group has not met. Mr. Haworth said others still have a chance to volunteer before the group’s first meeting. He encouraged comments or suggestions from anyone who has an interest, but it may not be the time to volunteer.

4. **Adopted Scorecard Ratios for the Private Flood MCAS Blank**

Mr. Haworth said the Private Flood blank was adopted last year, and the first collection of Private Flood MCAS data will be due on April 30, 2021. He said scorecard ratios are published each year for each line of business in the MCAS. The scorecards are useful to companies because a company can see how their ratios compare to the overall ratios in each state. Mr. Haworth said the aggregate ratios for each MCAS state are public, and they are also available to consumers.

Mr. Haworth said the ratios include a cross section of underwriting and claims data elements, but they are by no means exclusive. He said any number of ratios can be generated using MCAS data, but the scorecard ratios are some of the more useful measurements.

Mr. Haworth said he would like to adopt the scorecards during this meeting to allow NAIC staff to begin programming them into the MCAS for the 2020 data year.

Mr. Haworth said for Private Flood, there will be two sets of ratios—one for first dollar coverage and a second set for excess coverage. He said the two coverages are distinct enough to generate significantly different results.

Mr. Haworth said there are eight proposed ratios. He noted that they track very closely to the homeowners ratios. The first three ratios are the same as the homeowners ratios. However, ratio 3 measures the percentage of claims paid beyond 60 days. Mr. Haworth said flood claims may take longer to settle than the typical automobile or homeowners claim, he and asked if the Working Group wants to consider using a different time period for this ratio, such as 90 or 180 days.

Ms. Ailor said she would like to hear the experience of state insurance regulators or industry representatives prior to deciding on the time period to use. Mr. Hamblen said 60 days seemed to be a quick turnaround for flood claims. He said flood losses are often accompanied by other perils, such as wind, that can take significant time to adjust. He suggested beginning with a ratio using 60 days and adjusting it, if necessary, as the data is received and analyzed. Ms. Ailor suggested beginning with 90 days and adjusting, if necessary. Mr. Rouleau said he was inclined to begin with 60 days and adjust later, if necessary. Mr. Yuen said from his experience with Hawaiian flood claims, 60 days is tight.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she agrees with beginning with a ratio using at least 90 days. Birny Birnbaum (Center for Economic Justice—CEJ) said private flood coverage on homeowners insurance does not face the same multi-peril issues as policies written through the National Flood Insurance Program (NFIP). He said if the ratio was extended to 90 days, there would be a mismatch with the Homeowners MCAS ratios.

Mr. Haworth said ratios 4 and 5 are presented as 4a and 4b and 5a and 5b. He said the Working Group is being asked to decide whether to use 4a and 5a or 4b and 5b rather than all four. He said the Private Flood MCAS blank added a data element asking the company to provide the number of policies in force at the beginning of the reporting period. He said ratios 4a and 5a use this data element in the denominator. He said using this denominator more closely matches with “non-renewals” and “cancellations over 60 days.” He said for non-renewals (ratio 4), flood policies usually have a term of at least one year. He said that means policies only from the prior reporting period would be up for renewal during the reporting period, and policies written during the current reporting period should not be included in the denominator. He said for cancellations greater than 60 days from inception, ratio 5a’s denominator includes both “beginning policies in-force” and “policies written during”; i.e., the entire universe of possible policies that can be cancelled greater than 60 days from inception. Using policies in force at the end of the reporting period excludes policies that were terminated for other reasons during the year, so it does not contain all the possible policies.

Mr. Haworth said the other option is to keep ratios 4 and 5 the same as the ratios used in the Homeowners MCAS scorecard ratios. He said the advantage to this is being able to compare the Private Flood ratios to the Homeowners ratios.
Mr. Hamblen said it is important to be able to compare the Private Flood ratios with the Homeowners ratios.

Mr. Haworth said ratios 6 and 7 duplicate the Homeowners MCAS ratios.

Mr. Haworth said ratio 8 is a new ratio taking advantage of the additional data element asking for the number of lawsuits closed with consideration for the consumer. This is measured against the number of lawsuits closed during the period.

Mr. Hamblen made a motion, seconded by Ms. Vandevoorde, to adopt the Private Flood MCAS ratios (Attachment Two-B), using 60 days for ratio 3 and matching the Homeowners MCAS ratios 4 and 5. The motion passed unanimously.

5. Discussed the MCAS Attestation

Mr. Haworth noted that ever since the MCAS was centralized, the Working Group usually gets a few questions each year regarding the attestation process and requests for clarification or changes to the process. He said a few years back, the Working Group added a second attestation to address who is responsible for the recreation of reported data from the source data. He said one concern recently expressed is whether the attestation can be provided at a more granular level. He said currently, the MCAS tool is designed to collect the attestations at the NAIC company code level even if the same company reports different lines of business in multiple states. He said it is possible, for example, that a Property and Casualty company may also report Health business, and the appropriate people to attest for each would be different.

Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) thanked the Working Group for the MCAS extension for the Health MCAS this year. He said the additional time was appreciated by the carriers.

Mr. Zolecki said the single attestation per NAIC company code is a concern for carriers. He asked for some time for industry to consider this and other issues and come back to the Working Group with a more complete discussion. Mr. Birnbaum said it was not clear what the problem is. Mr. Zolecki said it is important for the governance of a specific line of business to be the ones to attest to the data. They are more likely to understand the data and its sources. Mr. Zolecki said the attestation should be a higher-level rubber stamp of a submission made at a lower level, especially submissions to multiple states on different lines of business. Mr. Birnbaum said a single attestor can attest to the data.

Mr. Haworth said the Working Group will address the issue after industry has an opportunity to consider it more fully.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call March 23, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Jimmy Harris (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Robin David (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Lori Cunningham and Sandra Stumbo (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Karen McAllister and Douglas Rees (NH); Ralph Boeckman (NJ); Hermoliva Abejar (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubbard (OK); Jeffrey Arnold (PA); Matt Gendron and Segun Daramola (RI); Michael Bailes (SC); Tracy Klausmeier (UT); Julie Fairbanks (VA); Christina Rouleau (VT); Theresa Miller (WV).

1. **Adopted its Feb. 20 Minutes**

The Working Group met Feb. 20 and took the following action: 1) adopted its Jan. 30 minutes; 2) discussed revisions to the **MCAS Best Practices Guide**; and 3) discussed a proposal to add travel insurance as the next line of business in the Market Conduct Annual Statement (MCAS).

Ms. Kroll made a motion, seconded by Ms. Dingus, to adopt the Working Group’s Feb. 20 minutes (Attachment Two-A1). The motion passed unanimously.

2. **Discussed Revisions to the **MCAS Best Practices Guide**

Ms. Rebholz said the drafting group began work revising the **MCAS Best Practices Guide**, but it has temporarily stopped meeting. She said the main document has been updated, and the drafting group is identifying the best practices that will be highlighted and added to a separate appendix. She said another appendix will be added to provide links to resources.

3. **Extended the MCAS Filing Due Date**

Mr. Haworth said most companies have their employees working remotely due to the COVID-19 crisis, and he asked if any members of the Working Group have given thought to an extension of the MCAS due date.

Mr. Hanson suggested polling the companies to see if they need extensions to meet the filing due date. He stated his general agreement with providing an extension to the filing due date. Ms. Ailor said the Arizona Department of Insurance (DOI) has already begun discussions of providing an extension. She thought it was better to meet the need for an extension proactively for all companies instead of handling each company’s extension request individually. Ms. Rebholz said she did not agree with a poll because it would intrude on critical business functions. She agreed with a 60-day or 90-day extension. Mr. Harris said the Arkansas DOI would agree with a 60-day extension. Ms. Rouleau said companies have herculean tasks ahead of them and she favored reasonable accommodations. Ms. Moran also agreed with an extension. Ms. Miller agreed with extending the due date.

Ms. Dingus said she was in favor of an extension only for companies that are required to file on April 30. She said the June 30 due date for the health insurance and disability income insurance MCAS filings could be addressed when we get past April 30. Ms. Abejar agreed with Ms. Dingus. Mr. Arnold said he favored a blanket extension for all lines of business so companies can support essential functions. Mr. Bailes suggested a 90-day extension just for the filings due April 30 and the consideration of other lines of business as the due dates get closer. Ms. Shipp agreed with Mr. Bailes. Mr. Daramola said the Rhode Island DOI supported a 90-day extension.

Michael Lovendusky (American Council of Life Insurers—ACLI) said the ACLI members have said they are pressed with sustaining daily operations, such as claims and underwriting. The companies would be appreciative of an extension to file their MCAS. He said the California DOI has granted 60-day extensions for many of their regulatory filings, and New York is providing 90-day extensions for many of their filings. He said a 60-day or 90-day filing extension seems the most reasonable since no one knows what the COVID-19 situation will look like in 30 days. Lisa Brown (American Property Casualty Insurers Association—APCIA) agreed with Mr. Lovendusky, and she said the majority of APCIA members are working from home.
She said staff normally dedicated to MCAS filings are being used to assist in other critical company functions. Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) said he supported a 60-day extension for all lines of business. He said working remotely slows down the process of cross-validating data.

Birny Birnbaum (Center for Economic Justice—CEJ) said he supports a blanket extension of 60-days for all lines of business. Mr. Lovendusky said he supported a blanket extension of all due dates. He said companies that have a June 30 due date are currently working on gathering data, and an extension of the due date would help them.

Ms. Dingus asked whether the MCAS portal would be open for filings once companies are prepared to file if there was an extension given. Randy Helder (NAIC) said the MCAS portal is open and accepting filings. If companies want to file early, they may.

Mr. Gendron made a motion, seconded by Ms. Rouleau, to extend all 2020 filing due dates by 60 days. The motion passed unanimously.

4. **Adopted Travel Insurance as the Next Line of Business in the MCAS**

Mr. Haworth said the Working Group has considered travel insurance for the MCAS a couple times. He said it was not adopted the first time because of an ongoing multistate examination, and the Travel Insurance Model Act (#632) was still under consideration. He said Mr. Birnbaum has proposed travel insurance again since the examination has been concluded and Model #632 has been adopted. Mr. Haworth said he is often asked, especially now due to the COVID-19 crisis, about how many travel insurance policies are written and in-force in Washington, and he cannot answer the question because they are not broken out in the financial annual statement.

John P. Fielding (US Travel Insurance Association—UStiA) said the last time travel insurance was proposed as the next line of business in the MCAS, it was not adopted because of the ongoing work of drafting Model #632. He said that even though the Model #632 was adopted, it has only been enacted in eight states. The UStiA is working towards having the Model #632 enacted in all states so there will be a level playing field and uniformity. He said with the differences remaining in the states, it does not make sense to have uniform reporting in the MCAS. He also noted that industry is still being closely monitored by the states since the multistate examination.

Mr. Birnbaum said if travel insurance was adopted for inclusion in the MCAS, the earliest it could be collected would be for 2022 data collected in 2023. He said that in 2023, Mr. Fielding’s concerns would no longer exist. Mr. Birnbaum said travel insurance will continue to grow even more rapidly after the COVID-19 crisis. He said the wide variety in the types of coverage, both medical and non-medical, in travel insurance makes it important to be collected in the MCAS. He said the market is large and growing quickly but he noted that even if the travel insurance market is smaller than many lines of insurance, it makes it more suitable for collection in the MCAS, as that is one of the only tools that would be available to state insurance regulators to monitor the market. He said more competition in a market does not translate to less abuse. He said that was the reason for the multistate examination, and he noted that the Regulatory Settlement Agreement (RSA) monitoring will end by 2023. He also said there does not have to be uniformity in the statutory standards of all the jurisdictions. He noted that states have different standards for many other lines of business, such as private passenger auto. He said the MCAS questions are very high level and generic. They apply to all states regardless of the differing standards.

Mr. Gendron asked what other regulatory scrutiny is occurring other than the Market Actions (D) Working Group multistate examination. Mr. Fielding said he was not aware of any other scrutiny, but he noted that the multistate examination was significant. Mr. Gendron said Rhode Island adopted the Model #632 with the assistance of the UStiA, and he expects more states to adopt it; however, to be most effective, it would help state insurance regulators to know who writes travel insurance and how much they write in their jurisdiction. Because travel insurance is reported within the inland marine line on the financial annual statement, an MCAS filing would be the most efficient way to know who is writing how much travel insurance. He said in his experience, more consideration is put into the development of an MCAS blank than other data calls.

Ms. Brown agreed with Mr. Fielding that it is too early to consider adding travel insurance to the MCAS. She also asked whether now is the right time to begin creating a new line of business while state insurance regulators and companies are responding to the COVID-19 crisis. Mr. Birnbaum said adopting travel as the next line of business in the MCAS gets it in the queue for creation, but work would not have to begin right away. Ms. Ailor confirmed Mr. Birnbaum’s statement. She said when she chaired the Market Conduct Annual Statement Blanks (D) Working Group, the work was prioritized and did not always begin immediately because of other work being done. Ms. Dingus said the Market Conduct Annual Statement Blanks
(D) Working Group is currently working on a few other issues and likely would not get to travel insurance until later in the year. She said she did not want to delay a vote. Mr. Arnold and Mr. Haworth agreed.

Ms. Rebholz made a motion, seconded by Ms. Moran, to adopt travel insurance as the next line of business in the MCAS. The motion passed unanimously.

5. Discussed Other Matters

Ms. Moran asked if the automatic deletion of the unapproved Market Analysis Review System (MARS) could be put on hold while states respond to the COVID-19 crisis. Mr. Helder said he would look into this. [Note to minutes—the automatic deletion of unapproved MARS reviews and the notification of unapproved reviews was turned off in late 2018.]

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 20, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebolz, Vice Chair (WI); Ryan James (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Jeffrey Zewe (LA); Dawn Kokosinski (MD); Timothy Schott (ME); Paul Hanson (MN); Stewart Freilich and Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Karen McAllister (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Landon Hubbart (OK); Jeffrey A. Arnold (PA); Matt Gendron (RI); Michael Bailes (SC); Tracy Klausmeier (UT); Julie Fairbanks (VA); Christina Rouleau (VT); Tom Whitener (WV). Also participating was: Sarah Crittenden (GA).

1. **Adopted its Jan. 30 Minutes**

The Working Group met Jan. 30 and took the following action: 1) adopted its Dec. 8, 2019, minutes; 2) discussed revisions to the *MCAS Best Practices Guide*; and 3) discussed a proposal to add travel insurance as the next line of business in the Market Conduct Annual Statement (MCAS).

Ms. Dingus made a motion, seconded by Mr. James, to adopt the Working Group’s Jan. 30 minutes (Attachment Two-A1a). The motion passed unanimously.

2. **Discussed Revisions to the *MCAS Best Practices Guide***

Ms. Rebholz said the small group began work revising the *MCAS Best Practices Guide*. She said revisions to the *MCAS Best Practices Guide should be complete* by March 4.

3. **Discussed the Market Analysis Framework**

Mr. Haworth asked for volunteers to form a small group to review the NAIC *Market Regulation Handbook* (Handbook) market analysis chapters. Ms. Rebholz agreed that was a good idea. Ms. Crittenden volunteered to be in the group. Mr. Haworth asked anyone who is interested to contact Randy Helder (NAIC).

4. **Discussed New Lines of Business for the MCAS**

Mr. Haworth said a suggestion was received from Birny Birnbaum (Center for Economic Justice—CEJ) to add travel insurance as the next line of business to be added to the MCAS. He said the Market Regulation and Consumer Affairs (D) Committee adopted travel insurance examination standards for the Handbook. He said since there is an examination standard, state insurance regulators need data to determine which companies may need to be examined. Mr. Haworth also noted that pet insurance may be proposed by the Property and Casualty Insurance (C) Committee.

Ms. Ailor said travel insurance needs to be considered for the MCAS because of the growth in the line of business. She said it is important to know who is writing travel insurance and to what degree.

Mr. James said only a few states have adopted the *Travel Insurance Model Act* (#632) and are still promulgating rules. He asked if it is possible to create a travel insurance blank if not all states may define travel insurance the same way. Mr. Haworth said the MCAS asks for items such as policies written and claims paid. The MCAS measures the activity in the state and can help determine what companies are writing in the state.

John Fielding (United States Travel Insurance Association—USTiA) asked if interested parties will be allowed to submit comments. Mr. Haworth said the Working Group would welcome comments.

Mr. Birnbaum said that given the timelines for adopting new lines of business if the travel insurance line of business were adopted at this meeting, the earliest it could possibly be implemented would be for 2022 data reported in 2023. He said if the
rate of growth for the travel insurance line of business continues at the same pace, there will be more than 100 million policies in the market when the MCAS collection begins.

5. **Discussed Private Flood Insurance MCAS Scorecard Ratios**

Mr. Haworth said the private flood MCAS blank was adopted in 2019, and the initial filing will be April 30, 2021, for the 2020 data year. He said the Working Group is responsible for developing the scorecard ratios for the MCAS lines of business. He said the number of ratios per line of business varies. He asked if there were any thoughts regarding the number of ratios that would be needed for the private flood MCAS blank. Ms. Ailor said it is difficult to say how many scorecard ratios are needed. She suggested that the available data elements need to be examined and that the Working Group needs to know what state insurance regulators need. She said referring to other line of business scorecard ratios would be good idea to see which scorecard ratios have been useful and which have been less useful.

Mr. Haworth said a small group will be formed to begin the process of developing scorecard ratios for the private flood insurance MCAS blank. He said volunteers should contact Mr. Helder. Mr. Helder said the scorecard ratios would need to be developed by September or October 2020.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Jan. 30, 2020. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Ryan James (AR); Cheryl Hawley (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Lori Cunningham and Sandra Stumbo (KY); Jeffrey Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huiskens (MI); Paul Hanson (MN); Teresa Kroll (MO); Jeannie Keller (MT); Reva Vandevoorde (NE); Douglas Rees (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Larry Wertel (NY); Angela Dingus (OH); Joel Sander (OK); Jeffrey A. Arnold (PA); Michael Bailes (SC); Julie Fairbanks (VA); Isabelle Keiser (VT); Desiree Mauller (WV).

1. **Adopted its Dec. 8, 2019, Minutes**

The Working Group met Dec. 8, 2019, and took the following action: 1) adopted its Nov. 21, 2019, minutes; 2) discussed its 2020 charges; 3) discussed a uniform process for addressing Market Conduct Annual Statement (MCAS) extension requests; and 4) discussed concerns arising from its decision to adopt “Other Health” as the next line of business in the MCAS.

Ms. Dingus made a motion, seconded by Mr. Zewe, to adopt the Working Group’s Dec. 8 minutes (*see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Six*). The motion passed unanimously.

2. **Received an Update on the STLD Medical Data Call Template**

Ms. Rebholz said NAIC staff sent the short-term, limited duration (STLD) data filings to all the participating states on Jan. 6. Along with the data, there was another spreadsheet showing all the companies that should have received a call letter. The spreadsheet indicated which companies filed and which companies sent an email advising they do not write STLD business. Ms. Rebholz said each state now needs to decide what to do with the information. She said Wisconsin sent 909 emails to companies that did not report or inform the NAIC they had nothing to report. She said more than 400 responses have been received, and all of them said they did not write STLD. She said the Working Group needs to consider whether it will take any concerted action against the companies that did not respond or leave this to the discretion of each state. She said Jo LeDuc (WI) input the data into Tableau, and Wisconsin has begun analysis. She said Wisconsin is willing to assist any other states.

Ms. Dingus said Ohio has not yet begun its analysis but has noticed a couple groups that indicated they had no business to report but the state has consumer complaints regarding STLD policies written by companies in the group. She said she is not ready to accept the data as complete or accurate and added she would be wary of collectively penalizing the wrong companies. Ms. Rebholz suggested states should share any information they have that indicates a company writes STLD even though they said they do not. Mr. Haworth noted that some companies said the call letter and reminder went to their spam email.

Ms. Rebholz said Wisconsin is willing to share a template of its communication to the companies that did not report to the initial NAIC data call.

3. **Discussed Revisions to the MCAS Best Practices Guide**

Ms. Rebholz said a small group has formed to begin work on needed revisions to the *MCAS Best Practices Guide* and other MCAS materials. She said the other materials are the MCAS web page, the MCAS Frequently Asked Questions (FAQ), the MCAS Users Guide, the MCAS call letter and training materials. She said that the group would begin with the best practices guide to make sure all changes to the guide are reflected in the other materials.

Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) asked if input will be accepted from industry. Mr. Haworth said for now it will be regulator only and will be exposed to interested parties at the Working Group level.
4. **Discussed the Market Analysis Framework**

Mr. Haworth said the current framework used by most market analysts on the state departments is described in Volume 2 of the *NAIC Market Regulation Handbook* which includes Chapters 6 through 8. He reviewed the contents of the chapters with the Working Group. He said the goal would be to identify changes that need to be made or insert additional relevant information and provide the recommended changes to the Market Conduct Examination Standards (D) Working Group.

5. **Discussed New Lines of Business for the MCAS**

Mr. Haworth said a suggestion was received from Birny Birnbaum (Center for Economic Justice—CEJ) to add travel insurance as the next line of business to be added to the MCAS.

Mr. Birnbaum said the travel insurance line of business was considered by the Working Group in 2018 but was declined because the multistate examination was still being finalized and the *Travel Insurance Model Act* (#632) was still being drafted. He said since that time, the examination has been completed, the model act has been adopted and standards for conducting a travel insurance examination are in the *NAIC Market Regulation Handbook*.

Mr. Birnbaum said the travel insurance market is growing rapidly, experiencing a 41% increase in premium from 2016 to 2018. He said 66 million people each year purchase a travel insurance product. He said the number of covered individuals increased 49% from 2016 to 2108, and the number of plans sold increased 36% in the same period. He said this type of growth warrants additional regulatory oversight because it is a fast-growing market with a complex product with many different coverages. He said there is currently no routine monitoring of the travel insurance market.

Mr. Haworth said there are some health products that are marketed with travel insurance but are marketed by both life and disability carriers, as well as property/casualty (P/C) carriers. He said in some states, the coverage is split between P/C and health. He said it is unclear how to track the premium in the financial annual statement. Mr. James asked if the health products should be reported on the “other health” MCAS. Mr. Haworth said that is a valid question and needs to be considered, but “other health” is typically critical illness or fixed indemnity type products. He said no framework for the “other health” blank has been developed yet.

John Fielding (United States Travel Insurance Association—UStiA) said Model #632 was adopted at the end of 2018 and has been adopted in eight states. He said it has provided a uniform approach for filing. He said 49 states require travel insurance to be filed as inland marine, and nine states additionally require it to be filed as health. He said uniformity will increase as Model #632 is adopted in more states. He also noted the multistate action has ended, but implementation and enforcement of the multistate action is continuing.

Mr. Birnbaum said that even if the travel insurance line of business were adopted at this meeting, the earliest it could possibly be implemented would be for 2021 data reported in 2022.

Mr. Haworth said the Working Group will continue to consider the travel insurance line of business.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Property & Casualty (Private Flood)

Same Ratios Apply Separately for First Dollar Coverage (stand-alone plus endorsements) and Excess Coverage (stand-alone plus endorsements)

Ratio 1. The number of claims closed without payment compared to the total number of claims closed

\[
\frac{\text{Number of claims closed during the period, without payment}}{\text{Number of claims closed with payment} + \text{Number of claims closed without payment}}
\]

Ratio 2. Percentage of claims unprocessed at the end of the period

\[
\frac{\text{Number of claims open at the beginning of period} + \text{Number of claims opened during period} - \text{Number of claims closed with payment} - \text{Number of claims closed without payment}}{\text{Number of claims open at the beginning of period} + \text{Number of claims opened during the period}}
\]

Ratio 3. Percentage of claims paid beyond 60 days

\[
\frac{\text{total number of claims closed with payment beyond 60 days}}{\text{total number of claims closed with payment for all durations}}
\]

Ratio 4. Company-Initiated Non-renewals to policies in force

\[
\frac{\text{number of company-initiated non-renewals}}{\text{number of private flood policies or endorsements in force at the end of the reporting period}}
\]

Ratio 5. Company-Initiated Cancellations over 60 days to policies in force

\[
\frac{\text{number of company-initiated cancellations that occur 60 days or more after the effective date}}{\text{number of private flood policies or endorsements in force at the end of the reporting period}}
\]
Ratio 6.  **Company-Initiated Cancellations under 60 days to new policies issued**

\[
\left(\frac{\text{number of company-initiated cancellations that occur in the first 59 days after effective date}}{\text{number of private flood policies or endorsements written during the reporting period}}\right)
\]

Ratio 7.  **Suits opened during the period to claims closed without payment**

\[
\left(\frac{\text{number of lawsuits opened during the period}}{\text{number of claims closed during the reporting period, without payment}}\right)
\]

Ratio 8.  **The percentage of lawsuits closed with consideration for the consumer**

\[
\left(\frac{\text{number of lawsuits closed during the period with consideration for the consumer}}{\text{number of lawsuits closed during the period}}\right)
\]
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 31, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Sharon P. Clark and Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Todd Oberholtzer (OH); Katie Dzurec (PA); Michael Bailes (SC); and John Haworth (WA).

1. **Adopted its June 24 Minutes**

The Working Group met June 24 and took the following action: 1) adopted its May 28, May 27, May 21 and May 20 minutes; 2) discussed Market Conduct Annual Statement (MCAS) Data Call and Definitions clarifications needed after adoption of changes to the Life, Annuity, Homeowners and Auto MCAS lines of business; and 3) adopted a motion to edit part of the first sentence of the definition for Individual Indexed Variable Annuity from “offers some principal protection” to “may offer some principal protection.”

Mr. Haworth made a motion, seconded by Mr. Swan, to adopt the Working Group’s June 24 minutes (Attachment Three-A). The motion passed unanimously.

2. **Discussed Possible Clarifications for Recently Adopted MCAS Updates**

   a. The first item discussed was clarification on how the definitions of the types of insurance (TOIs) are to be used within reporting for the data elements added in the Homeowners underwriting section. Four new data elements were added during the June 24 call: 1) the number of dwelling fire policies in force at the end of the period; 2) the number of homeowner policies in force at the end of the period; 3) the number of tenant/renter/condo policies in force at the end of the period; and 4) the number of all other residential property policies in force at the end of the period. Draft language was included in the call materials, and it was also posted to the Working Group’s web page for review. Ms. Rebholz stated that a note could be added at the beginning of the definitions section of the Data Call and Definitions to clarify how the definitions should be used. There were no comments by Working Group members, interested state insurance regulators, or interested parties. Any thoughts, suggestions or comments on this topic were requested to be submitted to Teresa Cooper (NAIC) by Aug. 19 for consideration.

3. **Discussed Possible MCAS Updates Previously Tabled**

   a. The first item for discussion was related to the third-party administrator (TPA) and managing general agent (MGA) reporting that was previously adopted for the Life, Annuity, Homeowner and Auto Interrogatories. For the Life and Annuity MCAS, an interrogatory was added to ask if the company uses TPAs; if so, it was asked to name each TPA and its function. For the Home and Auto MCAS, two interrogatories were added. One was to ask if the company uses MGAs; if so, it was asked to name each MGA. The other added interrogatory was to ask if the company uses TPAs; if so, it was asked to name each TPA.

Ms. Rebholz stated that Ms. Nickel has also suggested adding an interrogatory for the inclusion of the TPA’s and MGA’s national producer number (NPN). Mr. Hanson asked if all TPAs and MGAs would have an NPN. Ms. Nickel stated that she believes they are required to have an NPN. Mr. Haworth stated that some states do not license TPAs, so they may be tracked differently as a result. Any thoughts, comments or suggestions on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

   b. The next item discussed was the suggestion from the Center for Economic Justice (CEJ), to add definitions and data elements related to accelerated underwriting to the Life MCAS reporting. Comments for this suggestion were included in the meeting materials for the call. The suggested definition is: “accelerated underwriting means underwriting or pricing of life insurance in whole or in part on non-medical data obtained from other than the applicant or policyholder and includes, among other things, facial analytics, social media and consumer credit information.”
Birny Birnbaum (CEJ) stated that the life insurance industry is using non-medical, non-traditional data to develop models that replicate its traditional underwriting. Issues associated with accelerated underwriting may be of interest to market regulators. The proposal includes a definition for accelerated underwriting and three interrogatories. The suggestion would be that some of the data elements would be reported separately for accelerated underwriting related business versus non-accelerated underwriting business. For example, there is currently a data element for the total number of new policies issued by the company during the period; the proposal would suggest separating this into two data elements: one for the total number of policies issued by the company during the period utilizing accelerated underwriting and one for the total number of policies issued by the company during the period utilizing other than accelerated underwriting.

David Leifer (American Council of Life Insurers—ACLI) stated that there is a lot of work going on related to this subject among other NAIC working groups. He does not know if the definition proposed for accelerated underwriting is accurate, and he suggested working with other groups that are discussing this topic before making any final decisions here. Mr. Birnbaum stated that the CEJ has only proposed this, and if the Working Group decides this is an issue that should be considered as part of the MCAS blanks, the definition of accelerated underwriting will then be developed. He said he does not believe this subject should be delayed, as working on this now means that the earliest reporting would be 2022 data reported in 2023.

Brendan Bridgeland (Center for Insurance Research—CIR) stated support for Mr. Birnbaum’s proposal. He stated that consumers should have some idea of what is going into their rating and underwriting and why they have been denied access. For example, there could be duplicate factors disqualifying someone, such as a credit score in addition to a personal bankruptcy. Mr. Bridgeland stated that it would be useful to track the information proposed by the CEJ.

Commissioner Clark stated that the CEJ’s suggestion holds merit, and she would like the Working Group to consider collecting this data. Mr. Haworth stated that it is warranted to explore this topic because of the concerns with how different types of consumer information are being used, especially with the current economy. He stated that the Working Group can collaborate with others to create a definition, along with inserting terms for predictive analytics and a couple of others regarding algorithms. Ms. Nickel agreed. Any thoughts, comments or suggestions on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

c. The next item discussed was related to the placement of lawsuit and complaints data elements within the Home and Auto MCAS. There is concern that complaint counts are not reported accurately. Previous discussion noted four options. The first option discussed was to create a new reporting section for lawsuits and complaints. The concern with this option is that complaints are currently reported in total in the underwriting section, while lawsuits are reported by coverage in the claims section. Other lines require reporting of complaints by coverage. The second option discussed was to move the complaints questions to the interrogatories. The concern with this option is that it could cause issues when trending past data, and it would be inconsistent with other MCAS lines of business. The third option discussed was to add clarification to the complaint definition. The fourth option was to change the claims section title to be “Claims and Total Complaints section.”

Mr. Haworth stated that he does not see a need to make a change here. Ms. Nickel stated that she believes the concern here is that carriers are not reporting this data correctly. Mr. Haworth stated that he has seen situations in which the company does not have a correct way of tracking what a complaint is, by definition, so the department of insurance (DOI) shows more complaints than the company because of underlying reporting issues within the company.

Mr. Birnbaum stated that one of the concerns that was raised is that the current placement suggests that companies only report certain types of lawsuits or certain types of complaints. By pulling this information out into a section called “complaints and lawsuits,” it would be much clearer to reporting companies that the MCAS is looking for any type of complaint, or any type of lawsuit, regardless of whether it is related to claims, underwriting, or any other matter. Any thoughts, suggestions or comments on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

d. The next item discussed was the suggestion from the CEJ to break claims data elements for Homeowner Dwelling and Personal Property coverages into Digital Claims Settlements and Other than Digital Claims Settlement. This suggestion is detailed within the CEJ’s May 25 comment letter, which was included in the meeting materials.

Mr. Birnbaum stated that a digital claims settlement, sometimes referred to as virtual claim handling, refers to a loss appraisal not involving a human on-site inspection of the property, but it is based on digital information, including
photos taken by the insured or claimant, a plane or drone, or information provided by sensors or cameras within or near the property. For some cars, if there is an accident, the car will be able to send information to the insurer, who can run information through an algorithm and almost instantaneously produce a claim settlement proposal for the insured. While there are some great potential benefits, there are also some consumer protection issues, such as whether these digital/virtual claims settlements are fair or significantly different from those that involve a human being. Because of this change in claim settlements, the CEJ is suggesting that for homeowners and auto, the claim data elements be broken out into digital claims settlement and other than digital claims settlement. Then market analysts can determine whether any significant differences exist by company or by industry in the nature of the timing or the outcomes for digital claims settlements versus other than digital claims settlements. The CEJ proposal included a definition for each category and gave an example of how the two categories might be presented in the MCAS. Mr. Birnbaum discussed the definitions proposed, and he provided examples. He added that the volume of these types of claims has grown as a result of the pandemic, and it is unlikely that there will be a movement back to fewer digital claims.

Ms. Nickel stated that it would be a good idea to consider this because digital claims will likely increase as time goes on. She stated that considering the effects of underwriting on this topic would be something to think about going forward as well. Ms. Cunningham agreed that consideration of digital practices regarding underwriting would be useful. Mr. Haworth asked if the CEJ proposal applies to homeowners and auto lines. He stated that customers are using applications to submit photos of auto damages, and he pointed out the need to consider how supplements on claims would be addressed. Mr. Birnbaum stated that the proposal does apply to homeowners and auto. Ms. Rebholz stated that in Wisconsin, auto repair facilities are stating that they see a high number of supplemental claims on digital claims settlements because the initial settlement does not address the full scope of the damage. Mr. Birnbaum stated that there would be a presentation during the NAIC/Consumer Liaison Committee meeting on Aug. 14 regarding the issue of digital claims settlements for auto if anyone would like to learn more on this issue. Any thoughts, suggestions or comments on this topic were requested to be submitted to Ms. Cooper by Aug. 19 for consideration.

4. Discussed Other Matters

Richard L. Bates (State Farm Insurance) stated that State Farm recently learned that there was an adopted change to the Auto MCAS to add a data element for claims closed without payment when the damage is below the deductible. He asked what the purpose of adding this data element is, how the data would be used, and if the industry was consulted on if they could produce this information and the extent to which it would be accurate. He stated that there would be significant costs imposed on carriers, and therefore consumers, in trying to understand the regulatory concern here.

Ms. Nickel stated that it is important for state insurance regulators to know how many claims are being denied, and separating out claims that were closed just because they were below the deductible was a way to better understand the data being presented by carriers and determine if further analysis of a carrier is warranted. She also stated that there were industry representatives present for the discussion on this topic and the call was open to anyone that wanted to participate. She stated that if Mr. Bates could provide an analysis, comments, and any additional feedback from State Farm and/or other carriers by Aug. 19, they would be reviewed and considered. She also stated that if he has any suggestions that would remedy this issue for state insurance regulators and be suitable for insurers, those ideas would be welcome.

Mr. Birnbaum stated that this seems like a useful distinction. He explained that there can be a variety of reasons a claim is closed without payment, and if claims closed without payment due to being below the deductible are separated out, the remaining data on other claims closed without payment is more meaningful. He asked Mr. Bates how much State Farm would have to raise its rates to provide this information to state insurance regulators. Mr. Bates stated that he did not know and would check on that. He stated that he is looking at the assumption that there is always an ability for insurers to provide the reasons for claims closed without payment, and he suspects that State Farm will be able to satisfy some of that. He explained that there are times when a claim can close without payment below the deductible, and the insurer would not know that is the reason because the policyholder decided not to pursue their claim after filing it, as perhaps the policyholder learned the damages were below the deductible but never shared that with the insurer.

Ms. Rebholz stated that there is a ratio for claims closed without payment compared to the total number of claims closed. She stated that part of the discussion on this issue related to separating out claims closed without payment due to being below the deductible to ensure this ratio accurately reflected the claims that were being closed without payment for other reasons so that a carrier would not appear as an outlier just because they had so many high deductible plans.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
June 24, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call June 24, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Maria Ailor (AZ); Kurt Swan represented by Steve DeAngelis (CT); Scott Woods (FL); Lori Cunningham (KY); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV).

1. **Adopted May 28, May 27, May 21 and May 20 Minutes**

   The Working Group met May 28, May 27, May 21 and May 20 and took the following actions: 1) adopted its May 6 minutes; 2) discussed survey results and adopted various changes to the Life, Annuity, Homeowners and Private Passenger Auto (PPA) Market Conduct Annual Statement (MCAS) Blanks and Data Call and Definitions; 3) adopted edits to the Lender-Placed Insurance (LPI) MCAS regarding Blanket Vendor Single Interest (VSI); and 4) adopted a motion to add an interrogatory for the Homeowners and Auto MCAS.

   Ms. Nickel noted that it appeared that a change needed to be made to the May 28 minutes regarding the motion she made under Section 1, Item E, for reporting claims closed without payment that are below the deductible. Her understanding and intention of the motion was for the data element for claims closed without payment that are below the deductible be its own field. Ms. Cunningham agreed that she understood the motion to add a data element for reporting claims closed without payment that are below the deductible to be a separate field that would not remove those claims from the total number of claims closed without payment.

   Birny Birnbaum (Center for Economic Justice—CEJ) asked if the minutes as they were written just need to have the portion removed that states, “and to remove claims closed because the amount claimed is below the insured’s deductible from the reporting of the claims closed without payment data element.” Ms. Nickel said that was correct.

   Ms. Ailor noted that currently the questions on claims closed without payment include those claims that are closed because they were below the deductible. She asked if the proposed change is to collect that data in the same fashion that it has been collected previously, but to add a new data element to only collect claims closed without payment that were closed because they are below the deductible. Ms. Nickel said that was her understanding of the motion.

   Ms. Nickel made a motion, seconded by Ms. Cunningham, to correct the May 28 minutes under Section 1, Item E, to read, “Ms. Nickel made a motion, seconded by Ms. Cunningham, to add a data element for reporting claims closed without payment that are below the deductible. The motion passed unanimously.” The motion passed unanimously.

   Mr. Haworth made a motion, seconded by Ms. Nickel, to accept the May 28 (Attachment Three-A1), May 27 (Attachment Three-A2), May 21 (Attachment Three-A3) and May 20 minutes (Attachment Three-A4). The motion passed unanimously.

2. **Discussed MCAS Data Call and Definitions Clarifications Needed After Adoption of Changes to the Life, Annuity, Homeowners and Auto MCAS Lines of Business**

   a. The first items discussed were the changes adopted for the Life and Annuity MCAS lines of business. Surrender data elements were added for the number of policies surrendered with a surrender fee and the number of policies surrendered more than 10 years from policy issue. No clarifications were added for these data elements.

      The interrogatory added for the Life and Annuity MCAS was, “Does the company use third party administrators (TPAs) for purposes of supporting the business being reported? If yes, provide the names and functions of each TPA.” These updates were also added for the Home and Auto lines, but the function is not required for the other lines. Ms. Nickel suggested that in addition to this interrogatory, the definition of what a TPA is should be added, and it should include the TPA’s National Producer Number (NPN). Mr. Birnbaum noted that he did not believe this could be presented as clarification, as it appears to be a substantive change and it was not completed by June 1. He also believes a change like this would need to be a data element. After discussion among the Working Group, the decision was made to table this suggestion for next year.
The next item changed in the Life and Annuity MCAS was replacements. The number of external replacements issued during the period was removed and replaced with the following: 1) number of external replacements of unaffiliated company policies issued during the period; and 2) number of external replacements of affiliated company policies issued during the period. Definitions for external replacement of affiliated company policies and external replacement of unaffiliated company policies were also added.

The final changes discussed on the Life and Annuity MCAS were the lawsuit data elements and related definitions that were added, as used in the other lines of business.

b. The next items of discussion were the adopted changes for only the Annuity MCAS line of business. Individual Fixed Annuities was replaced with Individual Indexed Fixed Annuities and Individual Other Fixed Annuities. A definition was also added for Individual Indexed Fixed Annuity.

Individual Variable Annuities was replaced with Individual Indexed Variable Annuities and Individual Other Variable Annuities. A definition was also added for Individual Indexed Variable Annuity. Ms. Nickel noted that the definition of Individual Indexed Variable Annuity does not specify anything for the variable portion, and she asked if more clarification could be added. Mr. Birnbaum noted that the definition starts with stating variable annuities and limits the types of variable annuities to those whose accumulation or policy value is linked to an index or indices and offers some principal protection. He believes the variability is adequately covered by starting the definition with a variable annuity. He noted that if you wanted to add the word “may” in the first sentence so that the portion of the definition is “may offer some principal protection” instead of just “offers some principal protection,” he does not believe that harms the definition at all.

Ms. Nickel made a motion, seconded by Mr. Gaines, to edit part of the first sentence of the definition for Individual Indexed Variable Annuity from, “offers some principal protection” to, “may offer some principal protection.” The motion passed unanimously.

c. The next set of adopted changes discussed applied to the Homeowners and Auto MCAS lines of business. The following interrogatories were added: 1) Does the company use TPAs for the purposes of supporting the business being reported? If yes, provide the names of each TPA; and 2) Does the company use managing general agents (MGAs) for the purposes of supporting the business being reported? If yes, provide the names of each MGA. No clarifications were added for this data element. Whether or not the MGA or TPA’s NPN should be included in the reporting is an item that will be tabled and discussed next year.

A data element was also added for lawsuits closed with consideration for the consumer. Suits was updated to lawsuits within the existing lawsuit data elements, and related lawsuit definitions were added from other lines of business to make everything consistent across the blanks.

d. The next set of adopted changes discussed applied only to the Homeowners line of business. Updates were made to interrogatories 12 and 13, and no clarification was needed.

The underwriting data element for number of homeowner policies in force at the end of the period was replaced with the following: 1) number of dwelling fire policies in force at the end of the period; 2) number of homeowner policies in force at the end of the period; 3) number of tenant/renter/condo policies in force at the end of the period; and 4) number of all other residential property policies in force at the end of the period.

The definition of Dwelling Fire and Dwelling Liability Policies was updated to just be Dwelling Fire Policies. Homeowners policies were updated to include policies written on HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 policy forms. The definition of tenant/renter/condo policies was also added.

Ms. Rebholz noted that the Working Group needs to discuss clarification for Renter’s insurance within the Homeowners policy definition and how to ensure that claims reporting is not altered. Removing Renter’s insurance from the definition of Homeowners policies could cause renters data to be left out of the claims reporting. Ms. Nickel noted that she thought the Tenant and Renter’s policies should be included in the Homeowners policy definition so they can be reported in claims, cancellations, non-renewals and other areas, in addition to the Dwelling Fire. Mr. Birnbaum discussed his understanding of the adopted change for the Renter’s and Tenant policies made during the May 27 call. Mr. Gaines noted that his intent was not to completely break everything down, it was just to be able to capture that information. He did not want to make it more difficult on the carriers. Ms. Rebholz asked if the way the
adopted changes are outlined correctly, and Mr. Gaines confirmed they were. After further discussion, Ms. Rebholz suggested that the adopted changes remain as they are written for now, and if issues are seen in collecting these data elements, review and corrections can be made as needed in the future.

e. The next items discussed were the adopted changes to the PPA MCAS. Wording was updated in interrogatory questions 16 and 17. No clarification was needed.

The following interrogatory was added: Does the company use telematics or usage-based data? A definition was also added for Telematics and Usage-Based Data. A data element was also added for claims closed without payment because the amount claimed is below the insured’s deductible.

Mr. Haworth noted that the definition of lawsuits needs to be corrected under the Homeowners Data Call and Definitions, as it indicates it is for Life and Annuities. Teresa Cooper (NAIC) confirmed that was a typo that would be corrected. It will also be corrected under the PPA Data Call and Definitions.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
May 28, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 28, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Maria Ailor (AZ); Mark Duffy (CT); Scott Woods (FL); Lori Cunningham (KY); Angela Dingus and Guy Self (OH); Jefffrey Arnold (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV).

1. Discussed and Adopted Edits to the PPA MCAS Blanks Data Call and Definitions

Ms. Rebholz said that the survey results and a summary of items in the survey for this discussion are posted on the Working Group’s web page. A summary of the decisions made during the Working Group’s May 27 conference call for the homeowners Market Conduct Annual Statement (MCAS) was provided.

   a. Exclusions

The first item discussed was to change the granularity of the private passenger auto (PPA) reporting to exclude reporting for uninsured motorist bodily injury (UMBI), uninsured motorist property damage (UMPD), medical payments, combined single limit (CSL) and personal injury protection (PIP). This would mean going forward, the MCAS would focus only on collision, comprehensive, liability and property damage (PD). The Working Group did not express interest in making this change.

   b. Policies in Force

The next suggestion discussed was to require companies to report the number of policies in force by coverage type within the interrogatories. The Working Group did not express interest in making this change.

   c. Update to Question 16 and Question 17

The next item of discussion was to make a change to question 18 in the interrogatories to include “last three data years.” It appears the intent was to update question 16 and question 17 similarly to the update suggested for homeowners. The decision made for homeowners was to change the wording in question 12 and question 13 from “Has all or part of this block of business been sold, closed or moved to another company during the year?” to “Has all or part of the this block of business been sold, closed or moved to another company during the reporting period?”

Ms. Nickel made a motion, seconded by Mr. Haworth, to update the wording in question 16 and question 17 of the PPA MCAS to match the wording in question 12 and question 13 in the homeowners MCAS. The motion passed unanimously.

   d. Telematics or Usage-Based Data

The next item discussed was the suggestion to add two interrogatories for: “offers a transportation network company (Uber, Lyft) or similar rideshare endorsement” and “offers or uses telematics or usage-based products.” Working Group members, interested state insurance regulators and interested parties discussed the suggestion.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add the interrogatory “Does the company use telematics or usage-based data?” with a “yes” or “no” response. The motion passed unanimously.

   e. Reporting Claims Closed Without Payment That Are Below the Deductible

The next topic discussed was to add a data element for reporting claims closed without payment that are below the deductible. Ms. Nickel and Ms. Cunningham expressed interest in adding this data element.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said this does not seem to provide information on a company’s market activity and stated a better approach may be redefining claims closed without payment to exclude those...
that were closed because the claim was below the deductible. Ms. Nickel said some carriers report these claims incorrectly and explained this could be an indication of a company’s procedural or compliance issue. Further discussion took place.

Ms. Nickel made a motion, seconded by Ms. Cunningham, to add a data element for reporting claims closed without payment that are below the deductible. The motion passed unanimously.

f. **Phantom Claims**

The next suggestion was to edit the claim definition to avoid phantom claims. Mr. Self said an event reported for information only and coverage inquiries are not supposed to be included in claim counts. Ms. Brown said many states have statutes indicating an insurer cannot open a claim file based solely on an inquiry from a policyholder based on the potential of a claim. After discussion among Working Group members, there was no motion to make changes regarding this suggestion.

g. **Claims Closed With Payment Beyond 180 Days**

The next suggestion discussed was to remove data elements for claims closed with payment beyond 180 days. It was explained that removing these data elements removes the ability of NAIC staff to determine if the median days to final payment is reasonable. Mr. Arnold said he thinks these questions should remain due to the long tails that can take place on bodily injury (BI) claims. Ms. Ailor also supported keeping these data elements as PD claims can also last a long time and can be problematic if there are unnecessary delays in paying claims. There was no interest in removing these data elements.

h. **Separate Reporting for Each MGA**

The next suggestion was for reporting to be done separately for each managing general agent (MGA) to allow state insurance regulators to focus more on the MGAs that are potentially causing issues. During the Working Group’s May 27 conference call related to the homeowners MCAS, it was decided to add an interrogatory question to ask if the company uses any MGAs and if so, to list them by name.

Mr. Gaines made a motion, seconded by Ms. Nickel, to add the interrogatory question asking if the company uses any MGAs and if so, to list them by name. The motion passed unanimously.

i. **Company-Initiated Cancellations**

The next suggestion discussed was to break out the reporting of company-initiated cancellations after effective date in the underwriting section, excluding rewrites to a related company, to 0–29 and 30–59 days. Currently, the breakouts for this data element are 0–59 days, 60–90 days and beyond 90 days. This suggestion would add an extra bucket to separate those within the first 59 days. The Working Group did not express interest in making this change.

j. **Reporting of Terminations Triggered by Nonsufficient Funds**

The next suggestion discussed was to separate reporting of terminations triggered by nonsufficient funds and the insured’s request. Ms. Rebholz explained this data is already broken out by number of cancellations for non-pay or nonsufficient funds and number of cancellations at the insured’s request. There was no further discussion raised in making changes here.

k. **MD&A Section**

The next suggestion discussed was to add the submission of a management discussion and analysis (MD&A) section. This was discussed during the Working Group’s May 27 conference call, and the Working Group decided this suggestion would be passed to the Market Analysis Procedures (D) Working Group.

l. **Lawsuits Closed With Consideration for the Consumer**

The next suggestion discussed was to add a data element to reflect lawsuits closed with consideration for the consumer and adjust wording of lawsuits to make it consistent across all lines of business. The decision was made to add a question for lawsuits closed with consideration for the consumer for the homeowners line and to change the wording of lawsuits questions to use “lawsuits” versus “suits” and consistent definitions across the lines of business.
Ms. Nickel made a motion, seconded by Mr. Arnold, to add the “number of lawsuits closed with consideration for the consumer,” to adjust the wording to say “lawsuits” instead of “suits” and to keep the definitions consistent to the other lines of business. The motion passed unanimously.

m. Non-Renewals and Digital Claims

The next topic discussed was the letter received from Birny Birnbaum (Center for Economic Justice—CEJ). Mr. Birnbaum said that the auto and homeowners blanks have data elements for company-initiated non-renewals during the period. He said it would be useful to get more granular information on the cause of non-renewals to see what is driving them and suggested four buckets: 1) non-renewals based in whole or in part on claims history; 2) non-renewals based on catastrophe risk exposure; 3) non-renewals based on changes in credit score other algorithm using non-insurance personal consumer information; and 4) all other company-initiated non-renewals. The proposal has definitions for each bucket to ensure they are mutually exclusive and to avoid overlap.

Ms. Nickel asked the NAIC if this would change any of the current ratios being used. Teresa Cooper (NAIC) said it would not cause any issues with any current ratios.

Ms. Brown said the insurers she communicated with on this suggestion indicated they do not capture this information in their systems. They said they do not code the reasons for non-renewals as outlined in this suggestion. Mr. Birnbaum advised the MCAS timeline is set up the way it is to give companies time to prepare their systems to collect the data being requested in the future. After further discussion among Working Group members and interested parties, it was suggested that this suggestion would be tabled for future discussion and review. There was no motion to make changes here.

Ms. Rebholz advised there was also a suggestion by Mr. Birnbaum regarding breaking claims elements into digital claims versus other than digital claims. Mr. Birnbaum said unless there was a member of the Working Group that has an interest in this, it can also be tabled for future discussion. Ms. Nickel said she likes the idea and agrees it should be reviewed in the future. She expressed interest in knowing about inspections on structures for homes, specifically regarding claims and whether adjusters are looking at the damages. She asked how this would apply to personal property. Mr. Birnbaum advised it would apply in the same way as it would to structural damage—for example, if your home was hit by a hurricane and you sent pictures of the damage, and the claim was settled based on the pictures.

Ms. Brown said that homeowners and auto writers she discussed this with indicated they have a lot of claims that would have aspects of both, where initially they would accept a drone assessment of the policyholder’s loss but then later an adjuster is sent to inspect the damage. The same thing happens with auto claims, where initially the policyholder sends photos and then goes to a body shop, and then subsequent damage is found at the body shop. She said having these things be a part of the future discussion would be appreciated. Ms. Nickel said she sees a lot more of the drone use or use of Google images of homes before they are damaged. Carriers sometimes assess damage based on an older image that was taken years prior to the loss. Mr. Birnbaum said the definitions address some of the issues raised. He also said the National Insurance Crime Bureau (NICB) has a database of aerial photography. The NICB has planes flying over the country taking high-resolution photographs of properties that show resolution within two to three inches of every part of the country. It can use this to show the condition before a hurricane, and then a drone can look at the condition afterwards. This topic was tabled for future discussion.

2. Adopted Edits to the LPI MCAS Regarding Blanket VSI

Ms. Rebholz said that a subject matter expert (SME) group has discussed the lender-placed insurance (LPI) auto and home reporting issue for vendor single interest (VSI) products. The meeting material attachments four and five show redline copies of the LPI blank and data call and definitions that the SME group proposed. The proposal is to add separate reporting for blanket VSI auto and blanket VSI home. Mr. Birnbaum pointed out that the mock-up of the data call and definitions should be updated to have the new interrogatory wording consistent with those added in the blank. Each should say “Blanket Vendor” Single Interest.

Mr. Haworth said several different parties and state insurance regulators have reviewed and provided input on these proposed changes. Ms. Brown said the APCIA supports the proposal. Tom Keepers (Consumer Credit Industry Association—CCIA) said that while the CCIA was a part of the SME group and appreciated the collaboration on defining the data elements and being able to contribute to the process, the CCIA is still not supportive of reporting VSI.
Ms. Nickel made a motion, seconded by Mr. Haworth, to add separate reporting for blanket VSI auto and blanket VSI home, with interrogatory questions to be added for each additional coverage and additional columns to be added for the reporting of data. The motion passed unanimously.

3. **Adopted a Motion to Add an Interrogatory for the Homeowners and Auto MCAS**

Tanya Sherman (INS Companies) said that during the life and annuity conference calls last week, the Working Group agreed that third-party administrators (TPAs) would be added to the interrogatories. She said that during the conference calls today and yesterday, the Working Group agreed to add MGAs for property/casualty (P/C). She asked if also adding TPAs and not just MGAs to the P/C reporting would be appropriate. Ms. Nickel said she does not see a lot of TPA usage in Idaho. Mr. Haworth said Washington sees a lot of TPA use, and it has companies that contract out a lot of services either for underwriting or claim handling.

Ms. Nickel made a motion, seconded by Mr. Arnold, to add an interrogatory for the homeowners and auto MCAS asking if the company uses a TPA, and if so, to list the name and function. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
May 27, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 27, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating were: Sarah Crittenden (GA); and Jill Huisken (MI).

1. Adopted its May 6 Minutes

The Working Group met May 6 and took the following actions: 1) adopted its Feb. 26 minutes; 2) received an update on existing market conduct annual statement (MCAS) reviews and the other health MCAS development; and 3) adopted a $50,000 premium threshold for the private flood MCAS reporting.

Mr. Gaines made a motion, seconded by Mr. Arnold, to adopt the Working Group’s May 6 minutes (Attachment Three-A2a). The motion passed unanimously.

2. Discussed and Adopted Edits to the Homeowners MCAS Blanks Data Call and Definitions

Ms. Rebholz said the Working Group should come to consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. She said some issues may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. She said the survey results and a summary of items in the survey for this discussion are posted on the Working Group web page. The items highlighted in gray are related to the MCAS Market Analysis Prioritization Tool (MAPT). Ms. Rebholz said the Market Analysis Procedures (D) Working Group will forward rankings and ratios to Mr. Haworth for discussion.

a. Policies in Force

The first item discussed was a suggested interrogatory change dealing with policies in force. The suggestion was to add a question to the interrogatories where a company could provide an explanation for any significant difference between the number of policies in force at the end of the prior year and the number reported in force for the beginning of the current reporting period. The other related suggestion is to add a data element to report the number of total, in-force policies by coverage type in the interrogatories. There was no interest expressed to make changes here.

b. Renters and Tenant Policies

The next suggestion to the interrogatories was to break out reporting for renters and tenant policies. Working Group members discussed this suggestion. Birny Birnbaum (Center for Economic Justice—CEJ) advised if the Working Groups want to get the information on the number of renters policies, it should ask about the number of homeowners policies in force at the end or beginning of the period, how many dwelling fire policies were in force and how many renter/tenant/condo policies grouped together were in force.

Ms. Rebholz said the next suggestion to the interrogatories along this subject is to break out renters policies and homeowner coverage separate from dwelling since there is a separate definition within the data call and definitions.

Teresa Cooper (NAIC) said another option is to add the reporting of these values to the underwriting section since data is already collected for policies in force in that section for homeowners, renters and dwelling. Mr. Haworth and Mr. Arnold said they agree. Mr. Birnbaum stated the NAIC Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report) outlines how residential properties groups are categorized. The groups are: 1) dwelling fire, which is HO1; 2) homeowners, which is HO3 and HO5; and 3) renters/condo/co-op, which are HO4 and HO6. He suggested using the same three categories if adding them to the underwriting section.
Mr. Gaines made a motion, seconded by Mr. Arnold, to create three additional categories in the underwriting section: 1) dwelling fire; 2) homeowners; and 3) renters/condo/co-op. The motion passed unanimously.

c. Interrogatories

The next item of discussion was to make a change to question 12 and question 13 in the interrogatories. The question currently asks: “Has all or part of this block of business been sold, closed or moved to another company during the year?” The suggestion is to change the end of the question to ask for information during the “last three data years.”

Ms. Ailor asked if this is data that could be obtained from the dashboard. Tressa Smith (NAIC) confirmed the interrogatories will be available in the dashboard and that information on a current year would be available, as well as information up to five years back to see how responses have varied over time.

Ms. Crittenden said the three-year question seems to go outside of the MCAS annual reporting for the data year. Ms. Rebholz asked if it would be better to change the wording to: “Has all or part of this block of business been sold, closed or moved to another company during this reporting period?” with the understanding that the dashboard can provide information three years back. Mr. Haworth supported this idea.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she agrees with Ms. Crittenden and Mr. Haworth in that the companies have been reporting this data for quite a while on an annual basis and if the information can be obtained off the dashboard, the APCIA would support just changing the wording as suggested.

Ms. Nickel made a motion, seconded by Ms. Ailor, to edit the wording in the end of the question from “during the year” to “during this reporting period.” The motion passed unanimously.

d. Private Flood Coverage

The next item discussed was to add an interrogatory asking if the company writes private flood coverage outside the National Flood Insurance Program (NFIP). Mr. Haworth said if he wants to know this information, he reviews the private flood MCAS. After discussion among Working Group members and interested parties, there was no motion made to make this change.

e. Claims Closed Without Payment

The next topic discussed was to add a data element to the Claims category for reporting claims closed without payment for those that are below the deductible. Currently, claims that are for amounts below the insured’s deductible are reported as claims closed without payment, but they are not separated out from other claims closed without payment. If a data element is added, it might be necessary to exclude these from the current reporting of claims closed without payment. There was no motion to add this data element.

f. Phantom Claims

The next suggestion was a concern related to phantom claims. The current definition of a claim and the clarification instructing the insurer what to exclude was discussed. There was no motion to make edits here.

g. Claims Closed With Payment Beyond 90 Days

The next suggestion discussed was to remove claims question 26, question 27 and question 28. This would eliminate the reporting of claims closed with payment beyond 90 days. NAIC staff use the numbers reported in lines 23 through 28 to determine if the value reported on line 22 (median days to final payment) is reasonable. If elements 26 through 28 are removed, this check can no longer be done. After discussion among Working Group members and interested state insurance regulators, there was no motion to make changes here.

h. Separate Reporting for Each MGA

The next suggestion discussed was for reporting to be done separately for each managing general agent (MGA) to allow state insurance regulators to focus more attention on the MGAs that are potentially causing issues. During previous life and annuity
discussions, the Working Group decided that an interrogatory would be added to ask for a listing of third-party administrators (TPAs) that the company uses and each TPA’s function.

Mr. Gaines said that being able to identify which MGAs a company is using would be helpful.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add an interrogatory to list the names of MGAs that a company is using. The motion passed unanimously.

i. Complaints Questions in the Underwriting Section

The next suggestion discussed is to entirely remove the complaints questions in the underwriting section because companies do not seem to report the complaint counts correctly. Mr. Haworth, Mr. Arnold and Ms. Brown said they do not think it should be removed. Ms. Ailor said the location of the complaints question being in the underwriting section could be causing confusion. Mr. Birnbaum advised the complaints data and lawsuit data in other lines of business are broken out in different categories and suggested doing the same here to eliminate confusion that may exist.

Ms. Nickel made a motion to create a new category for complaints and lawsuit information and move the question that currently exists for complaints to that new category. Ms. Smith pointed out that currently the number of complaints received directly from any person or entity other than the department of insurance (DOI) is under the underwriting section, but that section is not broken out by coverage type. Data for complaints is not collected separately for dwelling, personal property, liability, medical payments and loss of use. Currently, complaints are collected as a whole, and lawsuits are collected by coverage type, so data collected for complaints and lawsuits are collected in different manners. Ms. Nickel then made a motion to move the complaint question out of the underwriting section and to the interrogatory section. Mr. Haworth asked if the data could still be pulled if the complaints were in the interrogatory section and expressed concern with consistency among other lines.

Mr. Birnbaum said if there is concern about having this question in the interrogatory section in terms of ease of access to the data, it could be kept as a data element. He said a reporting instruction could be added to report all complaints in the dwelling coverage and block out the other coverage boxes for that particular data element. Ms. Rebholz asked NAIC staff what would be the easiest option and if that was an option. Ms. Smith advised leaving the question in the underwriting section and said that adding some clarification would be the easiest solution, especially when considering looking at past data. The past data would still be in the underwriting section, and the new data would be in interrogatories if the question was moved, which is something to be aware of in considering changes here and future analysis. Ms. Brown asked if it would be easier to change the category name to “Underwriting and Total Complaints.” Mr. Birnbaum said he thinks there is a benefit to pulling out the lawsuits and the complaints data into a separate schedule as it has been done in other categories, so it is clearer that it is all complaints and all lawsuits.

Ms. Nickel made a motion to pull the two elements out for complaints and lawsuits and make one new section for complaints and lawsuits with all related questions into that category. There was no second and no changes or edits were made regarding that suggestion at this time. Ms. Rebholz advised this can be discussed in the future.

j. Fire Protection Classes

The next suggestion discussed was to add a data element to capture fire protection classes used and to collect information regarding fire protection classes that are used. Mr. Gaines said the Washington Insurance Examination Bureau conducts exams on companies for this, so Washington would not benefit from this addition. There was no interest expressed in collecting this information.

k. Terminations Triggered by Nonsufficient Funds and the Insured’s Request

The next suggestion discussed was to separate reporting of terminations triggered by nonsufficient funds and the insured’s request. There is also a suggestion to separate reporting of terminations triggered by nonsufficient funds and the insured’s request. Currently, there are two data elements for this information: 1) the number of cancellations for non-pay or non-sufficient funds; and 2) the number of cancellations at the insured’s request. There was no interest expressed in making changes here.

l. MD&A Section

The next suggestion discussed is for the addition of a Management Discussion & Analysis (MD&A) section to the MCAS. The suggestion is to add the submission of an MD&A. Insurers currently submit an MD&A document with their financial annual
statement filings. Ms. Nickel said she made this recommendation and explained why she supports this. Ms. Huisken asked if this information would be reported on a state-by-state basis. Ms. Nickel said she envisions the reporting would be on a national basis. Ms. Brown asked if there would be a different MD&A for market versus financial or if it would be a replication of what is done on financial. Ms. Nickel said it would focus on areas that would primarily affect the market, such as closed books of business and moving/shifting products from indexed annuities to variable products, use of TPAs and other general questions. Ms. Brown said she thinks this should be a separate market report on a national basis, separate from MCAS reporting since MCAS data is reported by state. Ms. Rebholz asked if Mr. Haworth could discuss this with the Market Analysis Procedures (D) Working Group to see if there was an interest there. He agreed to do so and said he does not believe it is suitable for MCAS reporting.

m. Lawsuits Closed With Consideration for the Consumer

The next suggestion discussed was to add a fifth data element to reflect lawsuits closed with consideration for the consumer and adjust wording of lawsuits to make it consistent across all lines of business. The MCAS lines of business of long-term care (LTC), disability, private flood and lender-placed have a data element for: “number of lawsuits closed with consideration for the consumer.” These were just added, along with: “number of lawsuits open at the beginning of the period,” “number of lawsuits opened during the period,” “number of lawsuits closed during the period” and “number of lawsuits open at the end of the period.” The current home and auto blanks do not have the “number of lawsuits closed with consideration for the consumer” and also refer to lawsuits as “suits.”

Ms. Brown said companies have indicated that this data is not easily captured. She said they would have to manually look at what offer was made prior to litigation in the settlement, and what payment or other thing of value would need to be added and defined to the claims handling process. Mr. Birnbaum said that in addition to the data element, the data definitions used in the other blanks should be updated to have consistency with other lines on the data elements and definitions. He also said this information is useful and can eventually be programmed into company systems.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add a data element for “number of lawsuits closed with consideration for the consumer” and to update the language from “suits” to “lawsuits” for consistency purposes. Ms. Cooper asked if the motion includes the definitions for the other lines, and Ms. Nickel said it does. The motion passed unanimously.

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

Conference Call
May 6, 2020

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 6, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Maria Ailor (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Katie Dzurec and Jeffrey Arnold (PA); Michael Bailes (SC); John Haworth (WA); and Letha Tate (WV).

1. **Adopted its Feb. 26 Minutes**

The Working Group met Feb. 26 and took the following action: 1) adopted its Dec. 17, 2019, minutes; 2) discussed the review of the life and annuity market conduct annual statement (MCAS); 3) discussed the review of the homeowners (HO) and private passenger auto (PPA) MCAS; 4) discussed vendor single interest (VSI) concerns for the lender-placed MCAS; and 5) discussed the Other Health MCAS Data Call approved by the Market Analysis Procedures (D) Working Group.

Mr. Haworth made a motion, seconded by Ms. Kroll, to adopt the Working Group’s Feb. 26 minutes (Attachment Three-A2a1). The motion passed unanimously.

2. **Received an Update on the Existing MCAS Line of Business Reviews and the Other Health MCAS Development**

Ms. Rebholz noted that due to the COVID 19 situation, the Working Group was previously asked to pause meetings. The Market Regulation and Consumer Affairs (D) Committee has since determined that the work of the Working Group is important and should move forward to avoid delays in the progress of MCAS edits and additions.

The first subject matter expert (SME) group that will now resume their work is for lender-placed VSI MCAS data reporting. Discussions on this topic will continue May 13. In January, the Consumer Credit Industry Association (CCIA) raised some concerns about the VSI products being collected with the other lender-placed business collected in the MCAS. First, the CCIA said VSI business is commercial business meant to protect only the bank. Second, VSI is written as a blanket policy prior to the consumer transactions. There are no consumer cancellations, claims, or any tracking of insurance. The CCIA also noted that the inclusion of these types of products in the MCAS would skew the numbers because they are not individually underwritten. The Center for Economic Justice (CEJ) agreed with the CCIA on the concerns about including the VSI numbers in the aggregate totals of the lender-placed insurance (LPI) filings. However, Birny Birnbaum (CEJ) made the argument that rather than exclude VSI business, it should be broken out on the MCAS blank as a separate type of LPI coverage.

The LPI VSI subgroup met March 11 and determined that VSI should be broken out and included in the MCAS. Mr. Birnbaum and Tom Keepers (CCIA) submitted recommended edits for the blank, which are posted on the Working Group web page. These will be discussed during the May 13 call. Once the SME group agrees on needed edits, they will then be sent to the Working Group for consideration.

Ms. Rebholz asked if Ms. Dzurec would like to discuss the upcoming call for the Other Health MCAS drafting. Ms. Dzurec noted that the Other Health SME group that is developing the new Other Health MCAS Blank and Data Call and Definitions will be meeting tomorrow, May 7. The Other Health drafting group had only one meeting before everyone’s focus was drawn to addressing the COVID-19 crisis. That call was regulator-only, and it was intended to allow the state insurance regulators to discuss the specifics of the recent Short-Term Limited-Duration (STLD) Data Call and produce a rough draft that could be exposed to a drafting group of state insurance regulators, consumer representatives, and industry representatives. After some discussion at the working group level, a decision was made that all drafting group calls should be open to interested parties.

After two cancellations of the drafting group conference calls, the Working Group was finally given permission to begin its work again. All interested parties who have volunteered to be on the drafting group should have received a notice of the upcoming call. If anyone did not receive the notice and would like to participate, they were advised to contact Randy Helder (NAIC).
Ms. Dzurec also noted that work will begin on the STLD portion of the Other Health MCAS Data Call and Definitions. Consumer representatives were the only stakeholders to submit comments on what was exposed in the past. Ms. Dzurec advised that if there are others who have comments on this matter, they should also provide them to Mr. Helder.

Ms. Rebholz noted that the SME group discussed Life and Annuity next. To review the results and suggestions from the Life and Annuity survey, there will be two Working Group meetings. These meetings will be held on May 20 and May 21. The discussion was turned over to Ms. Nickel who noted that a survey was conducted in 2018 asking the states to provide their input regarding needed edits to the Life and Annuity MCAS Blanks and Data Call and Definitions. Since that time, there have been SME group meetings to discuss the results, but no recommendations have been returned to the Working Group. During the last SME group call to discuss the Life and Annuity MCAS lines of business, the group discussed having each of the SMEs pick the top three issues they would like to address. No feedback from the SME group was received. In addition to the compilation of the 2018 survey results that are currently posted to the Working Group’s web page, a summarized list of issues from the Life and Annuity MCAS survey will be reviewed at the upcoming Working Group meetings to discuss the Life and Annuity MCAS lines. Possible additions, revisions and deletions for the Life and Annuity Blanks and Data Call and Definitions will be determined. The meetings to discuss this further will be May 20 and May 21 to determine what the priorities are and move forward from there. Anyone interested in reviewing the survey and providing comments were asked to do so prior to the May 20 call. Comments can be emailed to Tressa Smith (NAIC), Mr. Helder or Ms. Nickel.

Ms. Rebholz noted that two additional meetings will be held to discuss the results from the Home and Auto MCAS survey and any revisions that should be made for these lines of business. These meetings will be held on May 27 and May 28. The Home and Auto survey results were recently compiled, and they will be distributed prior to the calls. During these calls, the Home and Auto MCAS survey results will be reviewed, as well as a summarized list of the survey results. As with the Life and Annuity discussions and possible additions, revisions and deletions for the Auto and Home MCAS Blanks and Data Call and Definitions will be determined.

The meetings for both the Life and Annuity and the Home and Auto MCAS Data Calls will need to move quickly to complete the reviews and determine any needed updates within the allotted times. After completing the series of four calls, the goal is to have approved edits for all four lines of business that will be passed up to the Committee for its approval. If the review and edits are approved by the Working Group within the four calls, the June 1 deadline for proposals from the Working Group will be met. This would allow approved edits to be made applicable to the 2021 MCAS data year reported in 2022.

Materials containing the items to be discussed will be posted on the Working Group’s web page prior to the calls. Meeting notices will be sent out soon.

Ms. Nickel asked whether the revisions would go to the Committee or back to the Working Group first after the Home and Auto SME group meetings. Ms. Rebholz stated that her understanding is that the revisions would go to the Committee. Ms. Ailor asked if the changes will be exposed for a comment period. Ms. Smith explained that the calls will be at the working group level so that they are open, more transparent and documented. The Blanket VSI and Other Health lines will still be small group/SME calls, but the other two lines will be at the working group level.

3. **Considered the Private Flood MCAS Premium Threshold for Reporting**

Ms. Rebholz advised that the Working Group needs to determine a reporting threshold for the Private Flood MCAS. Last year, the Working Group and the Committee approved the Private Flood MCAS Blank and Data Call and Definitions; however, no premium reporting threshold was included in the Data Call and Definitions. Mr. Rebholz noted that to date, all other MCAS lines of business have a $50,000 premium threshold, except Long-Term Care (LTC), which has no threshold.

Mr. Haworth stated that he would be in favor of setting the threshold for the Private Flood MCAS at $50,000 to be consistent with the other MCAS lines of business. Ms. Dingus agreed. Mr. Birnbaum stated that the CEJ does not object to the $50,000 threshold, but he wanted to clarify that this amount applies to all Private Flood premium reported in the blank and that it is not $50,000 for each specific coverage, but an aggregate total of $50,000. Ms. Rebholz confirmed that this was her understanding, and if a company writes $50,000 in Private Flood coverage, they meet the premium threshold and would need to report. Lisa Brown (American Property Casualty Insurance Association—APCIA) noted that the APCIA would support the $50,000 threshold, and she agreed with Mr. Birnbaum’s suggestion that it should include all individual sub lines that were developed for the Private Flood MCAS Blanks.

Mr. Haworth made a motion, seconded by Mr. Arnold, to adopt the $50,000 premium threshold for the Private Flood MCAS. The motion passed unanimously.

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

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1. **Adopted its Dec. 17, 2019, Minutes**

The Working Group met Dec. 17, 2019, and took the following action: 1) adopted its Nov. 21, 2019, minutes; 2) discussed the review of the life and annuity market conduct annual statement (MCAS); 3) discussed the review of the homeowners (HO) and private passenger auto (PPA) MCAS; 4) discussed vendor single interest (VSI) concerns for the lender-placed MCAS; 5) discussed the other health MCAS data call approved by the Market Analysis Procedures (D) Working Group; and 6) discussed the extraordinary circumstance definition for health extension requests.

Prior to adopting the Dec. 17, 2019, minutes, Tom Keepers (Consumer Credit Industry Association—CCIA) pointed out a word change that needed to be made under item 4, in the first sentence of paragraph 5, regarding fees charged for blanket VSI by lenders. The wording was changed from “carriers” to “lenders” for his response.

Ms. Dingus made a motion, seconded by Ms. Nickel, to adopt the Working Group’s Dec. 17, 2019, minutes (Attachment Three-A2a1A). The motion passed unanimously.

2. **Discussed the Review of the Life and Annuity MCAS**

Ms. Rebholz advised that during the last meeting it was discussed that the life and annuity MCAS review subject matter expert (SME) group was being reformed to explore changes to the life and annuity MCAS blanks. These changes include not only the definitions and current data elements, but also the possible inclusion of new types of life insurance products beyond just cash value products and non-cash value products.

If interest was previously expressed in being included in this group, individuals should have received an email this week with documentation and a meeting invitation. The meeting is scheduled to take place on Wednesday, March 4, 2020. Ms. Nickel will lead this effort with the goal of having recommendations to the Working Group by June 1, 2020, if possible, but by the Fall National Meeting at the latest.

Anyone interested in participating in the group that did not receive any communication was advised to send a note to Tressa Smith (NAIC). There was no further discussion on this matter.

3. **Discussed the Review of the HO and PPA MCAS**

Ms. Rebholz said one of the Working Group’s charges for 2020 is to review the MCAS data elements and the data call and definitions for those lines of business that have been in effect for longer than three years and update them as necessary.

Volunteers for this group have come forward, but before review begins, a survey needed to be conducted to see what, if any, appetite there is for changes to the HO and auto lines of business. Market Conduct Analysis Chiefs and MCAS contacts for the states were sent a survey on Feb. 25, 2020. The collection of survey responses will run through March 20, 2020, and then survey results will be analyzed. Volunteers will then meet to determine what action needs to be taken with the results of the survey.

The goal is to have recommendations to the Working Group preferably before June 1, 2020, if possible, but by the Fall National Meeting at the latest.

Individuals interested in participating in the group that did not receive communication about it, should send a note to Ms. Smith. There was no further discussion on this matter.

4. **Discussed VSI Concerns for the Lender-Placed MCAS**
Ms. Rebholz advised that regarding the questions on the lender-placed insurance MCAS that were discussed during the Dec. 17, 2020, conference call, an SME group has been formed to discuss this. The first discussion will take place on March 11, 2020, and Ms. Rebholz will be leading the group discussions.

Individuals that expressed interest in participating should have received an email and meeting invitation from Ms. Smith on Feb. 24, 2020. Those interested in participating in the group that did not receive communication about it should send a note to Ms. Smith. There was no further discussion of this matter.

5. Discussed the Other Health MCAS Data Call Approved by the Market Analysis Procedures (D) Working Group

Ms. Dzurec said that state insurance regulators met Feb. 25, 2020, to discuss the direction and agenda for a full meeting of the other health MCAS SME group. They will meet next March 6, 2020. The other health line of business can be separated into short-term limited-duration (STLD) and mini-med-type products like limited benefits and other products that are used to create a federal Affordable Care Act (ACA) look-alike product or that are being marketed in a way that looks like an alternative ACA product. Because of the data collection needs, the SME group recommends separating this data into two separate blanks. The group will move forward with the STLD blank first, with the goal to get it done and forwarded to the Working Group in the next six weeks to meet the deadline for collecting 2021 data year STLD data in 2022 so state insurance regulators can have the information to meet legislative requests and understand their marketplace. In order to get this done within the next six weeks, comments should be provided by March 4, 2020. Comments should be sent to Randy Helder (NAIC). The MCAS blank review for the non-STLD types of products will proceed after the STLD blank review is complete, as this review will take more time.

Tanya V. Sherman (The INS Companies—INS) indicated that there was nothing in the Working Group webpage exposure drafts for interested parties to provide comments on and asked if comments should be based on the previous survey conducted. Ms. Dzurec explained that creating an exposure draft involves incorporating all considerations, so there is no wording to be considered yet; and all comments are welcome so that as many issues as possible can be factored in, in the context of an MCAS blank. She said the STLD data call that was due on Dec. 13, 2019, has information that can be reviewed for relevant information. There is also a memorandum from West Virginia dated July 27, 2018, addressed to Mr. Haworth regarding creating this MCAS blank.

Ms. Ailor said it would be helpful if the data call documents were posted on the Working Group’s web page. Ms. Smith said this information would be posted.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if the SME group has a working definition of STLD products available for review. Ms. Dzurec said there is not and that proposals for this are also welcome. Mr. Birnbaum also asked why the Feb. 25, 2020, and March 6, 2020, calls are regulator-only and why interested parties are not being asked to participate. Ms. Dzurec said the call is to pull together information for an exposure draft on a short timeline, and she explained that there is specific content regarding actual cases that states have experienced being discussed in these calls that are confidential under the state examination laws. She said the information gathered will be provided back to interested parties for feedback since right now this is still in the preparation phase. Interested parties can provide comments in preparation for the March 6, 2020, conference call. She said future calls will be open after the draft is created to be sure that all feedback is considered.

Ms. Dingus asked how often other health SME group conference calls would be discussed. Ms. Dzurec said once there is a draft to work from, calls will likely be on a weekly basis, and limited benefit calls will be more spread out.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Conference Call
December 17, 2019

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Dec. 17, 2019. The following Working Group members participated: Maria Ailor, Chair (AZ); Angela Dingus, Vice Chair (OH); Jimmy Harris (AR); Kurt Swan (CT); Scott Woods (FL); October Nickel (ID); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Jeffrey Arnold (PA); Michael Bailes (SC); Ned Gaines (WA); Jo LeDuc (WI); and Letha Tate (WV).

1. **Adopted its Nov. 21 Minutes**

   The Working Group met Nov. 21 and took the following action: 1) adopted its Oct. 23 minutes; 2) agreed to change the Market Conduct Annual Statement (MCAS) due dates occurring on weekends and federal holidays to the next business day; and 3) extended the health MCAS filing deadline for 2020, 2021 and 2022 from April 30 to June 30.

   Ms. Dingus made a motion, seconded by Mr. Swan, to adopt the Working Group’s Nov. 21 minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Seven). The motion passed.

2. **Discussed the Review of the Life and Annuity MCAS**

   Ms. Ailor said that the small group looking into changes to the life and annuity MCAS blanks will be reformed due to continued interest in this topic by some state insurance regulators and consumer representatives. The survey conducted in 2018 indicated most state insurance regulators thought the life MCAS needed to be more granular than just cash value and non-cash value products. Respondents seemed to favor variable and universal life products as the types of products they would like to have more data about. There was also a strong interest in individual pre-need, funeral and final expense life insurance. While most state insurance regulators were satisfied with the current data elements collected, there were still some suggestions for improvements. The responses were similar for the annuity blank but with less interest in more granular level beyond the fixed and variable annuities. More interest was expressed for additional data on equity indexed annuities.

   Ms. Ailor asked for volunteers to lead this small group next year with the goal of having recommendations to the Working Group preferably before June 1, 2020, if possible, but no later than the NAIC Fall National Meeting. Those interested in leading or participating in the group are to send a request to Tressa Smith (NAIC).

3. **Discussed the Review of the HO and PPA MCAS**

   Ms. Ailor said one of the Working Group’s charges for 2020 is to review the MCAS data elements and the Data Call and Definitions for those lines of business that have been in effect for longer than three years and update them as necessary. In addition to the Life and Annuity lines, she stated the private passenger auto (PPA) and homeowners (HO) lines should be reviewed. She suggested a similar survey as the one done for life and annuity be sent for PPA and HO.

   Ms. Ailor asked for volunteers to lead this group next year with the goal of having recommendations to the Working Group preferably before June 1, 2020, but no later than the NAIC Fall National Meeting. Those interested in leading or participating in the group are to let Ms. Smith know.

4. **Discussed Vendor Single Interest Concerns for the Lender-Placed MCAS**

   Ms. Ailor said that during the Market Analysis Procedures (D) Working Group meeting on Oct. 31, members heard comments from Tom Keepers (Consumer Credit Industry Association—CCIA) about blanket vendor single interest (VSI) being included in the lender-placed MCAS blank. He expressed concern that due to the way blanket VSI is written and issued, the reporting in the MCAS may be skewed and noted it is a small market with premiums only in the tens of millions nationwide. Birny Birnbaum (Center for Economic Justice—CEJ) said during that same Market Analysis Procedures (D) Working Group meeting that blanket VSI is a lender-placed insurance product that is necessary for state insurance regulators to receive data for and recommended creating a special data call and developing a separate MCAS blank for it. Ms. Ailor said the issue would be
referred to this Working Group for discussion and next steps, and in response received letters from Mr. Keepers and Mr. Birnbaum. The letters were made available to the Working Group for review.

Ms. Ailor asked if Mr. Keepers was on the conference call and would like to comment. Mr. Keepers explained that blanket VSI is a two-party, single-interest commercial insurance policy that protects the lender’s interest in the collateral against damage. He said consumers are not really engaged in the insurance transaction as no coverage is issued at point of sale, they are not a party to the lender-insurer master policy, and they are not issued individual certificates, so consumer cancellations and refunds do not apply. He explained that consumers are engaged in the lending process, not the insurance claims process, as by the time a claim is filed, the consumer has already defaulted on loan payments and the vehicle has been repossessed by the lender, such that the claim is between the lender and the insurer only. He further explained that there is not always a charge to consumers at loan closing and that he does not think the blanket VSI product should be included in the MCAS.

Ms. Ailor asked what kind of fee could be charged for this product, and Mr. Keepers said it generally ranges from $25 to $100 and sometimes higher. She also asked what kind of disclosures are provided to consumers, and he said in the lending documents, consumers are informed of this charge and their option to purchase it separately. He said the fee covers the collateral, and the lender may or may not charge the borrower.

Ms. Nickel said her understanding was that lenders always charged a fee for this type of product, and Mr. Keepers responded that there are plenty of lenders that do not charge fees for blanket VSI. She asked if insurers could track these types of claims, and Mr. Keepers confirmed they can. However, he said that this product is a commercial activity and that while it has fees that may be charged to consumers, it is a commercial product helping lenders mitigate their risks and consumers are not involved. He advised there is no forced placement and that it is just a claim filed to the insurer by the lender and that the only consumer involvement is the one-time fee at the time of the initial loan.

Mr. Birnbaum said one of the things that distinguishes VSI from other types of lender-placed insurance (LPI) is that consumers are charged for force-placed insurance regardless of whether they have a lapse of coverage or not. The other difference is how premium is calculated because rather than being based on an individual vehicle, it is based on the entire portfolio. The third difference is the absence of tracking the borrower’s insurance. He said VSI is a commercial policy issued to the lender and the insurers charge a premium to the lender, not to the borrower. The insurers are not involved in the fee charged by the lender to the borrower. It is a master policy issued to the lender and like traditional LPI, there is no individual lender or property for the underwriting. This puts consumers in a vulnerable position with no market power in the event of damage to the vehicle. Because of the differences in premium calculation and exposure count versus traditional LPI, blanket VSI and traditional LPI comparisons for underwriting, claims and suit data are not compatible and need to be reported separately. The CEJ recommends that VSI be broken out as a separate coverage within the LPI exhibit, which would enable state insurance regulators to address any problems with VSI that are raised by the CCIA.

Ms. Ailor said the Working Group needs to evaluate and decide on how to move forward, whether it be keeping the blank the same and offering further instructions and clarity as to how these products should be reported, adding it as a separate coverage in the blanks or removing it completely. Ms. Ailor asked if everyone review the comments submitted by the CEJ and the CCIA and to consider the discussion today and let Ms. Smith know if volunteers are interested in being part of the small group that will review this topic further in 2020.

5. **Discussed the Other Health MCAS Data Call Approved by the Market Analysis Procedures (D) Working Group**

Ms. Ailor said the Marketing Analysis Procedures (D) Working Group adopted “other health” as the next line of business for MCAS, and the Market Regulation and Consumer Affairs (D) Committee adopted it during the Fall National Meeting. Industry and state insurance regulators expressed concerns with how broad and ambiguous the term “other health” is, and this Working Group must carefully draft the data call so that the data elements, definitions and instructions are detailed and clear and there is no ambiguity about what is reported. Ms. Ailor said an immense amount of experience was gained from the health blank implementation. Data from the short-term, limited duration (STLD) template is available for review as a starting point.

For the “other health” MCAS blank to be successful, industry representatives, individual companies, state insurance regulators and consumer representatives participating in the group will need to be tasked with developing the draft. Ms. Ailor asked that volunteers be on the drafting group, and that those interested in leading or participating in this to notify Ms. Smith.

6. **Discussed the Extraordinary Circumstance Definition for Health Extension Requests**
Ms. Ailor said the due date for the health MCAS that was extended to June 30 for 2020, 2021 and 2022 will return to April 30 in 2023. Industry representatives made assurances that companies will not ask for individual extensions beyond June 30 except in extraordinary circumstances. Industry representatives have provided a letter with a proposed definition of “extraordinary circumstances,” and the letter has been made available on this Working Group’s web page for review.

Ms. Ailor asked if Joe Zolecki (Blue Cross and Blue Shield Association—BCBSA) would like to address the Working Group to discuss the letter, and Samantha Burns (America’s Health Insurance Plans—AHIP) said Mr. Zolecki was unable to attend the conference call and addressed the Working Group with regard to the letter on behalf of the Health Industry Interested Parties (HIIP) group. Ms. Burns stated the determination for extension request would be at the ultimate discretion and approval of the domestic state. She said the circumstances they consider to be extraordinary and outside of the carrier’s control, among other things, are the following: acts of God, mergers and requisitions, system issues, vendor issues, delayed new or modified federal Centers for Medicare & Medicaid Services (CMS) requirements, and substantive new health MCAS reporting requirements implemented by state insurance regulators.

Mr. Birnbaum stated the list of extraordinary circumstances provided by the HIIP group is far too expansive and that mergers and acquisitions are under the discretion and control of the carrier. System and vendor issues are also subject to the control of the carrier, which reinforces concerns about granting the extension for health MCAS data. He suggested that a list be specified by state insurance regulators for situations that would not qualify as an extraordinary circumstance.

Ms. Burns advised she does not believe carriers have control over the issues that arise stemming from mergers and requisitions and vendor issues and that these items should qualify as extenuating circumstances and be left up to the state to decide.

Mr. Gaines said in Washington, they receive requests extensions the day before the due date, claiming issues with collecting third-party data, even though the carrier just requested data from the vendor. Ms. Burns agreed this type of scenario should not fall under an extraordinary circumstance.

Ms. Ailor explained the extension to June 30 from April 30 has already been granted and that any additional extension is at the discretion of the state, not the domestic state, but the state in which the MCAS must be filed. Requests for extensions are addressed individually, and system issues, vendor issues and the laborious tasks sometimes associated with collecting information from third parties are some of the reasons that the extension to June 30 was granted.

Ms. Burns asked if there would be a vote on this definition, and Ms. Ailor said she does not believe a vote is needed. Randy Helder (NAIC) confirmed a vote is not necessary as the decision to extend beyond June 30 is ultimately up to the state that is receiving the filing.

7. Discussed Any Other Matters Brought Before the Working Group

Ms. Ailor advised she is stepping down as Working Group chair. She said Arizona will still be a member of this Working Group and that anyone interested in learning more about the chair role is asked to contact the NAIC, Mr. Helder, Ms. Smith or Ms. Ailor directly.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 21, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Crystal Phelps (AR); Sara Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Teresa Kroll (MO); Angela Dingus (OH); Katie Dzurec (PA); Michael Bailes and Rachel Moore (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating was: Sarah Crittenden (GA).

1. Discussed Annuity MCAS Survey Results and Possible Edits to the Blanks and Data Call and Definitions

Ms. Rebholz noted that the focus of this call is possible edits to the Annuity MCAS Blanks Data Call and Definitions. The results of the 2018 survey results are posted on the Working Group web page. In addition, a summary of items in the survey for this discussion is included in the materials for this call. The items highlighted in gray are related to the Market Conduct Annual Statement (MCAS) Market Analysis Prioritization Tool (MAPT) rankings and ratios, and they will be discussed by the Market Analysis Procedures (D) Working Group. These items are being passed along to Mr. Haworth for the Market Analysis Procedures (D) Working Group to discuss.

The Working Group should come to consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. Some issues may not be easily resolved, and they may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. Ms. Rebholz noted that Ms. Nickel would lead the discussions today, and she explained that time would be allowed for comments on each item discussed.

Ms. Nickel noted that many of the topics discussed yesterday for the Life MCAS would also apply to the Annuity portion of the MCAS and would be discussed to see if similar changes should be made. The survey results and possible edits specific to the Annuity MCAS will then be reviewed.

a. The first item discussed was to review the changes made to the Life MCAS on yesterday’s call and determine if the same changes should apply to the Annuity MCAS.

i. The first change discussed was adding a data element requesting the number of policies surrendered with a surrender fee. Mr. Haworth expressed an interest in making this change. Ms. Crittenden agreed. Mr. Swan asked if the same 10 year and over methodology would be applied here. Ms Nickel explained that the number of policies surrendered greater than 10 years from policy issue date was added to the Life MCAS, and she asked if there was also an interest in making this change on the Annuity line, explaining that this would be two separate additions. One addition would be for the number of policies surrendered with a surrender fee and one would be for the number of policies surrendered greater than 10 years from the policy issue date.

ii. The next item of discussion was to add an interrogatory asking the company to identify all third-party administrators (TPAs) the company uses and their function.

iii. The next suggestion was to add the following data elements related to lawsuits: 1) the number of lawsuits open at the beginning of the period; 2) the number of lawsuits opened during the period; 3) the number of lawsuits closed during the period; 4) the number of lawsuits closed during the period with consideration for the customer; and 5) the number of lawsuits open at the end of the period.

Ms. Nickel asked if there were any comments regarding the above changes being made to the Life MCAS and applying them all to the Annuity MCAS. Birny Bimbaum (Center for Economic Justice—CEJ) asked whether the intent was to add the interrogatory about TPAs for both Life interrogatories and Annuity interrogatories or to get one set of interrogatories regarding TPAs. Randy Helder (NAIC) noted that there would be a TPA question for the Life blank and then a separate TPA question for the Annuity blank in the interrogatories for both.
Mr. Haworth made a motion, seconded by Ms. Nickel, to add the data elements and interrogatory additions discussed here that were added to the Life MCAS yesterday to the Annuity blank. The motion passed unanimously.

b. The next item discussed was having internal and external replacements further defined, and possibly adding another category for external replacements for those that are replaced by another company within the same group of companies. Tanya Sherman (The INS Companies) asked for clarification on this topic.

Mr. Birnbaum noted that the blank defines internal replacement as being issued by your company and an external replacement as being issued by another company. There probably needs to be some clarification on what “another company” means. It can mean another insurer outside of your group, or it can mean another company within your group if you have multiple companies issuing annuities. Mr. Birnbaum would not want to categorize a replacement by another company within the group as an external replacement, as that appears misleading. He noted that it may be helpful to break down external replacements into two data elements; one could be when a policy or annuity is replaced and was issued by a company unaffiliated with your company, and the other could be an external replacement issued by another company that is affiliated with your company. The internal replacement would stand.

Ms. Rebholz noted that one of the suggestions along this line was to add a separate field to report a sister company replacement to help identify if churning may be occurring. Ms. Nickel asked if anyone wanted to move to add an additional level of detail regarding affiliated or unaffiliated company relationships on replacements. Mr. Haworth asked whether a motion made here would be consistent for the Life MCAS too. Ms. Nickel said that would be appropriate.

Mr. Haworth made a motion, seconded by Mr. Swan, to make the changes as discussed and clarify the external versus internal replacements including affiliated companies.

Mr. Birnbaum noted that the definition for internal replacement is described as a replacement by your company, and the current definition for external replacement is described as being issued by another company. He asked if the proposal is to retain the current definition of internal replacement and then to create two data elements for external replacement where one refers to another company affiliated with your company and then the second definition would be issued by another company unaffiliated with your company. Mr. Helder noted that his understanding of Mr. Haworth’s motion is to add a separate field to identify external replacements to an affiliated company, and he believes Mr. Birnbaum is asking if there would be a commensurate definition in the data call and definitions. Mr. Haworth confirmed that the definitions would have to be added, as there is a data field that will need to be explained and clarified. Ms. Nickel asked for clarification about whether external would be broken out into two separate definitions and internal would remain the same as a replaced policy. Mr. Helder said that is correct, and one more data element for external replacements would be added for affiliated companies and the definitions would be revised to explain what that means.

Ms. Phelps asked if all companies would understand what the term affiliated means. Mr. Birnbaum noted that the term affiliated is standard in the insurance industry, and when companies file their annual statement, they complete an organizational chart showing any affiliations. He believes that it is a straightforward term.

Ms. Nickel made a motion, seconded by Mr. Haworth, to add these additional data elements and definition pieces clarifying the external versus internal replacements to the Life MCAS blank as well. The motion passed unanimously.

c. The next item of discussion was the granularity of annuity reporting. Mr. Gaines expressed an interest in pulling out the variable annuity product data.

Mr. Birnbaum noted that the current MCAS breaks annuities into fixed and variable categories. The fixed category includes immediate fixed, deferred, qualified longevity annuity contract, and indexed annuities. The data includes experiences for very different product types sold to different types of consumers, sold by different types of producers in different markets. Variable annuities currently include variable; traditional variable; fixed variable; indexed variable, now called buffered annuities; and contingent deferred annuities. Mr. Birnbaum suggested breaking out the annuities into more granular categories to assist in a more useful and detailed market analysis.
Mr. Haworth noted that it looks like only 10 people responded to this topic on the survey and 22 people did not respond, and he asked if that was correct. Tressa Smith (NAIC) confirmed that as correct, and she said survey participants were not required to respond to these questions. The first part of the survey had a question that asked if it would be beneficial to have data broken down into a more granular level. Eleven people said yes, and 11 people said no. Of the 11 people that indicated that they would like more granularity, 10 of those then said they would like more granularity on this category. Mr. Haworth asked if Working Group members would like more granularity here. Mr. Gaines noted that he is interested in additional data on the variable side, specifically variable indexed annuities, and not as much on the fixed side. Mr. Birnbaum suggested categories for variable annuities of indexed variable and all variable annuities other than indexed. Then, the same thing could be done for fixed, having fixed-indexed annuities and all fixed annuities other than fixed-indexed annuities. This would add two additional categories.

After some discussion among the Working Group, Ms. Rebholz asked if there was a motion to make changes here. She explained that currently all fixed annuities are in one bucket and all variable annuities are in the other. The idea is to break out fixed annuities into fixed-indexed and all other fixed annuities, and then break out the all variable bucket into indexed variable and all other variable.

Mr. Haworth made a motion, seconded by Mr. Swan, to add the additional lines as discussed. The motion passed unanimously.

Ms. Nickel asked if there was any interest from the Working Group regarding adding additional levels of granularity here, such as immediate fixed annuities and deferred fixed annuities. There were no comments expressed to make additional changes here.

- The next topic discussed was the suggestion of adding a definition of in-force. There was no interest in making this addition to the Annuity MCAS.

- The next topic discussed was a comment regarding death claims closed with payment that does not fit for annuities, so this was not discussed.

- The next item discussed was the suggestion to collect information based upon contract state and resident state. There was no interest in making this addition to the Annuity MCAS.

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

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The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 20, 2020. The following Working Group members participated: Rebecca Rebholz, Chair (WI); October Nickel, Vice Chair (ID); Jimmy Harris (AR); Sara Borunda (AZ); Kurt Swan (CT); Scott Woods (FL); Lori Cunningham (KY); Paul Hanson (MN); Teresa Kroll (MO); Angela Dingus (OH); Jeffrey Arnold (PA); Rachel Moore (SC); Ned Gaines and John Haworth (WA); and Letha Tate (WV). Also participating was: Sarah Crittenden (GA); and Karen McCallister (NH).

1. Discussed Survey Results and Possible Edits to the Life MCAS Blank and Data Call and Definitions

Ms. Rebholz noted that in 2018, a survey was sent to state Market Analysis Chiefs and Market Conduct Annual Statement (MCAS) contacts to get their input regarding possible updates to the Life and Annuity MCAS. The results of the survey are posted on the Working Group’s web page. In addition, a summary of the items in the survey for this discussion is included in materials for this call. The items highlighted in gray are related to the MCAS Market Analysis Prioritization Tool (MAPT) rankings and ratios, and they will need to be discussed by the Market Analysis Procedures (D) Working Group. These items are being passed along to Mr. Haworth for the Market Analysis Procedures (D) Working Group to discuss. Tomorrow, the Annuity MCAS Blank and Data Call and Definitions will be discussed.

The Working Group should come to a consensus and vote on needed edits prior to the June 1 deadline for changes that would apply to the 2021 data year. Some issues discussed today may not be easily resolved, and they may require more in-depth consideration and review. If such an issue arises, it may be necessary to table it for a future discussion. Ms. Rebholz noted that Ms. Nickel would lead the discussions today, and she explained that time would be allowed for comments on each item discussed.

Ms. Nickel started by thanking the Center for Economic Justice (CEJ) and the American Council of Life Insurers (ACLI) for the comments submitted to the Working Group. Messages were also received in support of the CEJ comments. These letters of support were from Brendan Bridgeland (Center for Insurance Research—CIR), J. Robert Hunter (Consumer Federation of America—CFA), and Professor Ken Klein (California Western School of Law). Some CEJ comments were related to the frequency of MCAS data submissions. These comments will be shared with the Market Analysis Procedures (D) Working Group chair and vice chair for inclusion in its upcoming meetings. The CEJ, the ACLI, and other interested parties will be able to provide input on all edits discussed today.

During the last subject matter expert (SME) call, in which possible edits to the Life and Annuity MCAS were discussed, participants were asked to review the survey responses in detail and bring back their top three selections for changes to the next meeting. In the responses received from Working Group members, there was no consensus regarding the level of granularity needed. There was mention of adding some data elements to the Life MCAS blank.

   a. The first item discussed was the level of reporting granularity for the Life blank. In Attachment 1 of the meeting materials are the survey results related to Life granularity. It is a percentage based on each different coverage line. There were comments made for additional areas that were not identified in that coverage by line of business or coverage type. The comments were related to credit and other products with no cash value, preneed, final expense, and funeral contracts. The ACLI provided a basic overview with differences related to those types of products, specifically for final expense and preneed products. Ms. Nickel asked if Working Group members had an interest in pulling out preneed and final expenses. She noted that the credit line was already rejected by the Market Analysis Procedures (D) Working Group for a new line of business for the Market Conduct Annual Statement Blanks (D) Working Group to work on. Therefore, this will also need to be brought back up with the Market Analysis Procedures (D) Working Group for it to be the Market Conduct Annual Statement Blanks (D) Working Group’s charge to discuss the credit line of business.

   Tanya V. Sherman (INS Companies) noted that it is challenging when conducting analysis when these unique products are mixed in with other lines, and she felt that it would be nice to break these out. Ms. Nickel asked for clarification about whether Ms. Sherman meant these products should be separated or they could be grouped into one. Ms. Sherman felt that they could be grouped into one category.
Birny Birnbaum (CEJ) noted that there are two reasons to segregate preneed and final expense. One would be because you have an interest in consumer outcomes for a specific product. The second is that you do not want consumer outcomes in a specific product line to muck up the data for other product lines that you have an interest in. Mr. Birnbaum noted that both instances for preneed and final expense warrant separation from the current overly aggregated categories of cash and non-cash values. He believes that during prior calls, industry stakeholders expressed that preneed was significantly different than final expense, and he felt that these comments should be reviewed so they are not aggregated together.

Ms. Nickel noted that it did not appear that there was a large consensus to make changes here, but it would be beneficial in some respects to pull apart the preneed and final expense. Based on the comments made, there does not appear to be enough interest to make these changes now. Ms. Rebholz agreed, and she asked if there was a motion from the Working Group members to break out individual preneed and final expense to the Life MCAS reporting blanks. There was no motion made.

Mr. Bridgeland noted that he has reviewed this and looked at what information can be gathered by consumers, academics and consumer organizations. It used to be that in the annual statement, you could gather some basic information about generally smaller face value life insurance policies because they fell into the industrial life policy category. Now, however, because of the way it is defined, there is no information reported and industrial life does not exist as its own category. Over the years there have been changes in terms of what information is available about certain types of life insurance products that you used to be able to segregate from the financial data, which you can no longer do because of the way industrial life has been defined and classified over the years. Mr. Bridgeland noted that there is a gap here because state insurance regulators used to be able to pick up information from annual statement reporting, but it is missing now. He feels that market conduct assessment would help because as a consumer advocate, when he hears from families or funeral service directors, it is commonly related to preneed and burial policies. From a consumer perspective, he believes it is important; and he wants to note that because of changes over the years, there is a gap in data available to state insurance regulators and consumers.

Monica Sole (Lincoln Heritage) noted that one of the problems Lincoln Heritage faces is that there is only one line of business for Lincoln Heritage and it is final expense. Final expense is not defined by the NAIC or any state insurance regulator, and it is not the same as preneed. Ms. Sole asked how bigger companies would report what is final expense policy is and what is not since it is just a way of marketing a small face policy and there is no definition. She asked if large companies would report differently based on the face value of a policy. She feels that it should be separated from preneed, as it is its own line of business.

Mr. Birnbaum noted that the March 4 letter from the ACLI outlines the difference between final expense and preneed. Final expense is a whole life policy that is marked as final expense, and preneed is a whole life policy used to prepay a funeral on a contingent assignment. Preneed could be easily defined as a contractual relationship. To separate out final expense, you could segregate it as a whole life policy marketed for final expense. Mr. Birnbaum feels that this would be a straightforward way of doing it, as a company knows if they are marketing something as final expense or not.

Ms. Nickel agreed that companies generally would know what their different product lines are and how to properly file them. Ms. Rebholz asked if anyone from the Working Group wanted to make a motion to add this endowment coverage to the Life MCAS reporting. There was no motion made.

b. The next item of discussion was Individual Universal Life Insurance and Individual Variable Universal Life Insurance. There was no interest from the Working Group or any state insurance regulators to segregate Universal Life products.

Mr. Birnbaum noted that for most of these product lines, there is a different market and a different target population. There have been different types of market problems associated with that. If you look at traditional universal life, there have been problems with companies that promise vanishing premium, and now consumers are being faced with extraordinary premium. With indexed universal life (IUL), there is a different set of issues with unrealistic or misleading illustrations or hidden fees. If you aggregate all of this into cash value products, there is no way to distinguish what is happening with whole life versus universal life versus IUL versus variable life; as a result, the market analysis is ineffective. A company that might be an outlier if you were looking at IUL does not show up as an outlier because that experience is hidden through aggregation with other products. Mr. Birnbaum believes that the pandemic illustrates why there is a problem. People are now being marketed certain products, claiming that they can
be protected in the event if a market turndown; yet, there is no way to see what is going on in the marketplace in the aftermath of the pandemic. For those reasons, CEJ suggests not only a breakout for universal life separate from IUL, but also a break-out for variable life and whole life as part of the cash value breakouts. Ms. Nickel asked if anyone else has comments to add, and there were none. There was not enough interest here to make changes to Universal Life.

Ms. Nickel then asked for comments on Individual Variable Universal life. Mr. Birnbaum noted that he believes there should be a break-out here as well. Ms. Sherman noted that she was looking at Attachment 1 that has the survey notes for the Life MCAS, and she asked for clarification on the percentages. Tressa Smith (NAIC) noted that the survey results are on the webpage, and they are more than just the summaries for anyone that would like to review them in more detail. There were 32 responses; 19 of those answered that yes, they would like additional break outs for more granularity for the Life MCAS. The percentages shown are from the 19 people that answered yes as to what they would find beneficial. Mr. Birnbaum further expressed his support for breaking these lines out further to assist with a more detailed market analysis. Ms. Rebholz encouraged Working Group members to speak up on these matters to have a good understanding of how they feel about making changes to each item as the call progresses. She asked if there was a motion to make any changes to the Individual Universal Life and individual variable universal life, and there were none.

c. Ms. Nickel noted that the next topic to discuss is Individual Term Life Insurance with no Cash Value and Other Individual Life Insurance with no Cash Value. She asked if any Working Group members have an opinion or interest to include Individual Term Life Insurance with no Cash Value and Other Individual Life Insurance with no Cash Value as a separate line. Mr. Gaines noted that he does not feel that this needs to be broken down further. There were no comments by interested state insurance regulators or interested parties made on this topic. There was no motion to make changes here.

d. The next topic discussed was Individual Equity Indexed Life Insurance products. There were no comments from Working Group members, other state insurance regulators, or interested parties with an interest to break this product line out, so no motions were made to make changes here.

e. The next item discussed was whether there is an interest in separating Individual Whole Life Insurance and Individual Variable Life Insurance. Mr. Gaines noted that based on the survey, if there is a specific line that has a clear number of states in the majority, the group should consider making changes. Ms. Nickel noted that the 19 people who indicated that they would like to see changes represented 15 states, which did not seem to represent a significant enough interest from the majority. She explained that in future surveys, it may need to be a requirement for the states to answer these kinds of questions to have a better understanding of all the states. There were no other comments from Working Group members, other state insurance regulators, or interested parties on this topic, and no motion to make changes was made here.

f. Ms. Nickel noted that the next item of discussion is regarding comments received on surrenders. She asked if any Working Group members want to discuss surrenders being broken out by years and how that would be useful. She asked what the current options are, and Teresa Cooper (NAIC) noted that the options are contracts surrendered under two years of issuance, between two and five years of issuance, and between six and 10 years of issuance. Ms. Nickel asked if there was any interest in modification to these timeframes.

Mr. Birnbaum suggested adding an option for 10 years or longer. Ms. Crittenden noted that she supports adding the option for 10 years or longer, and she expressed interest in knowing about surrender fees. Ms. Nickel asked if she had a proposal regarding surrender fees. Ms. Rebholz noted that there was a suggestion in the survey that suggested adding a data element to collect the number of policies surrendered where a surrender fee was applied. She noted that the questions for the Working Group to decide are: 1) whether it would be useful to know how many policies were surrendered; and 2) of those surrendered, how many had a surrender fee applied.

After some discussion among Working Group members, Mr. Haworth made a motion, seconded by Ms. Nickel, to collect the number of policies surrendered where a surrender fee was charged. The motion passed unanimously.

Mr. Haworth asked if adding the option for contracts surrendered past 10 years is going to be discussed further. After some discussion, Ms. Nickel made a motion, seconded by Mr. Woods, to add the option for contracts surrendered beyond 10 years. The motion passed unanimously.
g. Ms. Nickel noted that there was feedback received for in-force contracts and definitions needing more clarity. There was dialogue in the survey regarding policies taken and not taken. Ms. McCallister noted that she was the one that made this comment, as she had several companies that were not including their non-taken, and she found it odd that some companies are including non-taken while some are not. She believes that since it is a formal offer, they should be included, and she is looking for clarity here. There was no interest from other call participants to make changes here, so this subject has been tabled for future discussions if filing discrepancies continue to be a concern. Ms. McCallister noted that the next matter up for discussion on adding data elements to both Individual Cash Value Policies and Individual Non-Cash Value Policies could be disregarded, as she was referring to the financial annual statement and the comment does not apply here, so there is no need to discuss it.

h. Ms. Nickel noted that the next item to discuss is the Individual Cash Value Policies related to nonforfeiture. She noted that this relates to the surrender topic discussed earlier on this call, and even though the surrender and nonforfeiture options are different, this could be clearer with the changes being made to the surrender data. She asked if additional separation here is necessary or if the surrender changes agreed on would suffice. Mr. Haworth agreed that with the changes being made regarding surrender fee data, clarity for nonforfeiture is also gained. There were no additional comments here, so no changes will be made.

i. Ms. Nickel noted that the next topic to discuss is the comment made regarding the Life interrogatories and whether it would be valuable information to include third-party administrator (TPA) information. The comment suggested requesting whether the company utilizes a TPA for the line of business, the name(s) of the TPA, and what the TPA does. Mr. Haworth noted he could see merit with this request because this also came up in the short-term limited-duration (STLD) data call as a topic people wanted to be aware of. He advised it would probably need to be an interrogatory that says whether a TPA is utilized to list the name and for what function.

Mr. Haworth made a motion, seconded by Ms. Nickel, to collect TPA information on an interrogatory and the functions that they carry out. The motion passed unanimously.

Mr. Birnbaum noted that the reporting here is limited to individual coverages, as group coverages are not provided. He asked whether the question about TPAs is intended to relate to the use of TPAs for individual coverages or if it is a broad application question. Mr. Haworth noted that for this context, it would just be for individual business; however, by being able to track it this way, they can see who these companies work with.

j. The next item discussed was for a comment received that stated the following: “We find that most companies do not have comments about being a potential outlier because they do not have any basis for comparison to state and national averages at the time of their filing.” Ms. Nickel asked if the person who made the comment was on the call and available to elaborate on this. There was no response. Ms. Nickel noted that the score cards are available for everyone to review, including insurance companies and consumers; and even at an individual state level, carriers have the ability to review where they fall and review trends over periods of time to determine what kind of outliers they may have. She asked if anyone else had comments. Mr. Haworth noted that he believes this is more of an educational comment, as he has had to assist various parties by showing them the tools available to find information on potential outliers. There were no changes to be made here.

k. Ms. Nickel noted that the final comment regarding the Life MCAS interrogatories supports the incorporation of illustration certification fields. She asked that Working Group members interested in this topic provide further clarification on this request by email to Randy Helder (NAIC) or other NAIC staff to get a better idea of what is being asked for.

l. Ms. Nickel noted that there were some questions on definitions for data being reported by a resident state or an issue state. She advised that this should fall in line with what is used in the Financial Annual Statement (FAS). For example, if you issue a policy to a resident of the state of Idaho, then it is an Idaho policy. Ms. Nickel asked that anyone interested in elaborating on this topic further email their comments and feedback to her, Mr. Helder, Ms. Smith or Mr. Haworth.

m. The next item discussed was the proposal from the CEJ. Mr. Birnbaum has suggested edits to the MCAS related to lawsuit questions that are asked within the Life, Annuity, Home and Auto MCAS blanks. His suggestion is to make the lawsuit questions consistent across all lines of business. The current life and annuity lines of business do not contain information related to lawsuits. The other lines of business include the number of lawsuits open as of the end of the period, the number of lawsuits opened as of the beginning of the period, the number of lawsuits opened during the
period, and the number of lawsuits closed during the period in total. With exception of Homeowner and Private Passenger Auto, the other lines also include a data element to collect the number of lawsuits closed during the period with consideration for the consumer. It needs to be determined whether lawsuit data collection is an addition that should be made to the Life MCAS Blank.

Mr. Birnbaum noted that all MCAS blank lines have data elements related to lawsuits except life and annuity, and all recent MCAS blanks have five lawsuit data elements: 1) the number of lawsuits open at the beginning of the period; 2) the number of lawsuits opened during the period; 3) the number of lawsuits closed during the period; 4) the number of lawsuits closed during the period with consideration for the consumer; and 5) the number of lawsuits open at the end of the period. He suggested that these data elements be added to the life blanks. Ms. Nickel made a motion, seconded by Mr. Arnold, to add these lawsuit elements to the life MCAS. The motion passed unanimously.

n. Ms. Nickel noted that Mr. Birnbaum has also suggested new data elements to address accelerated life underwriting. With accelerated life underwriting, insurers use credit scores, facial analytics, and other non-medical data to underwrite applicants and price policies. Mr. Birnbaum has suggested a definition of accelerated underwriting and several interrogatory questions asking whether a company utilizes accelerated underwriting, on what products, and what data sources and vendors they use, to replicate the underwriting questions to answer specifically for accelerated underwriting. For example, in addition to asking for the total number of policies issued, we would also ask for the total policies issued utilizing accelerated underwriting. Ms. Nickell said she sees the benefits with this.

David Leifer (ACLI) asked if there is a definition of accelerated underwriting that would be used. Mr. Birnbaum stated that they proposed a definition and explained that historically, life insurers have relied on information provided by consumers and medical information through blood tests, family histories, and things of that nature. In the last five years, life insurers have started predictive modeling, and they are projecting mortality using non-medical third-party data sources. The reason the CEJ is making these suggestions is that this is a qualitatively different approach to underwriting and sales than has been done in the past. In some ways, it is an almost completely digital process as opposed to a traditional, in-person and hands-on process. There may be different consumer outcomes when there is information being used that the consumer is not aware of and has no idea how that information is being used. There is not much information that state insurance regulators have about accelerated underwriting outcomes in the marketplace right now.

The suggestion from the CEJ is that there be some additions to the life blank related to accelerated underwriting, starting with the definition of accelerated underwriting meaning underwriting and pricing of life insurance in whole or in part on non-medical data obtained from other than the applicant or policy holder and includes, among other things, facial analytics, social media, and consumer credit information. The CEJ also suggests adding interrogatories: 1) whether the company uses accelerated underwriting for life insurance; 2) whether the company uses accelerated underwriting for life insurance and for what product categories it is used; and 3) whether the company uses accelerated underwriting for life insurance and a list of the data sources used and vendors supplied, the data, or the algorithm. The CEJ also suggests that the specific underwriting data elements have an addition for the total number of new policies issued by the company during the period utilizing accelerated underwriting, so state insurance regulators could get some sense of how much accelerated underwriting is being used and what portion of the book of business is developed using accelerated underwriting.

Mr. Haworth asked if this information could be reviewed as possible data elements to see what this looks like when trying to capture this information, as he believes that there is some merit to this request. Ms. Rebholz asked if he was suggesting a mock set of blanks for review. Mr. Haworth confirmed that that is what he is suggesting. Ms. Rebholz agreed. Mr. Birnbaum noted that he would provide the mock set of data elements related to accelerated underwriting for review if that would be helpful. Ms. Nickel agreed.

Mr. Leifer noted they are not allowed to change rates after policies are issued, nor do they generally use rating models. He stated that there is no good definition of accelerated underwriting, and life insurance companies have used things like credit and other non-medical information for decades. He believes that this is an extremely complicated topic, and he noted that the NAIC has a working group dedicated to looking at life insurance and accelerated underwriting. He feels that this level of granularity could be premature. Ms. Nickel noted that reviewing the mock set of data elements and then having further discussion about it would be a good place to start, but it may need to be tabled for another year. Ms. Rebholz agreed and explained that the working group already working on this topic may need to be consulted once this is reviewed further.
Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
Market Conduct Examination Standards (D) Working Group Conference Call July 23, 2020

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met July 23, 2020. The following Working Group members participated: Bruce R. Ramge, Chair, Laura Arp and Reva Vandevoorde (NE); Russell Hamblen, Vice Chair (KY); Mel Heaps and Crystal Phelps (AR); Sarah Borunda and DeLon Price (AZ); Damion Hughes (CO); Kurt Swan (CT); Cheryl Wade (DC); Doug Ommen and Lindsay Bates (IA); Erica Weyhenmeyer (IL); Mary Lou Moran (MA); Jill Huisken (MI); Paul Hanson (MN); Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman (NJ); Laura Baca and Leatrice Geckler (NM); Sylvia Lawson (NY); Nick Stosic and Peggy Willard-Ross (NV); Rodney Beetch, Rick Campbell and Todd Oberholtzer (OH); Landon Hubhart and Shelly Scott (OK); Brian Fordham (OR); Katie Dzurec and Gary Jones (PA); Julie Fairbanks and Landon Hubbart (WV); Katie Dzurec and Gary Jones (PA); Julie Fairbanks and Bryan Wachter (VA); Christina Rouleau (VT); Ned Gaines and John Haworth (WA); and Barbara Belling, Darcy Paskey and Rebecca Rebholz (WI).

1. **Heard Opening Comments**

Director Ramge welcomed returning Working Group members and a new member state, Illinois, represented by Ms. Weyhenmeyer. Changes in Working Group member state representation since the Working Group’s last meeting include New Mexico, represented by Ms. Baca and Ms. Geckler, and Ohio, represented by Mr. Oberholtzer. Director Ramge said that the Working Group has not met since March 4, due to the COVID-19 pandemic, and is now resuming scheduled conference calls. Director Ramge said that he wishes to keep state insurance regulators’ many commitments related to COVID-19 in mind and to make sure that Working Group members, interested state insurance regulators, subject matter expert (SME) volunteers and any other parties are not overwhelmed with any workload arising from Working Group calls. Director Ramge asked the Working Group and interested state insurance regulators to reach out to him if that is the case, now, and as the Working Group moves forward on its tasks throughout the year.

2. **Adopted its March 4 Minutes**

The Working Group met March 4 and took the following action: 1) continued discussion on draft limited long-term care insurance (LTCI) examination standards for inclusion in the Market Regulation Handbook (Handbook), which was a carryover item from 2019; 2) began discussion of a new inland marine in force policies standardized data request (SDR) and an inland marine claims SDR for incorporation into the reference documents of the Handbook; and 3) discussed the 2020 Working Group charges and potential tasks, which may include, but are not limited to, updating NAIC SDRs and revising the Handbook with updated examination standards corresponding to recent amendments to Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), the amendments adopted in February to the Suitability in Annuity Transactions Model Regulation (#275) and monitoring the planned activity of the MHPAEA (B) Working Group, as one of its charges is “to provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.”

Mr. Haworth made a motion, seconded by Mr. Swan, to adopt the Working Group’s March 4 minutes (Attachment Four-A). The motion passed unanimously.

3. **Adopted the Dec. 11, 2019, Draft of New Limited LTCI Examination Standards Chapter for Inclusion in the Handbook**

Director Ramge said that the draft limited LTCI examination standards were developed by state insurance regulator SMEs for the Working Group’s review, discussion and consideration of adoption for inclusion as a new market conduct examination standards chapter in the Handbook. The draft standards were initially exposed Oct. 29, 2019, for public comment and have been discussed during the Working Group’s Nov. 20, 2019, Dec. 18, 2019, and March 4, 2020, meetings.

Director Ramge said that the limited LTCI examination standards draft was revised by Ms. Moran and redistributed on Dec. 11, 2019, to Working Group members, interested state insurance regulators and interested parties for the Working Group’s Dec. 18, 2019, meeting. He said that Ms. Vandevoorde indicated during that meeting that the revisions made by Ms. Moran addressed the issues raised in Ms. Vandevoorde’s Dec. 3, 2019, comments.
Director Ramge said the Dec. 11, 2019, exam standards draft was discussed during the Working Group’s March 4 meeting, and the Working Group decided not to adopt the draft at that time since it was the first Working Group meeting of 2020. Director Ramge said the draft that was circulated for the July 23, 2020, meeting is identical to the Dec. 11, 2019, draft, except for the attachment numbering and the copyright date.

Mr. Swan made a motion, seconded by Mr. Pyle, to adopt the Dec. 11, 2019, draft limited LTCI examination standards chapter for inclusion in the Handbook (Attachment XXXXX). The motion passed unanimously.


Director Ramge said the draft inland marine in force policies SDR and the draft inland marine claims SDR, which were circulated Feb. 24, were developed by state insurance regulator SMEs for the Working Group’s review, discussion and consideration of adoption. Director Ramge said the drafts were discussed for the first time during the Working Group’s March 4 meeting. No comments had been received on the drafts.

Mr. Hamblen made a motion, seconded by Mr. Haworth, to adopt the Feb. 24 draft inland marine in force policies SDR and the inland marine claims SDR for incorporation into the reference documents of the Handbook (Attachment XXXXX). The motion passed unanimously.

5. **Discussed Other Matters**

Mr. Hamblen said additional SDRs the Working Group plans to work on in 2020 includes, but are not limited to, LTCI, title insurance and business owners policy (BOP).

Director Ramge said that two state insurance regulator volunteers have been tasked with reviewing the Handbook with regard to recent amendments to Model #170, and they will report during the next Working Group meeting on what corresponding changes may need to be made to the applicable chapters of the Handbook.

Director Ramge said that with regard to the February amendments to Model #275, Director Ommen, chair of the Annuity Suitability (A) Working Group, has asked the Market Conduct Examination Standards (D) Working Group to wait before proceeding to update the “Conducting the Life and Annuity Examination” chapter in the Handbook until the Annuity Suitability (A) Working Group has completed its current draft Annuity Suitability Q&A document.

Ms. Arp said that the Working Group had drafted a new Mental Health Parity and Addiction Equity Act (MHPAEA) chapter for the Handbook in 2018 (Chapter 24B—Conducting the MHPAEA Related Examination); the chapter was a combined work product resulting from Working Group members, federal agencies that enforce MHPAEA and industry working together to develop numerous revisions during the comment process, and the draft that was ultimately adopted by the Working Group, the Market Regulation and Consumer Affairs (D) Committee and the Executive (EX) Committee and Plenary. Ms. Arp said the U. S. Department of Labor (DOL) has included a reference to the Handbook’s MHPAEA chapter in its 2020 revision of its Self-Compliance Tool.

Director Ramge said that with regard to the MHPAEA (B) Working Group’s charge “providing supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook,” he will be looking for guidance and support from the Market Regulation and Consumer Affairs (D) Committee and the Health Insurance and Managed Care (B) Committee leadership to see how the Working Group and the MHPAEA (B) Working Group should coordinate their efforts to create additional examiner guidance, as the DOL continues to update its MHPAEA guidance and compliance tools, keeping in mind that the Market Conduct Examination Standards (D) Working Group does not create policy; the Working Group creates examiner guidance to support policy created by DOL. Ms. Dzurec, chair of the MHPAEA (B) Working Group said that she would welcome communication and coordination between the two working groups, since having a clearly defined direction regarding what type of guidance is to be developed by which working group would provide more clarity to MHPAEA examiners, as well as regulated entities.

Director Ramge said that with regard to the MHPAEA (B) Working Group’s charge “providing supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook,” he will be looking for guidance and support from the Market Regulation and Consumer Affairs (D) Committee and the Health Insurance and Managed Care (B) Committee leadership to see how the Working Group and the MHPAEA (B) Working Group should coordinate their efforts to create additional examiner guidance, as the DOL continues to update its MHPAEA guidance and compliance tools, keeping in mind that the Market Conduct Examination Standards (D) Working Group does not create policy; the Working Group creates examiner guidance to support policy created by DOL. Ms. Dzurec, chair of the MHPAEA (B) Working Group said that she would welcome communication and coordination between the two working groups, since having a clearly defined direction regarding what type of guidance is to be developed by which working group would provide more clarity to MHPAEA examiners, as well as regulated entities.

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur in late August or early September.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
Market Conduct Examination Standards (D) Working Group
Conference Call
March 4, 2020

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 4, 2020. The following Working Group members participated: Bruce R. Ramge, Chair, (NE); Russell Hamblen, Vice Chair (KY); Jimmy Harris, Mel Heaps and Gwen McClendon (AR); Sarah Borunda and DeLon Price (AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Sarah Crittenden (GA); Lindsay Bates (IA); Jill Huiskens (MI); Win Nickens (MO); Tracy Bielhna and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman (NJ); Hermoliva Abejar, Nick Stosic and Peggy Willard-Ross (NV); Rodney Beetch and Angela Dingus (OH); Kevin Foor and Shelly Scott (OK); Gary Jones and Christopher Monahan (PA); Julie Fairbanks and Yolanda Tennyson (VA); John Haworth and Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Mary Kay Rodriguez, Darcy Paskey and Rebecca Rebholz (WI).

1. Heard Opening Comments

Director Ramge welcomed returning Working Group members and a new member state, North Carolina, represented by Ms. Knowles. Changes in Working Group member state representation in 2020 include Ms Abejar, Landon Hubbart (OK), and Brian Fordham and Tashia Sizemore (OR).

2. Adopted its Dec. 18, 2019, Minutes

The Working Group met Dec. 18, 2019, and took the following action: 1) adopted a new farmowners in force standardized data request and a new farmowners claims standardized data request for inclusion in the reference documents of the Market Regulation Handbook (Handbook); and 2) discussed a new chapter of limited long-term care insurance (LTCI) examination standards for inclusion in the Handbook. The new examiner guidance is based on the Limited Long-Term Care Insurance Model Act (#642) and the Limited Long-Term Care Insurance Model Regulation (#643).

Ms. Plitt made a motion, seconded by Ms. Dingus, to adopt the Working Group’s Dec. 18, 2019, minutes (Attachment Four-A1). The motion passed unanimously.

3. Discussed Potential 2020 Tasks

Director Ramge said the charges of this Working Group, as adopted by the Market Regulation and Consumer Affairs (D) Committee, are to:

- Develop market conduct examination standards and uniform market conduct procedural guidance, as necessary.
- Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models by the Fall National Meeting.
- Develop updated standardized data requests for inclusion in the Market Regulation Handbook by the Fall National Meeting.

Director Ramge said the Working Group will not meet at NAIC national meetings; it will accomplish its assigned tasks via regularly scheduled conference calls, to occur approximately every four to six weeks.

Regarding the adopted 2020 charges, the Working Group plans to continue discussion on draft limited LTCI examination standards, which is a carryover item from 2019. Additional state insurance regulator guidance the Working Group plans to work on in 2020 includes, but is not limited to: 1) updating NAIC standardized data requests; and 2) revising the Handbook with updated examination standards corresponding to recent amendments to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170), the new Guideline on Nonadmitted Accident and Health Coverages (#1860), and the recent amendments to the Suitability in Annuity Transactions Model Regulation (#275).

Director Ramge asked for state insurance regulator volunteers to: 1) review any of the identified adopted models; and 2) report to the Working Group at its next call regarding whether the Handbook needs updating in these subject areas. Ms. Crittenden and Ms. Plitt volunteered to review Model #170. Director Ramge asked for additional volunteers to review Guideline #1860 and Model #275. He indicated that state insurance regulator subject matter expert (SME) volunteers will subsequently be...
needed to draft revisions to the examination standards regarding these two models and guideline, and he asked that all volunteers for these drafting projects contact either himself or Petra Wallace (NAIC).

Current, but not yet completed, NAIC model development activity which the Working Group will be monitoring in 2020—for the purpose of developing corresponding examination standards in the future—includes, but is not limited to: 1) amendments to the Unfair Trade Practices Act (#880) currently being considered by the Innovation and Technology (EX) Task Force; 2) the planned activity of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which will begin drafting a new NAIC model in 2020 to address certain pharmacy benefit manager (PBM) activities; and 3) the planned activity of the recently formed MHPAEA (B) Working Group, as one of its charges is “to provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.” Director Ramge asked the Working Group and interested state insurance regulators to forward any additional areas of focus to himself or Ms. Wallace.


Director Ramge said that the draft limited long-term care (LTC) examination standards were developed by state insurance regulator SMEs for the Working Group’s review, discussion, and consideration of adoption as a new market conduct examination standards chapter in the Handbook. The draft was initially exposed Oct. 29, 2019, for a public comment and has been discussed during the Working Group’s Nov. 20, 2019, and Dec. 18, 2019, calls.

Director Ramge said that the limited LTC examination standards draft was revised by Ms. Moran and redistributed on Dec. 11, 2019, to Working Group members, interested state insurance regulators, and interested parties for the Dec. 18, 2019, call. He said that Reva Vandevoorde (NE) indicated during the Dec. 18, 2019, call that the revisions made by Ms. Moran addressed the issues raised in Ms. Vandevoorde’s Dec. 3, 2019, comments. He said the draft that was forwarded for the March 4, 2020, call is identical to the Dec. 11, 2019, draft, except for the attachment numbering and the copyright date. He extended the due date on the draft to April 1, 2020.


Director Ramge said the new draft inland marine in force standardized data request and the new draft inland marine claims standardized data request, which were circulated Feb. 24, 2020, were developed by state insurance regulator SMEs for the Working Group’s review, discussion and consideration of adoption. When the inland marine standardized data requests are adopted, they will be included in the Handbook reference documents. Director Ramge asked that comments on the inland marine standardized data requests be submitted by March 25, 2020.

6. Discussed Other Matters

Director Ramge asked the Working Group members to participate in as many Working Group conference calls as possible this year so the Working Group can accomplish the tasks that are planned in 2020.

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur in April.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met on Dec. 18, 2019. The following Working Group members participated: Bruce R. Ramge, Chair, and Reva Vandevooorde (NE); Russell Hamblen, Vice Chair (KY); Jimmy Harris (AR); DeLon Price (AZ); Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Frank Pyle (DE); Sarah Crittenden (GA); Mary Lou Moran (MA); Maureen Belanger (NH); Ralph Boeckman (NJ); Peggy Willard-Ross (NV); Rodney Beetch (OH); Kevin Foor, Joel Sander and Shelly Scott (OK); Brian Fordham (OR); Katie Dzurec (PA); Julie Fairbanks and Yolanda Tennyson (VA); John Haworth (WA); Barbara Belling, Diane Dambach, Sue Ezalarab, Darcy Paskey and Rebecca Rebholz (WI); and Desiree Mauller (WV).

1. **Adopted New Farmowners SDRs for Inclusion in the Reference Documents of the Handbook**

Director Ramge said that a new draft farmowners in force standardized data request (SDR) and a new draft farmowners claims SDR were developed by state insurance regulator subject matter experts (SMEs) for the Working Group’s review, discussion, and consideration of adoption for inclusion in the reference documents of the *Market Regulation Handbook* (Handbook). The drafts were initially exposed Oct. 29 for a public comment period ending Dec. 2.

Director Ramge said the farmowners in force SDR was subsequently revised and redistributed to Working Group members, interested state insurance regulators, and interested parties on Dec. 11, along with the Oct. 29 farmowners claims SDR, for the Dec. 18 conference call. Mr. Hamblen said the description of the field name CanTerRs (reason for cancellation/termination of coverage) in the Dec. 11 draft farmowners in force SDR was revised so that it would not duplicate the data obtained by field name CanTer (who cancelled the coverage); and the field name CanTer was moved up one row so that it would more logically occur above field name CanTerRs, Ms. Crittenden made a motion, seconded by Mr. Hamblen, to adopt the Dec. 11 draft farmowners in force SDR and the Oct. 29 draft farmowners claims SDR. The motion passed unanimously.

2. **Discussed Dec. 11 Draft of New Limited LTC Chapter for Inclusion in the Handbook**

Director Ramge said that new draft limited long-term care (LTC) exam standards were developed by state insurance regulator SMEs for the Working Group’s review, discussion, and consideration of adoption for inclusion as a new market conduct examination standards chapter in the Handbook. The draft was initially exposed Oct. 29 for a public comment period ending Dec. 2.

Director Ramge said that the limited LTC examination standards draft was revised by Ms. Moran and redistributed on Dec. 11 to Working Group members, interested state insurance regulators, and interested parties. Ms. Vandevooorde said that the revisions made by Ms. Moran in the Dec. 11 draft addressed the issues raised in Ms. Vandevooorde’s Dec. 3 comments. Director Ramge extended the due date on the draft to the Dec. 31 conference call and indicated that the work on the draft would continue into 2020.

3. **Discussed Other Matters**

Director Ramge welcomed Mr. Harris to the Working Group, representing Arkansas.

Director Ramge said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur early in 2020, after the Working Group is reappointed by the Market Regulation and Consumer Affairs (D) Committee.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.
Draft Pending Adoption

Market Regulation and Consumer Protection (D) Committee
8/11/20

Privacy Protections (D) Working Group
Virtual Summer National Meeting
July 30, 2020

The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call July 30, 2020. The following Working Group members participated: Cynthia Amann, Chair, and Marjorie Thompson (MO); Ron Kreiter, Vice Chair (OK); Damon Diederich (CA); Erica Weyhenmeyer (IL); LeAnn Crowe and Brenda Johnson (KS); T.J. Patton and Paul Hanson (MN); Kendall Cotton (MT); Chris Aufenthie and Anders Odegard (ND); Martin Swanson (NE); Tasha Sizemore (OR); Gary Jones (PA); and Don Beatty (VA). Also participating were: Jimmy Harris and Crystal Phelps (AR); Damion Hughes (CO); Evangelina Brooks (FL); Doug Ommen (IA); Kristen Finau and Michele Mackenzie (ID); Kate Kixmiller (IN); Peggy Willard-Ross (NV); Don Layson (OH); Landon Hubbart (OK); Ignatius Wheeler and Carole Cearley (TX); John Haworth (WA); and Barbara Belling (WI).

1. **Adopted its May 5 Minutes**

Ms. Amann said the Working Group met May 5 and took the following action: 1) adopted its Feb. 19 minutes; 2) heard an update on state and federal privacy legislation; and 3) discussed comments received on the *NAIC Insurance Information and Privacy Protection Model Act* (#670).

Mr. Kreiter made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group’s May 5 minutes (Attachment Five-A). The motion passed unanimously.

2. **Received an Update on State and Federal Privacy Legislation**

Jennifer McAdam (NAIC) said a review of the laws about consumer privacy start with data privacy, addressing how data is collected and used by businesses, while data security addresses how data is stored and protected. Ms. McAdam said the NAIC has three model laws governing data privacy: 1) *Health Information Privacy Model Act* (#55); 2) *NAIC Insurance Information and Privacy Protection Model Act* (#670); and 3) *Privacy of Consumer Financial and Health Information Regulation* (#672).

Ms. McAdam said Model #670 was adopted in 1980 to set standards for the collection, use and disclosure of information gathered in connection with insurance transactions. She said it has been enacted by 17 states and addresses how information is collected by insurance institutions, agents and insurance support organizations (ISOs). She said Model #670 balances the need for information by those conducting the business of insurance and the public’s need for fairness; establishes a regulatory mechanism to enable consumers to ascertain what information is being or has been collected about them and to have access to such information so they can verify or dispute its accuracy; limits the disclosure of information collected in connection with insurance transactions; and enables insurance applicants and policyholders to find out the reasons for any adverse underwriting decision. She said Model #670 does this by requiring insurers to provide notice that alerts the individual of the insurer’s information practices and giving consumers the right to request that an insurer: 1) give access to recorded personal information; 2) disclose the identity of the third parties to whom the insurer disclosed the information; 3) provide the source of the collected information; 4) correct and amend the collected information; 5) amend the personal information; and 6) delete the collected personal information.

Ms. McAdam said the federal Fair Credit Reporting Act (FCRA) was enacted in 1970 to address the fairness, accuracy and privacy of the personal information contained in the files of the consumer reporting agencies and the Federal Privacy Act was enacted in 1974 to govern the collection, maintenance, use, and dissemination of personally identifiable information about individuals that is maintained in systems of records by federal agencies.

Ms. McAdam said following enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NAIC adopted Model #55 in 1998. She said Model #55 set standards to protect health information from unauthorized collection, use and disclosure by requiring carriers to establish procedures for the treatment of all health information. She said it requires carriers to: 1) create policies and procedures governing health information; 2) notify consumers about those policies and procedures; 3) provide consumers a right to access their protected health information (PHI); 4) provide a right to amend PHI; 5) provide a list of disclosures of consumer PHI; and 6) obtain authorization for collection, use or disclosure of PHI.
Ms. McAdam said the federal Gramm-Leach-Bliley Act (GLBA), enacted in 1999, imposed privacy and security standards on financial institutions and directed state insurance commissioners to adopt certain data privacy and data security regulations.

Ms. McAdam said the NAIC adopted Model #672 in 1999 to: 1) require insurers to provide notice to consumers about their privacy policies and practices; 2) describe the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and 3) provide methods for individuals to prevent a licensee from disclosing that information with “opt out” for financial information and “opt in” for health information. She said Model #672 is intended to be enforced via states’ Unfair Trade Practices Act. She said the provisions governing protection of health information were taken directly from Model #55 and the health information privacy regulations promulgated by U.S. Department of Health and Human Services (HHS) pursuant to HIPAA. She also said the provisions governing protection of financial information are based on privacy regulations promulgated by federal banking agencies. Ms. McAdam said the key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information but insurers must get explicit authorization prior to sharing health information (which is considered “opt in”). She said every state has adopted a version of Model #672.

Ms. McAdam said generally applicable data privacy laws, such as the European Union’s General Data Protection Regulation (GDPR), are not insurer-specific and require companies to obtain explicit consent from consumers to collect their data (“opt in”) with an explanation of how the data will be used. The GDPR also contains standards for safeguarding the data. She said the California Consumer Privacy Act (CCPA) became effective this year and gives consumers the right to request that a business: 1) disclose the categories and specific pieces of personal information collected, the categories of sources the information was collected from, the business purpose for collecting the information, the categories of third parties with whom the information is shared, and the specific pieces of personal information that was shared; 2) delete any personal information; and 3) give consumers the right to opt-out of their information being disclosed to third parties. It also prevents companies from discriminating against consumers who exercise their rights under the law and provides a full exemption for PHI governed by HIPAA and a partial exemption for information subject to the GLBA. However, if the information subject to the GLBA is breached, the consumer can pursue a private civil action against the company.

Ms. McAdam said there has not been much change in the state legislative arena. She said in 2019, 24 states considered some type of data privacy legislation but only three states enacted laws: Illinois; Maine; and Nevada. She said five states—Connecticut, Hawaii, Louisiana, North Dakota and Texas—passed bills establishing task forces to study the issue of data privacy by reviewing laws in other states and making recommendations for what would be appropriate privacy standards. Ms. McAdam said more than 15 states introduced data privacy legislation in 2020 but none of them has been passed. She said many of these bills were fairly comprehensive and similar to the CCPA.

Brooke Stringer (NAIC) said there has not been a lot of activity on the federal level since the last Working Group call. She said for today’s federal update, she would provide: 1) an overview of a new federal data privacy bill from U.S. Sen. Sherrod Brown (D-OH), who serves as the ranking Democrat on the U.S. Senate Committee on Banking, Housing and Urban Affairs; 2) briefly recap the four other bills previously proposed; and 3) conclude with a mention of some COVID-19 data privacy bills that have been introduced.

Ms. Stringer said, as she had mentioned before, the key issues for congressional debate focus on trade-offs regarding the extent of preemption, private rights of action, and the stringency of the standard. She said the most recent draft bill is from Sen. Brown, the “Data Accountability and Transparency Act,” which: 1) establishes a new federal agency to protect individuals’ privacy that would have rulemaking, supervisory and enforcement authority, the ability to issue civil penalties for violations of the act, and an Office of Civil Rights to protect individuals from discrimination; 2) prohibits the use of personal data to discriminate in housing, employment, credit, insurance and public accommodations; 3) requires anyone using decision-making algorithms to provide accountability reports to the new federal agency; 4) does not preempt more protective state laws and provides for enforcement by the state attorneys general; 5) bans the use of facial recognition technology, as well as the collection, usage or sharing of any of that personal data; 6) and contains a private right of action.

Ms. Stringer said, as a recap, she would mention some of the other legislative proposals the Working Group has discussed previously:

- U.S. Senate Committee on Commerce, Science and Transportation Chairman Roger Wicker’s (R-MS) draft bill, the “Consumer Data Privacy Act,” that proposes stringent data privacy standards and preempts all state data privacy and
Mr. Peterson said this analysis compares various approaches to regulating privacy, which the NAIC would use to determine whether those gaps are significant and/or relevant to state insurance regulators, insurance consumers and the insurance industry. He said before conducting this final analysis or final phase of its gap analysis, the Working Group should establish a base for conducting comparative analysis, as well as determine parameters for conducting analysis and evaluating gaps. Mr. Peterson agreed with the Working Group that the most logical approach would be to use Model #672 because it reflects the NAIC’s most current thinking on privacy regulation; it is universally adopted at the state level; and other NAIC models have previously been rejected as base models by the Working Group during its meetings. He said the health insurance industry he represents has submitted a side-by-side comparison as a first step in completing a gap analysis.

Ms. Stringer said, in addition to comprehensive data privacy proposals, she wanted to mention that there have been several bills introduced that specifically address COVID-19 data privacy. She said the following proposals would put temporary rules in place regarding the collection, processing and transfer of data used to combat the spread of COVID-19: 1) Chairman Wicker’s “COVID-19 Consumer Data Protection Act (S. 3663),” which requires covered entities to obtain affirmative consent before collecting, processing or transferring an individual’s personally identifiable information for the purpose of contact tracing with respect to COVID-19. It preempts state laws and has no private right of action; and 2) the “Public Health Emergency Privacy Act (S. 3749/H.R. 6866)” by U.S. Sen. Richard Blumenthal (D-CT) and U.S. Rep. Anna Eshoo (D-CA) requires opt-in consent and data minimization, has a private right of action and does not preempt state laws. Ms. Stringer noted that the U.S. Congress is struggling with passing the next COVID-19 relief bill, so it is unlikely there will be any immediate action on the aforementioned COVID-19 bills.

Ms. Stringer said, in terms of future actions on comprehensive data privacy legislation, given the pandemic, the fact that it is an election year and with the general partisan discord, she said it is unlikely there will be any major congressional movement before the November elections. She also said it may be the next U.S. Congress that ultimately tackles these issues.

3. **Heard a Presentation that Included a Comparative Analysis and Comments Received July 24**

Chris Peterson (Arbor Strategies, LLC), representing America’s Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA) and the Coalition (an organization that includes Aetna, Anthem, Cigna, Health Care Service Corporation and UnitedHealthcare), said phase one of any gap analysis by the Working Group should be a side-by-side comparison. He said the health insurance industry he represents has submitted a side-by-side comparison as a first step in completing a gap analysis.

Mr. Peterson said the analysis should not regulate business in general, non-insurance practices or non-insurance transactions. He said any gaps that are identified should only be filled by concepts that have consensus support at the state level (also known as the “Walter Bell Rule”) and that the resulting model should be aligned with existing federal laws. Mr. Peterson provided a comparison of the following aspects of Model #672, HIPAA, Model #670, the CCPA and the GDPR: 1) applicability; 2) definition of “covered or personal information”; 3) privacy notices; 4) opt-in/opt-out rights; and 5) consumer rights.
Lauren Choi (BCBSA) said while she applauds the Working Group’s efforts, she reiterated that updates made to any privacy model would require a deliberative and considered approach based on facts and policy. She said state insurance regulators and the industry together can move forward only if the current landscape of existing federal law in the privacy arena is understood. To assist the Working Group in its efforts, she said the BCBSA and the Coalition has conducted a gap analysis of the specific privacy requirements with which certain insurance licensees must comply, including HIPAA, the CCPA, Model #670, Model #672 and the GDPR.

Ms. Choi said she hopes this material will be helpful to the Working Group to increase the Working Group’s understanding of the existing consumer protections under current regimes. She said the BCBSA and the Coalition have learned that the Working Group has determined it is more beneficial for to focus its efforts on Model #672 instead of Model #670. Ms. Choi said the BCBSA fully supports and appreciates this decision, because, as it compares to Model #670, the newer Model #672 was developed to improve on Model #670; is much more reflective of current regulatory thinking and attitudes; and has been far more widely accepted in the states. She said Model #672 is a viable foundation for the Working Group to review and to determine what changes, if any, are needed to effectively protect consumer interests in the insurance arena.

4. Discussed Plans to Begin a Gap Analysis Discussion by Working Group Members, Interested State Insurance Regulators and Interested Parties Using Model #672 as a Baseline Model

Ms. Amann said the Working Group will begin its gap analysis discussion using Model #672 as a baseline. She said the plan is to break the analysis discussion down into three separate areas: 1) consumer issues; 2) industry obligations; and 3) regulatory enforcement. She said to help the Working Group visualize each of the topics to be discussed, two comparison charts created by Ms. McAdam indicating how Model #670, Model #672, the GLBA, HIPAA and the CCPA address them were posted to the Working Group’s page on the NAIC website prior to this meeting. She said the Working Group would start its discussion at its next meeting with consumer issues such as disclosures, notifications, portability, opt-in/opt-out, changes, deletions, etc.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 5, 2020. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (OK); Damon Diederich (CA); Erica Weyhenmeyer (IL); LeAnn Crowe (KS); T.J. Patton (MN); Kendall Cotton (MT); Chris Aufenthie (ND); Brian Fordham (OR); and Don Beatty (VA). Also participating were: Jimmy Harris and Crystal Phelps (AR); Damion Hughes (CO); Evangelina Brooks (FL); Doug Ommen (IA); Kristen Finau and Michele Mackenzie (ID); Kate Kixmiller (IN); Brenda Johnson (KS); Paul Hanson (MN); Marjorie Thompson (MO); Anders Odegard (ND); Peggy Willard-Ross (NV); Don Layson (OH); Landon Hubbart (OK); Ignatius Wheeler and Carole Cearley (TX); John Haworth (WA); and Barbara Belling (WI).

1. **Heard Opening Remarks**

Ms. Amann said this is the Working Group’s second conference call in 2020. She said the Working Group is still in the process of building its membership, as well as forming distribution lists for interested state insurance regulators and interested parties. She asked those interested in joining the Working Group or being added to a distribution list to contact Lois E. Alexander (NAIC). Ms. Amann said the Working Group is charged with addressing the privacy of consumer data. She said data privacy is concerned with how data is collected and used by businesses; however, she said the security of consumer data is concerned with how data is stored and protected. She said data security is not being addressed by this Working Group, but it is being addressed by other working groups. She said NAIC staff support for related working groups are coordinating efforts to ensure that there is no overlap nor duplication of effort. She said the Working Group will continue to track and work closely, as needed, with the other working groups in this arena—the Artificial Intelligence (EX) Working Group, the Accelerated Underwriting (A) Working Group, etc.—as each has its unique set of issues that nevertheless require coordination. She said a significant change going forward is that the Working Group will address health care privacy as it applies to the *NAIC Insurance Information and Privacy Protection Model Act* (#670) and the *Privacy of Consumer Financial and Health Information Regulation* (#672) after more general privacy issues have been reviewed and discussed. She also said the Working Group will have conference calls approximately every six weeks following the Workplan/Briefing document posted on the webpage.

2. **Adopted its Feb. 19, 2020, Minutes**

Mr. Beatty made a motion, seconded by Ms. Weyhenmeyer, to adopt the Working Group’s Feb. 19 minutes (Attachment Five-A1). The motion passed unanimously.

3. **Heard an Update on State and Federal Privacy Legislation**

Jennifer McAdam (NAIC) said there have not been very many state legislative changes since the Working Group’s Feb. 19 call. She said more than 15 states are now considering data privacy legislation. She said regulations for the California Consumer Privacy Act (CCPA) are currently under review and posted to the California Attorney General’s website. She said four research charts updated by NAIC Legal staff on April 20 were posted on the Working Group’s web page prior to today’s call.

Brooke Stringer (NAIC) said there has not been a lot of activity on the federal level since the last Working Group call either. She said there has been one new bill on privacy and security introduced by U.S. Sen. Jerry Moran (R-KS), the “Consumer Data Privacy and Security Act (S. 3456).” She noted that the bill would preempt state data privacy and security laws with exceptions, and it would not supersede state laws that address financial information held by financial institutions as defined in Title V of the Gramm-Leach-Bliley Act, which includes persons providing insurance.

4. **Discussed Comments Received on Model #670**

Ms. Amann thanked everyone who submitted comments on the exposure draft that the state insurance regulator subject matter expert (SME) group created of key issues. She said all comments received would be discussed by the Working Group on future conference calls. She said sections 14–19 and 22–24 had been referred to NAIC Legal staff for review and an update with similar language from other NAIC models that were adopted recently in the interest of saving time and not recreating the wheel.
She said sections 20 and 21 would require a great deal of discussion, so they will be delayed until later. She said Mr. Kreiter is working on replacing outdated definitions with pertinent standard definitions that were already adopted in other models or taken from the NAIC Market Regulation Handbook or IT Exam Standards Handbook. She asked that the Working Group read the charts prepared by NAIC Legal staff closely, as they provide a very good overview of the CCPA, the European Union’s (EU’s) General Data Protection Regulation (GDPR), and other state legislation. She said the Working Group may decide to update Model #670, Model #672 or both.

Chris Petersen (Arbor Strategies LLC) suggested that the Working Group consider doing a gap analysis of the existing laws first to compare the consumer privacy protection requirements in the current NAIC models to the desired future privacy protection requirements. Ms. McAdam noted that Model #670 is based on the federal Fair Credit Reporting Act (FCRA), so its requirements are closer to those required by the CCPA.

Ms. Amann said the Working Group can have this discussion when this is added to the strikeout version going forward, but it will follow the agenda and walk through Model #670 comments at this time starting with the Preamble. Mr. Hanson suggested replacing the word “institutions” with the word “entities” throughout the document. Ms. Kitt objected to the phrase “natural person,” and she recommended that it be changed. Mr. Diederich said this term was defined in the Fourteenth Amendment to distinguish individuals from a legal entity. Mr. Hanson said it referred to a physical person rather than a corporation, and Mr. Kreiter concurred. Ms. McAdam said she would check to see how this was handled in the recently adopted Insurance Data Security Model Law (#668). Bob Ridgeway (AHIP) said this is an exclusive state standard, and there is only one, not several, set by the Attorney General in each state.

Kate Kiernan (American Council of Life Insurers—ACLI) said the ACLI distinguishes the lines of business separately, and she suggested that the modernized wording from Model #672 be inserted into Model #670. She said this would help all lines of business by having clear instruction about what consumers need to know by the line of business they are considering. She said legal transparency is very important in situations dealing with the privacy protection of insurance consumers.

Ms. Amann said the data that is currently being collected on consumers is very broad and from a multitude of sources, so it is important to use the same consumer privacy protection requirements for all lines of business. Mr. Petersen said it is not separated in Model #668. Mr. Hanson said “institutions” should be changed to “licensee” throughout the document to agree with Model #672 in order to clarify it as not meaning an agent (producer). He said Section D under Scope may not be needed, as it relates to title insurance, or it may need to be cleaned up, as it is unique to title coverage. Elizabeth Blosser (American Land Title Association—ALTA) said language specific to insurance needs to use publicly recognizable terms. Ms. Kiernan said industry finds the Definitions section the most troubling obstacle about areas needing updating. Ms. Amann said the state insurance regulators who are SMEs would refer the Working Group to other models or federal legislation.

Ron Troy (Blue Cross Blue Shield Association—BCBSA) asked what gap the Working Group is trying to fill, and he suggested that the Market Regulation and Consumer Affairs (D) Committee be contacted for clarification of the Working Group’s charges.

Karrol Kitt (The University of Texas at Austin) and Brenda J. Cude (The University of Georgia) said they will submit comments related to the protection of consumer data privacy for the next Working Group call.

Ms. Kiernan said she would send the technical terms she mentioned to the Working Group.

Mr. Petersen said he would send the Model #672 terms to be used in Model #670 to the Working Group.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 19, 2020. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (OK); Damon Diederich (CA); Erica Weyhenmeyer (IL); LeAnn Crowe (KS); T. J. Patton (MN); Kendall Cotton (MT); Bob Harkins (NE); Chris Aufenthie (ND); Brian Fordham (OR); and Don Beatty (VA). Also participating were: Vanessa Darrah (AZ); Michele Mackenzie (ID); Jennifer Demory and Don Layson (OH); John Haworth (WA); Barbara Belling (WI); and Bill Cole (WY).

1. **Heard Opening Remarks**

Ms. Amann said this is the first conference call of the Working Group since its 2020 charges were adopted by the Market Regulation and Consumer Affairs (D) Committee during its Dec. 9, 2019, meeting in Austin, TX. She said the Working Group is still in the process of building its membership, as well as forming distribution lists for interested state insurance regulators and interested parties. She asked those interested in joining the Working Group or being added to a distribution list to contact Lois E. Alexander (NAIC).

2. **Adopted its 2019 Fall National Meeting Minutes**

Mr. Kreiter made a motion, seconded by Ms. Cotton, to adopt the Working Group’s Dec. 8, 2019, minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Ten). The motion passed unanimously.

3. **Heard an Update on State and Federal Privacy Legislation**

Jennifer McAdams (NAIC) said 15 states—i.e., Arizona, Florida, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, Pennsylvania, South Carolina (applies only to biometric information), Virginia and Washington—have pending data privacy legislation.

Ms. McAdams said many of the bills are comprehensive and like the California Consumer Privacy Act (CCPA). She also said several of the bills contain exemptions for entities or information subject to the Gramm-Leach-Bliley Act (GLBA). She said the New York bill was carried over from 2019, would go further than the CCPA, and would establish a fiduciary duty for companies to act in the consumer’s best interest regarding the consumer’s personal information. However, she said the legislation in South Carolina applied only to biometric information.

Ms. McAdams said updated legal research charts on the Privacy Protections (D) Working Group web page will be posted soon. She said one of the charts lists general state data privacy laws—laws that are applicable to all businesses and not specific to insurers. She said the chart lists the entity responsible for enforcement, exemptions, whether it is “opt-in” or “opt-out,” and consumer notice requirements.

Brooke Stringer (NAIC) said there are three major legislative proposals in the U.S. Congress (Congress) currently, all of which apply to both data security and data privacy. She said some of the key issues focus on trade-offs regarding the extent of preemption, private rights of action, and the stringency of the standard.

Ms. Stringer said the Chairman of the U.S. Senate (Senate) Committee on Commerce, Science, and Transportation, Sen. Roger Wicker (R-MS), has released draft legislation that contains data privacy standards that are very high—higher than California law in several instances according to the committee website. She said it broadly preempts all state laws on data privacy and data security. She said the bill provides standards for transparency and consumer rights to access, correct and delete their data; requires affirmative consent before collecting, processing or transferring data; calls for a Federal Trade Commission (FTC) study examining the use of algorithms that may violate anti-discrimination laws; and provides for the enforcement of the bill’s provisions by the FTC and state Attorney General. She said the legislation currently has a carve out for the GLBA; however, she said the net effect of the proposal would be to preempt all state data privacy or data security laws. She said NAIC staff is
working with the Senate Committee on Commerce, Science, and Transportation to try to clarify the bill language with respect to insurance.

Ms. Stringer said Sen. Maria Cantwell (D-WA), the Ranking Democrat on the Senate Committee on Commerce, Science, and Transportation has introduced her own legislation (S. 2968). She said this legislation contains standards like those in Sen. Wicker’s proposal, but Sen. Cantwell’s proposal allows for a private right of action and would establish a preemptive floor.

Ms. Stringer said the U.S. House of Representatives (House) Committee on Energy and Commerce has released a bipartisan draft proposal that provides the FTC with significant rulemaking authority to implement standards. However, she said questions surrounding preemption and private right of action remain subject to negotiation at this time.

4. Discussed Next Steps

Ms. Amann said it was suggested during the 2019 Fall National Meeting that a public hearing be held to determine how insurers are using the data they collect on consumers. However, she said it was determined that a public hearing will not be necessary since the charges for the Working Group are very clear regarding this issue. She said next steps include the Working Group meeting at 11:00 am on Sunday, March 22, 2020, in Phoenix, AZ at the Spring National Meeting. She said a regulator subject matter expert (SME) group would create a draft of key issues to be exposed to the Working Group for comment prior to the Spring National Meeting. She said all comments received prior to the national meeting will be discussed by the Working Group in Phoenix, AZ.

Having no further business, the Privacy Protections (D) Working group adjourned.

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The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 20, 2020. The following Working Group members participated: John Haworth, Chair (WA); Bill Cole, Vice Chair (WY); Lindsay Bates (IA); Erica Weyhenmeyer (IL); Mary Lou Moran (MA); Jason Decker (MD); Paul Hanson (MN); Cynthia Amann (MO); Tracy Biehn (NC); Reva Vandevoorde (NE); Edwin Pugsley (NH); Robert Doucette (NM); Angela Dingus (OH); Landon Hubbart (OK); Brian Fordham (OR); Christopher Monahan (PA); Michael Bailes (SC); Julie Fairbanks (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were: Pam O’Connell (CA); Jill Huisken (MI); and Matt Gendron (RI).

1. **Adopted its Jan. 30 Minutes**

The Working Group met Jan. 30 to discuss the pilot volunteers’ suggested revisions to the Voluntary Market Regulation Certification Program (Program).

Mr. Doucette made a motion, seconded by Ms. Moran, to adopt the Working Group’s Jan. 30 minutes (Attachment Six-A). The motion passed unanimously.

2. **Discussed Comments Concerning Certification Pilot Volunteers’ Suggestions**

Mr. Haworth said one set of comments was received since the Working Group’s Jan. 30 conference call. The comments were from Michael Lovendusky (American Council of Life Insurers—ACLI). Mr. Haworth said the comments recommended requirement 5 include a provision that the department of insurance (DOI) have cybersecurity requirements equal to or more rigorous than those required of regulated entities. He said the comments also discussed requirement 3 for overseeing contractors. Because contractor costs can be very high, the ACLI comment letter recommends companies be allowed to enter into tri-party agreements with contract examiners. Finally, the comment letter said the ACLI cannot support requirement 6 because the Market Actions (D) Working Group policies and procedures are for state insurance regulators only and cannot be viewed by the regulated entities.

Mr. Haworth said the NAIC Market Regulation Handbook (Handbook) summarizes the Market Actions (D) Working Group processes. Mr. Lovendusky said there was no understanding by industry of the Market Actions (D) Working Group deliberation processes. He suggested it may be helpful for the Working Group to hold an open meeting with industry to discuss industry concerns.

Ms. Moran said she took issue with Mr. Lovendusky’s comments concerning contractor costs. She said Massachusetts is very careful about keeping costs for examinations down. She said Massachusetts only uses approved contractors and requires and reviews the contractor budgets for every examination. The DOI will conduct an examination if it is too costly. No work is begun until there is direct approval from the DOI. The DOI makes sure that costs are as low as possible. She said most states control the cost of contractors. Mr. Doucette said the New Mexico DOI has a robust procedure for selection and takes Mr. Lovendusky’s charges seriously. Mr. Cole said the Wyoming DOI use contractors frequently because of the DOI’s size and if the cost is exorbitant, the DOI would find another way to address a concern.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said the cost of contractors has been a concern for many years and is beyond the scope of the Working Group’s discussion regarding the certification program revisions. She said she has been told the Market Actions (D) Working Group’s policies and procedures are confidential and cannot be shared with industry. She agreed with Mr. Lovendusky’s comments that the APCIA cannot support requirement 6 for this reason. She suggested that the requirement could reference the Handbook’s description of the Market Actions (D) Working Group’s processes rather than reference its policies and procedures manual. She also asked if a request could be made to the Market Actions (D) Working Group to make their policies and procedures public. Mr. Haworth said that is a consideration for the Market Actions (D) Working Group to take up.
3. **Discussed Pass and Fail Metrics**

Mr. Haworth said the discussion of the definitions for “unqualified pass” and “provisional pass” in requirement 4 leads to a broader discussion of what the criteria for passing or failing for each requirement should be, as well as the passing and failing of the entire certification program. He noted the terms “unqualified pass” and “provisional pass” are only found in requirement 4. He asked if those measurements should be used for other requirements or not used at all. He noted within requirement 4, it was not clear when a pass would be unqualified or provisional. Mr. Cole said he sees the usefulness of allowing a jurisdiction to pass provisionally if there are conditions outside of their control such as a collective bargaining agreement.

Mr. Haworth suggested possibly using a percentage of positive responses to all the checklist questions to determine whether a jurisdiction passes or fails. For example, if a jurisdiction had a positive response for 70% of the questions, it would pass. He said it would make sense, however, to weight some requirements more than others. He said, for example, if a jurisdiction failed the requirement to be able to maintain confidentiality, the jurisdiction should fail the entire certification program. Mr. Doucette agreed with the importance of weighting more important requirements heavier than the less important requirements. Mr. Cole noted the requirement for participation in the Market Conduct Annual Statement (MCAS) may be weighted less. He said the Working Group would need to determine which requirements are weighted heavier and by how much.

Ms. Amann asked whether each requirement would be rated as “1, 2, 3” or “High, Medium, Low,” and Mr. Haworth said it seemed to be the way the Working Group was leaning. He said in that manner, a jurisdiction would also know which requirements it needs to work on. Ms. Huisken suggested using the financial accreditation program scoring methodology as a template. Mr. Gendron said he supports a weighted scoring. Ms. Dingus also said a weighted option is appropriate but said she needs some time to consider how each would be weighted.

Ms. O’Connell said it makes sense that some requirements are make or break but others are not so important. A single aggregate score may not be appropriate if they are missing a requirement that must be in place.

Mr. Haworth said that he and Mr. Cole would develop a matrix for scoring based on the discussions.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.

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Market Regulation Certification (D) Working Group
Conference Call
January 30, 2020

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Jan. 30, 2020. The following Working Group members participated: John Haworth, Chair (WA); Bill Cole, Vice Chair (WY); Jimmy Harris (AR); Lindsay Bates (IA); Erica Weyhenmeyer (IL); Holly Williams-Lambert (IN); Mary Lou Moran (MA); Jason Decker (MD); Cynthia Amann (MO); Tracy Biehn (NC); Reva Vandevoorde (NE); Edwin Pugsley (NH); Angela Dingus (OH); Landon Hubbard (OK); Scott Martin (OR); Christopher Monahan (PA); Michael Bailes (SC); Tracy Klausmeier (UT); Isabelle Keiser (VT); and Theresa Miller (WV). Also participating were: Pam O’Connell (CA); and October Nickel (ID).

1. Adopted its Nov. 20, 2019, Minutes

The Working Group met Nov. 20 to discuss the pilot volunteers’ suggested revisions to the Voluntary Market Regulation Certification Program (Program).

Ms. Dingus made a motion, seconded by Ms. Biehn, to adopt the Working Group’s Nov. 20, 2019, minutes (see NAIC Proceedings – Fall 2019, Market Regulation and Consumer Affairs (D) Committee, Attachment Nine). The motion passed unanimously.

2. Discussed Comments Concerning Certification Pilot Volunteers’ Suggestions

Ms. O’Connell said the reorganization of the Program is an improvement. She said placing the checklist for each requirement with its corresponding requirement and guidelines makes it clearer to understand, but some of the criteria for what constitutes success on some of the standards is still unclear.

Regarding requirement 1, Ms. O’Connell said the guidelines are not clear as to what standards a jurisdiction must meet in order to pass the requirement. She said the fourth paragraph of the guidelines for this requirement only describes one item as something a jurisdiction must have in order to pass, which is the authority to coordinate with other jurisdictions. The paragraph then says a jurisdiction should have the authority to conduct analysis, examinations and enforcements but does not say it must be able to. She said the paragraph then describes a jurisdiction with the “ability” to conduct analysis, examinations and enforcement, but not the ability to perform continuum actions as marginally passing. She said it is not clear whether the word “ability” is really intended to mean “authority.” She said “authority” seems to be the correct word, or else how would a jurisdiction’s “ability” to do continuums be measured?

Ms. O’Connell said it is not clear how a jurisdiction’s authority or ability to conduct analysis, examinations, enforcement and continuum actions relates to whether the jurisdiction has the authority to collaborate with other states, which is the only specified “must have” according to the guidelines. Ms. O’Connell said the guidelines should be precise with respect to what is required for a jurisdiction to pass this aspect of the requirement.

Ms. O’Connell said while the requirement says part of the evaluation pertains to whether the jurisdiction has adopted or is in the process of adopting key consumer protection laws and the guidelines list a series of key laws a jurisdiction should have, the checklist collects no information regarding the reporting jurisdiction’s consumer protection laws. She said it is unclear how it will be determined whether a jurisdiction meets this portion of the requirement.

Ms. O’Connell said if the items in the second paragraph under the guidelines for requirement 2 are required in order for a jurisdiction to pass this requirement, they should be incorporated into the third paragraph, which begins, “To evaluate whether your jurisdiction passes Requirement 2...”.

Ms. O’Connell said that because the checklist for requirement 3 has been modified to create one question about staff examiners and a separate question about contract examiners, the second bullet point in the sixth paragraph of the guidelines needs to be revised to account for the new structure and for the new wording of all of the other questions that follow the current question 3e. She said the original intent of these bullet points, when 3d addressed both staff and contract examiners, was to say if a jurisdiction uses contract examiners for exams and continuums, additional criteria surrounding contractor
hiring practices and oversight must be met in order to pass. She said the second bullet point no longer tracks in this manner due to the changes to lettering.

For checklist item 3c, Ms. O’Connell asked the reasoning behind separating the numbers of companies upon which market analysis is performed during the year between single-state/multistate and L&H/P&C. She said there is not any pass/fail metric tied to the mix of companies analyzed during the review period. She recommended removing the additional layer of detail in order to make the self-reporting for this item less time intensive.

For the newly number questions 3i and 3j, Ms. O’Connell said it is not clear what they are intended to measure and what is meant by “quantitative and subjective measurements” to ascertain whether the Department of Insurance (DOI) is achieving its staffing policies and procedures. She said the Working Group should define these more specifically so jurisdictions will be clear on the standards to which they may be held in the future.

Ms. O’Connell said the narrative for question 3g seems to say the written premium to be entered into the table should be the combined written premium of all entities examined or subject to an action during the calendar year. She said it is not clear how this will demonstrate that the jurisdiction has enough staff to properly oversee its market. For example, she said if state A has total premium writings of $10 billion in its market overall but only did one exam on an insurer with premium writings of $5 million, comparing the $5 million figure with the number of examiners state A has on staff or under contract would provide no perspective on whether that examiner count is reasonable compared to the overall size of state A’s $10 billion market.

Ms. O’Connell said item 3h’s demand for a list of all examiners either on staff or contracted by name, along with specifics about their educational and work history backgrounds, is not relevant to whether the DOI has a properly sized staff or the ability to hire contractors to meet market regulation needs as stated in requirement 3. She noted that item 3g already asks for counts of examiners. She said 3h should be deleted.

Ms. O’Connell said under the requirement 4 structure proposed for unqualified pass and provisional pass for the various subparts of the guidelines, a jurisdiction whose rules for hiring and establishing conditions of employment are subject to collective bargaining and specific civil service rules could only ever attain a provisional pass. In the note to evaluators, it says that for provisional pass items, progress is recommended and expected during successive reviews. She said it is not clear what progress the Working Group expects to see a jurisdiction, bound by collective bargaining, make from year to year when these items are outside the control of the DOI. She said it also is not clear what the consequence would be if a jurisdiction is not able to demonstrate the desired progress.

Ms. O’Connell said the core competencies section of the NAIC Market Regulation Handbook (Handbook) with which, according to requirement 4, a jurisdiction’s methods of ensuring qualifications of staff should be consistent, lists and describes a number of designations and credentials indicative of a high degree of proficiency in market regulation. She said, however, that it also very specifically says the designations listed are not intended to be exhaustive nor is it intended for designations to be required for qualification. She said California is not in favor of the current structure of the guidelines because they set a higher standard for passing than is called for by the language of the requirement and the Handbook. She recommended simplifying this set of guidelines to eliminate the unqualified pass and provisional pass distinctions and instead establish clear criteria to measure whether jurisdictions have processes allowing them to select applicants with appropriate education, work experience, skills and abilities to perform market regulation work regardless of specific designations, and whether the jurisdictions have programs and procedures to encourage and promote professional development of staff.

Ms. O’Connell noted the first line of the second paragraph of the requirement 6 guidelines incorrectly refers to the Market Actions (D) Working Group as the Market Analysis (D) Working Group.

Ms. O’Connell said for requirements 6, 7 and 8 at the bottom of each checklist, there is an unnumbered item that states, “Have there been any changes to your requirements since last year’s review. If “yes,” provide an explanation.” She said it is unclear what the phrase “your requirements” is in reference to. She said the question should be more specific to clarify what the jurisdiction should be reporting in the way of changes during the interim period.

Ms. O’Connell said the requirement 9 guidelines are not clear with respect to expectations for participation in working groups and task forces beyond the Market Analysis Procedures (D) Working Group and Market Conduct Examination Standards (D) Working Group. She said the fourth paragraph of the guidelines, which begins “To evaluate whether your jurisdiction passes Requirement 9,” lists three things the jurisdiction must be able to do at a minimum to pass— 1) answer “yes” to 9a and 9b; 2) document who in the department monitors or participates in the Working Groups; and 3) accurately document a list of any other market analysis or market conduct related working groups or task forces the jurisdiction participates in or monitors. She
said the third element conflicts with the last paragraph of the guidelines that says it is at the jurisdiction’s discretion to participate in or monitor the Market Information Systems (D) Task Force or any other working group or task force that reports to the Market Regulation and Consumer Affairs (D) Committee. She said the Working Group should modify the guidelines to eliminate this conflict by either making participation in or monitoring of these other groups mandatory or discussing them in the guidelines as something the jurisdiction should consider being a best practice.

Ms. O’Connell recommended modifying the requirement 11 guidelines and the criteria for what passes this requirement to mirror the current national analysis program process with the recognition that the process could change in the future, in which case the guidelines will be reevaluated and modified. She said the current structure of the national analysis program calls for: 1) a lead state for each line of business that is responsible for the selection process; 2) individual jurisdictions to perform analysis on selected companies; and 3) a summarizing jurisdiction responsible for compiling the results of all individual state analysis for a single company. She said a state currently gets no credit under the certification program for acting as a summarizing jurisdiction. She said the limited number of lead state spots per year will not allow all 56 jurisdictions to have the opportunity be a lead state every other year as needed to pass the requirement. She recommended restructuring the requirement, guidelines and checklist to allow a state to pass the requirement if it reviews national analysis data on an annual basis and on an every other year basis either acts as a lead state responsible for the selection process or acts as a summarizing jurisdiction.

Finally, Ms. O’Connell said the years identified throughout the Proposal for Implementation need to be updated to reflect the current timeline. She said the Working Group should consider a more generic description, such as “two weeks before the Fall National Meeting of the first year following adoption by the membership” since it is not known when the Market Regulation and Consumer Affairs (D) Committee and the Executive (EX) Committee and Plenary will adopt the program. Mr. Decker agreed with updating the implementation dates.

Ms. Nickel said the word “or” needs to be included in the second sentence of the requirement 1 wording, “Additionally, the jurisdiction has adopted, is in the process of adopting, …” to read, “… or is in the process of adopting …”.

Ms. Nickel said the fourth bullet point under section b of the requirement 4 guidelines references “similar organizations.” She said this needs to be defined to specify whether it includes associate or higher-level designations from the Society of Financial Examiners (SOFE) or the Life Office Management Association (LOMA), which are already a requirement in other NAIC standards. She said Ms. O’Connell’s idea to be more general is the best solution.

Ms. Nickel said section d of the requirement 4 guidelines asks if the market regulation section recognizes the licenses and credentials of cybersecurity and information technology (IT) experts. She said this may be duplicative because the financial examinations section of DOIs uses these experts on targeted examinations of domiciled companies where a cyber event occurs. She said this is part of any financial examinations conducted as scheduled by Idaho and is already required by the NAIC financial accreditation standards. Mr. Haworth noted that non-domestic examinations are often left to the market regulation departments to conduct. Ms. Amann noted that the IT Examination (E) Working Group has a charge to work with the Market Conduct Examination Standards (D) Working Group to assist in the development of regulatory oversight policy with respect to cybersecurity examination issues, as requested by the Innovation and Technology (EX) Task Force. She said the guidance from this work may assist smaller states.

Ms. Nickel said the first paragraph of requirement 8 should be rewritten to be more in line with the objective statement and checklist of requirement 8. She suggested (suggested changes in italics): “The department enters data as information is available for sharing into all NAIC systems, including, but not limited to, the Complaint Database System (CDS) and the Regulatory Information Retrieval System (RIRS). Except for immediate concerns as defined in the Market Regulation Handbook, the department enters data into the Market Action Tracking System (MATS) at least 60 days prior to the start of the on-site examination. Additionally, the department enters continuum actions into MATS as appropriate.”

Ms. Nickel said the reporting of continuum actions should be “as appropriate.” She noted the objective statement of requirement 8 indicates the goal is to ensure other jurisdictions are timely informed of market conduct actions that “have occurred, are ongoing, or that are anticipated.” In the checklist, the entry into MATS for on-site examinations are required 60 days prior, but there is no other requirement for continuum activities entry to be 60 days prior. She said that is correct since it would be impossible to enter continuum activities 60 days prior if they were the result of a Market Analysis Review System (MARS) Level 1 or Level 2 recommendation, a referral from the consumer complaints section, a company self-reporting, or if there was an immediate concern.
Ms. Nickel said the checklist item 8c reference to “appropriate databases” is unclear. She said if there are databases other than MATS, she suggested rewording 8c to say: “Does the department enter continuum actions into the other appropriate NAIC database, such as MATS, as recommended and the resulting applicable final status reports or updates (if applicable) at least quarterly?” However, if 8c is intended to be specific to MATS and continuum activities, and there is no quarterly reporting requirement, she suggested rewording 8c to: “Does the department enter continuum actions into MATS including the resulting applicable final status reports or updates as appropriate (or as recommended/required by the Department)?”

Ms. Nickel noted Idaho does not have the resources to continuously update MATS actions quarterly. She said as part of the DOI’s market analysis procedure, MATS actions are entered and updated throughout the course of the continuum activity, which may only be when initially entered and at finalizing the action. She said this may take longer than three months.

Ms. Nickel asked what was necessary to pass certification overall. Do all requirements need to be passed or simply most requirements be passed, or some other number of requirements?

Mr. Decker said he has the same concerns as Ms. O’Connell about needing more objective standards for passing requirement 1. He also noted the same issues with being sure the checklist references are correct for renumbered item numbers.

Mr. Decker asked if any of the pilot program participating states that answered “yes” to requirement 3 checklist items 3i and 3j would share examples of their policies and procedures and the quantitative and subjective measurements that they used in determining if they passed. He said the standards for determining whether a state passed seemed subjective.

For the requirement 8 checklist, Mr. Decker asked if a jurisdiction must be 100% compliant for items 8c and 8e. If not, he suggested incorporating error tolerance rates.

Mr. Decker suggested a metric for measuring success in meeting requirement 9. He said the current measurement is subjective and would be improved by adding a percentage metric similar to the 50% attendance requirement that is used in requirement 10 checklist item 10c.

Mr. Decker said the requirement 10 checklist item 10d does not define how “actively monitor” will be measured. He said a metric should be added for item 10d. He also suggested adding “or their designee” to the individuals who monitor bulletin board discussions.

Lisa Brown (American Property Casualty Insurance Association—APCIA) noted the certification program contains discussion of rating such as “pass,” “unqualified pass,” or “provisional pass” but no discussion on what a “fail” rating would be. She asked if this was because the checklist would only be submitted by jurisdictions that passed each requirement, or because it is intended for each jurisdiction to pass.

Ms. Brown also noted the absence of any requirements to protect insurers, such as requiring states to submit budgets, time frames for review and confidential feedback mechanisms when contract examiners are used.

Ms. Brown said she agrees with Ms. O’Connell regarding requirement 3 checklist item 3j that it is difficult to measure whether a jurisdiction has achieved its policies and procedures for staffing.

Ms. Brown said the use of premium volume of companies examined since it implies jurisdictions will be measured by the premium volume examined. She noted this could skew jurisdictions into examining only large companies rather than companies where potential problems or misconduct exist. Mr. Haworth said it may be more helpful to measurement staffing needs by total market premium rather than the premium of just the examined entities.

Ms. Brown also said requirement 6 asks if a jurisdiction’s policies and procedures are consistent with the Market Actions (D) Working Group’s policies and procedures. She said industry object to a requirement conditioned on a document to which it has no access.

Michael Lovendusky (American Council of Life Insurers—ACLI) said the ACLI agrees with the comments submitted by the APCIA. In addition, he said he would recommend a new bullet point for requirement 5 that would read: “The department shall have the authority and capability to: Comply with cybersecurity requirements equal or more rigorous than those required of regulated entities.” He said the regulated entities have concerns that government agencies have processes and protections to ensure against cybersecurity breach, especially as they increasingly use contract vendors.
Mr. Lovendusky said the proposal to delete checklist items pertaining to contract examiners would eliminate critical information about the cost of contract examiners, which is often passed on to the regulated entity.

Mr. Lovendusky agreed with the APCIA’s concern that industry has no access to the Market Actions (D) Working Group’s policies and procedures and said it is more critical if the Market Actions (D) Working Group or a member state relies on contract examiners.

Mr. Haworth said he and Mr. Cole would incorporate the recommended changes and circulate the next version of the certification program prior to the next meeting.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.
Chapter 26A—Conducting the Limited Long-Term Care Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state’s own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter applies to limited long-term care insurance policies. This chapter does not apply to qualified limited long-term care insurance contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement limited long-term care insurance. This chapter also does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

This chapter provides a format for conducting limited long-term care insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of limited long-term care insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management  
B. Complaint Handling  
C. Marketing and Sales  
D. Producer Licensing  
E. Policyholder Service  
F. Appeal of Benefit Trigger Adverse Determination  
G. Underwriting and Rating  
H. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

IIPRC-Approved Products
When conducting an exam that includes limited long-term care insurance products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind the uniform standards, and not state-specific statutes, rules and regulations, are applicable to the content and approval of the product. The IIPRC website is www.insurancecompact.org and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a
compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards). Under the uniform standards, a limited long-term care insurance product approved by the IIPRC can be used in a compacting state’s partnership program provided the company has obtained the necessary approval from the compacting state or made the necessary certification to the compacting state, as applicable. Please note that the company must still comply with a compacting state’s laws for minimum daily benefit amounts, minimum benefit periods and maximum elimination periods when selling a limited long-term care insurance product approved by the IIPRC.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
OPERATIONS/MANAGEMENT

**Standard 1**
The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.

**Apply to:** All limited long-term care companies

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations
- Insurance department records of reports and certifications made by the entity

**Others Reviewed**

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**NAIC Model References**

- *Limited Long-Term Care Insurance Model Act* (#642)
- *Limited Long-Term Care Insurance Model Regulation* (#643)

**Review Procedures and Criteria**

Each insurer shall file with the insurance commissioner, prior to offering group limited long-term care insurance to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory limited long-term care insurance requirements substantially similar to those adopted in the state of issue (Model #643 Section 20 & Model 642 Section 5). (Note: Section 20 of the *Limited Long-Term Care Model Regulation* (#643) requires an evidentiary filing only from discretionary groups.

Each insurer should file with the insurance commissioner a copy of any limited long-term care insurance advertising intended for use in the state—whether through written, radio or television medium—for review or approval to the extent required by state law. All advertisements should be retained for at least three years from the date of first use.

Determine if replacement/lapse reporting is submitted by the entity as required. Items to be reported are:

- Top 10 percent of producers with the highest percentage of replacements and lapses; and
- Number of lapsed policies as a percentage of annual sales and policies in force at the end of the previous calendar year.

Determine that the entity complies with filing and certification requirements set forth by statutes, rules and regulations for associations endorsing or selling limited long-term care insurance. Generally, these requirements are imposed on an association group meeting the definition of a professional/trade/occupational association found in Section 4E(2) of the *Limited Long-Term Care Insurance Model Act* (#642).
Ensure that the insurer has filed all requested advertising with the insurance department regarding association sold or endorsed limited long-term care insurance, as may be requested by the insurance department. Any such advertising must disclose:

- The specific nature and amount of compensation that the association receives from the endorsement or sale of the policy or certificate to its members; and
- A brief description of the process under which the policies and the issuing insurer were selected.

Determine that the entity submits suitability and rescission information as required by applicable statutes, rules and regulations.

Determine the regulated entity has proper procedures in place to ensure its producers are properly trained and that the training meets the minimum standards established by the applicable laws and regulations.

Insurers subject to the Limited Long-Term Care Insurance Model Act (#642) shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A of the Long-Term Care Insurance Model Act (#640) and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of limited long-term care, including Medicaid, in a state. These records shall be maintained in accordance with state record retention requirements and shall be made available to the commissioner upon request. Pursuant to Model#642, Section 9 – Producer Training Requirements are optional.

Most states have a limited long-term care partnership policy forms certification process in order for limited long-term care partnership forms to be sold in their state.
B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
STANDARDS
MARKETING AND SALES

Standard 1
The entity has suitability standards for its products, where required by applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Recommended

Documents to be Reviewed

____ Applicable statutes, rules and regulations
____ Producer records
____ Training materials
____ Procedure manuals
____ Underwriting/Policy files

Others Reviewed

____ ____________________________
____ ____________________________

NAIC Model References

*Limited Long-Term Care Insurance Model Act (#642)*
*Limited Long-Term Care Insurance Model Regulation (#643)*

Review Procedures and Criteria

Determine whether the entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have the entity run a policyholder history to identify the number of policies sold to those individuals.

Determine if entity guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine if the entity has developed and uses suitability standards and procedures to determine whether the purchase or replacement of limited long-term care insurance is appropriate for the needs of the applicant. Suitability standards and procedures should include:

- Consideration of the advantages and disadvantages of insurant to meet the needs of the applicant; and
- Discussion with applicants of how the benefits and costs of limited long-term care insurance compare with long-term care insurance.
- Agent training in its suitability standards and procedures
- Maintain a copy of suitability standards and procedures and make them available for inspection upon request by the commissioner.
If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent. Either the applicant’s returned letter or a record of the alternate method of verification shall be made a part of the applicant’s file.

Note: Pursuant to Section 25H of the Limited Long-Term Care Insurance Model Regulation (#643), suitability standards do not apply to life insurance policies or riders that accelerate benefits for limited long-term care as defined in the Limited Long-Term Care Model Act, Section (# 642), Section 4(D).

Determine if the insurer is reporting suitability information to the insurance commissioner as required by applicable statutes, rules and regulations.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used by the entity.

Ensure the entity maintains a written statement specifying the standards of suitability used by the insurer and provides the standards to its producers, and that both follow the standards. The standards should specify that no recommendation should be made and/or no policy issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant (based on information known to the insurer or producer making the recommendation).
STANDARDS
MARKETING AND SALES

Standard 2
Policy forms provide required disclosure material regarding standards for benefit triggers.

Apply to: All limited long-term care products
Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
_____ Claim procedure/Underwriting manuals
_____ Claim files
_____ Policy forms

Others Reviewed

_____ __________________________
_____ __________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ensure the policy conditions the payment of benefits on a determination of the insured’s ability to perform activities of daily living (ADLs) and cognitive impairment.

Ensure that the policy contains the definition of ADLs, cognitive impairment and other key terms as required by statutes, rules and regulations.

Determine that the eligibility for payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the ADLs or the presence of cognitive impairment. Ensure that payment of benefits is not more restrictive than those allowed by statutes, rules and regulations.

Ensure that the policy contains a clear description of the process for appealing and resolving benefit determinations.
STANDARDS
MARKETING AND SALES

Standard 3
Marketing for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Required reports filed with the insurance department

_____ Marketing materials filed with the insurance department

_____ Underwriting files or other files containing proof of issuance of outline of coverage

_____ Review state statutes, rules and regulations to determine if state limited long-term care requirements apply to annuity products with a limited long-term care element. If so, then the applicable Annuity Disclosure Model Regulation (#245) would apply

Others Reviewed

_____ ________________________________

_____ ________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Life Insurance Disclosure Model Regulation (#580)
Life Insurance Illustrations Model Regulation (#582)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity uses applications for limited long-term care insurance policies or certificates containing clear and unambiguous questions designed to ascertain the health condition of the applicant. (In most cases, application forms should have been reviewed by the insurance department’s rates and forms division.)

Verify that the entity complies with right to return/“free look” requirements.

Verify that the outline of coverage is delivered to the applicant at time of initial solicitation through means that prominently directs the attention of the recipient to the document and its purpose.
Verify that at the time of policy delivery the insurer has delivered a policy summary for an individual life insurance policy that provides limited long-term care benefits within the policy or by rider. In the case of direct response solicitations, verify that the insurer has delivered the policy summary upon the applicant’s request, but regardless of request has made delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, ensure that the summary also includes:

- An explanation of how the limited long-term care benefit interacts with other components of the policy;
- Any exclusions, reductions and limitations on benefits of limited long-term care; and
- A statement that any limited long-term care inflation protection option required by the applicable state’s statutes, rules and regulations regarding inflation protection option requirements comparable to Section 13 of the Limited Long-Term Care Insurance Model Regulation (#643) is not available under this policy.

In addition to the above, if applicable to the policy type, ensure that the summary includes the following:

- A disclosure of the effects of exercising other rights under the policy; and
- A disclosure of guarantees related to limited long-term care costs of insurance charges.

The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with the applicable state’s basic illustration requirements comparable to Sections 7 and 8 of the Life Insurance Illustrations Model Regulation (#582) or into the life insurance policy summary, which is required to be delivered in accordance with the applicable state’s life insurance policy summary requirements comparable to Section 5 of the Life Insurance Disclosure Model Regulation (#580).

Verify that the entity complies with records maintenance and reporting requirements:

- Entity must maintain records for each producer of that producer’s amount of replacement sales as a percentage of the producer’s total annual sales and the amount of lapses of limited long-term care insurance policies sold by the producer as a percentage of the producer’s total annual sales;
- Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements;
- Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year; and
- Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year.
STANDARDS
MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>All advertising and sales materials are in compliance with applicable statutes, rules and regulations.</td>
</tr>
</tbody>
</table>

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for advertisements approved by the IIPRC)
- All company advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials
- Policy forms, including any required buyer’s guides, outline of coverage, limited long-term care insurance personal worksheets and disclosure forms as they coincide with advertising and sales materials
- Producer’s own advertising and sales materials

Others Reviewed

- ____________________________
- ____________________________

NAIC Model References

*Limited Long-Term Care Insurance Model Act* (#642)
*Limited Long-Term Care Insurance Model Regulation* (#643)
*Unfair Trade Practices Act* (#880)

Review Procedures and Criteria

Evaluate the company’s system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either at least three years from the date the advertisement was first used or later if required by state statutes, rules and regulations.
Review advertising materials in conjunction with the appropriate policy form. Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead prospective buyers to believe that they are purchasing an investment or savings plan. Problematic terminology may include the following terms: investment, investment plan, founder’s plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences;
- Use terms such as “non-medical” or “no medical examination required,” if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is a fact. Enrollment periods may not be described in terms such as “special” or “limited” when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in the advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact; and
- Misrepresent any policy as being shares of stock.
Materials should:

- Clearly disclose the name and address of the insurer;
- If using a trade name, disclose the name of the insurer, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to the policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed; and
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact. Any proprietary relationship or payment for the testimonial must be disclosed.

Determine if the company approves producer sales materials and advertising. Ensure that copies of sales material other than company-approved materials, if permitted, are maintained in a central file. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer’s capacity as an insurance producer. Improper terms may include “financial planner,” “investment advisor,” “financial consultant” or “financial counseling,” if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Review the use of the words “free,” “no cost,” “without cost,” “no additional cost,” “at no extra cost” or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy, unless it is a fact. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a limited long-term care insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

Determine that company procedures and materials relative to limited long-term care products comply with right to return/“free look” requirements.

Review the company and producer’s Internet sites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised products are (or are not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?
For the review of Internet advertisements:

- Run an inquiry with the company’s name;
- Review the company’s home page;
- Identify all lines of business referenced on the company’s home page;
- Research the ability to request more information about a particular product and verify that the information provided is accurate; and
- Review the company’s procedures related to producers’ advertising on the Internet and ensure that the company requires prior approval of the producers’ web pages, if the company name is used.
STANDARDS
MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 5</th>
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<tbody>
<tr>
<td>Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.</td>
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</tbody>
</table>

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

___ Applicable statutes, rules and regulations
___ Replacement register
___ Policy/Underwriting file
___ Loan and surrender files, if applicable

Others Reviewed

___ __________________________
___ __________________________

NAIC Model References

*Life Insurance and Annuities Replacement Model Regulation* (#613), if applicable
*Limited Long-Term Care Insurance Model Regulation* (#643)

Review Procedures and Criteria

Review policy/underwriting files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm applicant’s receipt of replacement notice.

Review replacement disclosure forms for completeness and signatures as required.
STANDARDS
MARKETING AND SALES

Standard 6
Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations
_____ Replacement register
_____ Policy/Underwriting file
_____ Agency correspondence file/Agency bulletins
_____ Agency procedural manual
_____ Claim files
_____ Agency sales/Lapse records
_____ Company systems manual

Others Reviewed

_____ ________________________________
_____ ________________________________

NAIC Model References

*Life Insurance and Annuities Replacement Model Regulation* (#613), if applicable
*Limited Long-Term Care Insurance Model Regulation* (#643)

Review Procedures and Criteria

Determine if the company has advised its producers of its replacement policy.

Determine if the company has separate commission schedules for replacement business, pursuant to applicable state statutes, rules and regulations. Note: Some states limit the compensation payable on replacement business to no more than that payable on renewal policies.

Determine if the company has provided timely notice to the existing insurers of the replacement.

Examine the company system of identifying undisclosed replacements for effectiveness.

Determine if the company has the capacity to produce the data required by replacement regulation to assess producer replacement activity.
Determine if the company has issued letters in a timely manner to policyholders advising of the effects of preexisting conditions on covered benefits.

Review policy/underwriting files to determine if the company is retaining required records for required time frames.

Examine company procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the company provides required credit for preexisting conditions or probationary periods on replacements.
D. Producer Licensing

Use the Producer Licensing Standard 2 that is provided in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
## STANDARDS

### POLICYHOLDER SERVICE

<table>
<thead>
<tr>
<th>Standard 1</th>
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<tbody>
<tr>
<td>Policy renewals are applied consistently and in accordance with policy provisions.</td>
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</table>

**Apply to:** All limited long-term care products  
**Priority:** Essential

### Documents to be Reviewed

- [ ] Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- [ ] Underwriting/Policy file
- [ ] Underwriting/Administrative procedure manuals

Others Reviewed

- [ ]
- [ ]

### NAIC Model References

- Limited Long-Term Care Insurance Model Regulation (#643)

### Review Procedures and Criteria

Review renewal business to determine if the entity’s procedures for handling renewals are in accordance with applicable statutes, rules and regulations.

Ensure that individual policies or certificates do not contain renewal provisions other than “guaranteed renewable” or “noncancellable,” and that these terms are adequately defined in the policy or certificate.

Review the underwriting/policy file to determine if premium notices were sent in a timely and accurate manner.

Review mailroom records for billings sent by the entity to ensure they were sent in a timely manner.
STANDARDS
POLICYHOLDER SERVICE

**Standard 2**
Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

- Underwriting/Administrative files

**Others Reviewed**

- _________________
  _________________

**NAIC Model References**

- *Limited Long-Term Care Insurance Model Act (#642)*
- *Limited Long-Term Care Insurance Model Regulation (#643)*

**Review Procedures and Criteria**

Determine if the required notification of lapse or termination is sent to the proper addressee(s), within the required time frames and that the required information is provided, per applicable statutes, rules and regulations.

Ensure that the entity receives designation of a person(s), other than the insured, to receive notice of lapse or termination of the policy or certificate for nonpayment of premiums or a written waiver by the insured not to designate an additional person(s) to receive notice.

Ensure that the insurer notifies existing insureds of their right to change their written designation at least once every two years, or as specified by state statutes, rules and regulations.

Verify that nonforfeiture and reinstatement provisions were applied consistently and in a non-discriminatory manner. Nonforfeiture provisions upon lapse and reinstatements should be applied per policy provisions and in accordance with applicable statutes, rules and regulations.

Ensure that the policy includes a provision that provides for reinstatement of coverage in the event of lapse, if the entity has provided evidence that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option should be made available to the insured for a period of 5 months after the date of termination.
**STANDARDS**

**POLICYHOLDER SERVICE**

<table>
<thead>
<tr>
<th>Standard 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.</td>
</tr>
</tbody>
</table>

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- Underwriting/Administrative file
- Entity procedures manual

**Others Reviewed**

- __________________________
- __________________________

**NAIC Model References**

*Limited Long-Term Care Insurance Model Act (#642)*

*Limited Long-Term Care Insurance Model Regulation (#643)*

**Review Procedures and Criteria**

Determine if the entity offers applicants the opportunity to purchase a limited long-term care policy that includes a nonforfeiture benefit, as required by applicable statutes, rules and regulations.

If the applicant declines the nonforfeiture benefit, ensure that the entity provides a contingent benefit upon lapse of the policy for a specified period following a substantial increase in premium rates, as required and defined by applicable statutes, rules and regulations.

Ensure that a policy offered with nonforfeiture benefits contains the same coverage elements, eligibility, benefit triggers and benefit length as a policy without the nonforfeiture benefit.

Determine if the entity provides notice as required by applicable statutes, rules and regulations prior to the due date of the premium reflecting a substantial premium increase.

Ensure that the entity offers the proper nonforfeiture benefit and nonforfeiture credit, as required by applicable statutes, rules and regulations.

Determine if the policy contains the proper time frames for nonforfeiture benefit and the contingent benefit upon lapse, as required by applicable statutes, rules and regulations.

Determine if the correct nonforfeiture option is provided in case of policy lapse.
Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to nonforfeiture values, refer to applicable statutes, rules and regulations regarding the calculation of nonforfeiture values.

Review the entity’s procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Ensure that the entity notifies policyowners of material changes to any nonforfeiture benefits in accordance with applicable statutes, rules and regulations.
STANDARDS
POLICYHOLDER SERVICE

Standard 4
Policyholder service for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedures manuals

_____ Procedure manuals

Others Reviewed

_____ ________________________________

_____ ________________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity offers nonforfeiture benefits.
F. Appeal of Benefit Trigger Adverse Determination

Use the standard set forth below.
STANDARDS
APPEAL OF BENEFIT TRIGGER ADVERSE DETERMINATION

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.</td>
</tr>
</tbody>
</table>

**Apply to:** All limited long-term care insurers

**Priority:** Essential

**Documents to be Reviewed**

- Company’s written procedures explaining administration of appeals process and template denial letters
- Internal company procedures which describe the appeals process
- Applicable statutes, rules and regulations
- Request copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective

**Others Reviewed**

- _______________ __________________________
- _______________ __________________________

**NAIC Model References**

*Limited Long-Term Care Insurance Model Regulation* (#643)

**Review Procedures and Criteria**

Ask insurer how it describes its appeal procedures to the insured.

Ask for copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective.

In the event the insurer has determined that the benefit trigger of a limited long-term care insurance policy has not been met, verify that the insurer has provided a clear, written notice to the insured and the insured’s authorized representative, if applicable, of all of the following:

- The reason that the insurer determined that the insured’s benefit trigger had not been met;
- The insured’s right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request within 120 calendar days of receipt of the notice; and
- The insured’s right, after exhaustion of the insurer’s internal appeal process, to have the benefit trigger determination to contact their state insurance department and their State Health Insurance Program (SHIP) office.

Ensure that the individual or individuals making the internal appeal decision are not the same individual or individuals who made the initial benefit determination.
Verify that the insurer, within 30 calendar days of the insurer’s receipt of all necessary information upon which a final determination can be made, has completed and sent written notice of the internal appeal decision to the insured and the insured’s authorized representative, if applicable.

If the insurer’s original determination is upheld upon internal appeal, ensure that the notice of the internal appeal decision describes any additional internal appeal rights offered by the insurer.

If the insurer’s original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their state insurance department and their State Health Insurance Program (SHIP) office, pursuant to applicable state statutes, rules and regulations.

Verify that if any new or additional information not previously provided to the insurer is submitted by the insured or the insured’s authorized representative, the insurer either (1) considers and affirms or (2) overturns its benefit trigger determination.

If the insurer overturns its benefit trigger determination, verify that the insurer has provided notice to the insured and the insured’s authorized representative, if applicable, and the commissioner of its decision.
G. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- Rating practices;
- Underwriting practices;
- Use of correct and properly filed and approved forms and endorsements;
- Termination practices;
- Unfair discrimination;
- Use of proper disclosures, outlines of coverage and delivery receipts;
- Reinsurance; and
- Marketing and sales materials.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Individual and group issued and renewed policy files;
- Policy summaries;
- Replacement and conservation materials;
- Documentation of required disclosures and delivery receipts;
- Individual and group canceled policy files and certificates;
- Documentation of premium refund upon election of “free look” period;
- Recessions occurring prior to a claim;
- Policy forms, endorsements and applications, along with appropriate filings;
- Producer licensing information;
- Producer compensation agreements, where applicable;
- Premium statements and billing statements;
- Group trust arrangements, where applicable;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;
- Reinsurer policies/treaties; and
- Reinsurer guidelines and manuals.

For the purposes of this chapter, “underwriting file” means the file or files containing the new business application, renewal application, certificates or evidences of coverage, including binders, rate calculation sheets, billings, medical information, credit information, inspection or interview reports, all underwriting information obtained or developed, policy summary page, endorsements, cancellation or reinstatement notices, correspondence and any other documentation supporting selection, classification, rating or termination of the policy.
In selecting samples for testing, individual policies should generally not be combined with group policies. Because these two areas are generally not homogeneous, any conclusions or inferences made from the results of sampling may not be valid if combined. The examiner should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies, endorsements and premium statements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice of the examination.

Next, determine the entity’s policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain that the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner’s responses should maximize objectivity; the examiner should avoid replacing examiner judgment for entity judgment.

a. Rating Practices

It is necessary to determine if the entity is in compliance with rating systems that have been filed with and, in some cases, approved by the insurance department. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the entity’s own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by an entity might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that an entity is engaged in unfair competitive practices. Inconsistent application of rates or classifications can result in unfair discrimination.

If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the use of improperly worded, vague or obsolete rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

Occasionally, the examiner may need to review loss statistics to determine if premiums are fair and reasonable in relation to the associated claims experience. When possible, the examination team should make use of audit software to verify the correct application of specific rating components and the consistent use of rates. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

The rating practices for renewal policies and newly issued policies should be reviewed. The examination team should also review premium notices and billing statements. The examiner should ensure the proper application of rate increases or rate decreases.

The examiner should also ensure that the underwriting files contain sufficient information to support the rates that have been developed.
b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the entity’s underwriting manuals, underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and entity minutes that may furnish evidence of anti-competitive behavior may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the entity’s compliance with its own manuals and guidelines. The examiner should confirm that the entity’s underwriters and producers consistently apply the entity guidelines for all business selected or rejected. The examination team should verify that the entity has correctly classified insured individuals.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the entity’s management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of the business. Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each applicable field office.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to the insurance department’s counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Termination Practices

The examination team should review the entity’s policy cancellation and reinstatement practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the entity’s own rules, guidelines and policy provisions.

Cancellation and lapsed policy processing should include a formal notice to the insured, including secondary addressees, where elected by the insured. Adherence to policy provisions for renewal language and for applicable grace periods should be reviewed.

The examination team should verify that premium refunds upon election of “free look” provisions are handled correctly, uniformly and in a timely manner.

The examination team should review reinstatement offers and determine what the entity’s practice is for offering reinstatement. In addition, the examination team should be mindful of billing practices that may encourage policy lapses.
e. Unfair Discrimination

The examination team should be mindful of entity underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional, yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

f. Use of Proper Disclosures, Buyer’s Guides and Outlines of Coverage

The examination team should review the entity’s use of required disclosure forms, buyer’s guides, policy summaries, replacement notices, “free look” periods and outlines of coverage. In addition to the use of such required items, the examiner may wish to verify that the above items contain the correct content and are in the correct format.

g. Reinsurance

Most state statutes include a feature that for many lines of business the entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files.

Adherence to the requirement is easy to test, but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It also may reflect on the care that the entity’s management places on its selection of business, and represent a danger to the financial health of the entity. Errors in this area should be forwarded to the appropriate state financial examiners. Any tests of this type must be coordinated with the state’s financial examiners.

h. Marketing and Sales Materials

It is recommended that a review of all forms and materials be conducted by reviewing the marketing and sales standards simultaneously during the underwriting and rating review.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the entity’s underwriting activities. The sequence of the standards listed here does not indicate priority of the various standards.
STANDARDS
UNDERWRITING AND RATING

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mandated definitions and requirements for group limited long-term care insurance are followed in accordance with applicable statutes, rules and regulations.</td>
</tr>
</tbody>
</table>

Apply to: All group limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Rating/Quote information provided electronically

_____ Marketing materials

_____ Correspondence to producers

Others Reviewed

_____ ________________________________

_____ ________________________________

NAIC Model References

*Limited Long-Term Care Insurance Model Act (#642)*

*Limited Long-Term Care Insurance Model Regulation (#643)*

Review Procedures and Criteria

If a group policy is issued to an employer or labor organization or association, determine if the group meets the required criteria to qualify the association or organization as a bona fide organization established for the benefits of its members.

Determine if all group limited long-term care policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group limited long-term care policy standard provisions that are applicable in the examining jurisdiction are incorporated into the group policy. These provisions include, but are not limited to, grace periods, periods of incontestability, required copies of applications, deemers of representations and not warranties, medical or other evidence of insurability, provision for a certificate of insurance and conversion to an individual policy in the event of termination or total disability.
STANDARDS
UNDERWRITING AND RATING

<table>
<thead>
<tr>
<th>Standard 2</th>
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</thead>
<tbody>
<tr>
<td>Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.</td>
</tr>
</tbody>
</table>

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All applications

Others Reviewed

_____ ____________________________________________

_____ ____________________________________________

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and inflation protection options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Determine if the application complies with applicable statutes, rules and regulations regarding form and content.
STANDARDS
UNDERWRITING AND RATING

<table>
<thead>
<tr>
<th>Standard 3</th>
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<tbody>
<tr>
<td>The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.</td>
</tr>
</tbody>
</table>

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations
- Applications and related disclosure and consent forms
- Health questionnaires for applicants
- Medical underwriting guidelines
- Entity guidelines regarding the handling of AIDS-related test results, if such tests are allowed

**Others Reviewed**

- ____________________________
- ____________________________

**NAIC Model References**

*Limited Long-Term Care Insurance Model Regulation (#643)*

**Review Procedures and Criteria**

Ensure the entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional.

Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test, and should be a part of the underwriting file. Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

Questions may ask if the applicant has been diagnosed with AIDS or ARC, if they are designed to establish the existence of the condition, but are not to be used as a proxy to establish sexual orientation of the applicant.
Ensure the entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant’s sexual orientation a factor in the determination of insurability.

Review a sample of underwriting files for denied applications in order to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the entity guidelines (e.g., based on the amount of insurance).

Neither the marital status, the living arrangements, the occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant’s sexual orientation.
STANDARDS
UNDERWRITING AND RATING

Standard 4
Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting/Administration file

_____ Policies, riders, amendments, endorsements, applications and certificates of coverage

Others Reviewed

_____ _________________ _________________

_____ _________________ _________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the policy contains the required terms and definition of such terms per applicable statutes, rules and regulations, including, but not limited to:

- Guaranteed renewable and noncancellable;
- Activities of daily living, acute condition, adult day care, bathing, cognitive impairment, continence, dressing, eating, hands-on assistance, home health care services, Medicare, mental or nervous disorder, personal care, skilled nursing care, toileting and transferring. In addition, coverage specific to limited long-term care benefits may include non-skilled nursing care by providers of service, including but not limited to skilled nursing facility, extended care facility, convalescent nursing home, personal care facility, specialized care providers, assisted living facility, and home care agency; and
- Reasonable and customary/usual and customary.

Determine if riders and endorsements added after the original date of issue, at reinstatement or renewal that reduce or eliminate benefits or coverage (except as requested by the insured) require signed acceptance by the insured.

Ensure that the entity has not established a new waiting period in the event existing coverage is converted or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the individual or group policyholder.
Ensure that the entity does not apply preexisting condition provisions more restrictive than “…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person,” unless the insurance commissioner has extended limitation periods.

A limited long-term care insurance policy or certificate, other than a policy or certificate issued to a defined group, may not exclude coverage for a loss or confinement that is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

A limited long-term care insurance policy or certificate may not exclude or use riders or waivers to exclude, limit or reduce benefits for specifically named or described preexisting conditions or physical conditions beyond the defined waiting period.

Determine if the policy meets the requirements under applicable statutes, rules and regulations with regard to prior hospitalization/institutionalization. The policy may not:

- Condition eligibility of any benefits on a prior hospitalization requirement, or, in the case of benefits provided in an institutional care setting, on the receipt of a higher level of institutional care;
- Condition eligibility for benefits (other than waiver of premium, post-confinement, post-acute care or recuperative benefits) on a prior institutionalization requirement;
- Condition eligibility of non-institutional benefits based on the prior receipt of institutional care on a prior institutional stay of more than 30 days; and
- Condition the receipt of benefits following institutionalization upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge.

A policy or rider containing post-confinement, post-acute care or recuperative benefit shall contain in a separate paragraph titled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.

Determine if the policy contains any limitations regarding preexisting conditions, and, if so, ensure that they are outlined in a separate paragraph titled “Preexisting Condition Limitations.”

Ensure that the policy measures the need for limited long-term care on the activities of daily living (ADLs) and cognitive impairment, and that they are described—along with any additional benefit triggers, benefits and entity-required certification of functional dependency—in a separate paragraph titled “Eligibility for the Payment of Benefits.”

If a limited long-term care policy provides benefits for home health care or community care services, ensure that it meets the required minimum standards required by applicable statutes, rules and regulations.
STANDARDS

UNDERWRITING AND RATING

Standard 5
Underwriting and rating for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All group limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Insurance department approval of forms

_____ Underwriter’s file or notes on a system log

_____ Insured’s request (if applicable)

_____ Entity cancellation/nonrenewal guidelines

_____ Certificate of mailing

Others Reviewed

_____ ____________________________

_____ ____________________________

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and applicable statutes, rules and regulations.

Review entity procedures for cancellation/nonrenewal to determine if the entity is following its own guidelines.

Review cancellation and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the forms, if necessary, were approved by the insurance department.
In addition to other applicable review procedures, verify the following:

- The entity has not cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;
- The entity has not established a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
- The entity does not provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; and
- The entity does not apply preexisting condition provisions more restrictive than “…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person,” unless limitation periods have been extended by the insurance commissioner.

Verify that standards for incontestability periods are no more restrictive than as follows:

- Within 6 months, misrepresentations must be material;
- Within 2 years and more than 6 months, misrepresentation must be material and pertain to the condition for which benefits are sought; and
- After 2 years, benefits are contestable only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured’s health.

Verify that the entity’s underwriting practices reflect minimum requirements related to guaranteed renewability, noncancellability and continuation or conversion.

Replacement of a group limited long-term care policy with another group limited long-term care policy shall offer coverage to all persons covered under the previous group policy on its date of termination, with no preexisting condition exclusions that would have been covered on the prior policy and shall not vary or otherwise depend on the individual’s health or disability status, claim experience or use of limited long-term care services.

Verify that the entity provides notice to the designated person, in addition to the applicant, for termination of a policy or certificate for nonpayment of premium.

Verify that the entity allows for reinstatement of coverage in the event of lapse if provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

Verify that prior to issuance of a limited long-term care policy or certificate to an applicant age 80 or older, the insurer obtains one of the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician’s statement; or
- Copies of medical records.

Verify that the entity delivers a copy of the completed application or enrollment form (whichever is applicable) to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

Verify that the entity maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. The entity shall annually furnish this information to the insurance commissioner in the format prescribed by applicable statutes, rules and regulations.

Verify that the premium charged does not increase due to increase of age beyond 65 or the duration the insured has been covered under the policy.
STANDARDS
UNDERWRITING AND RATING

Standard 6
The company’s underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Apply to:  All limited long-term care products

Priority:  Essential

Documents to be Reviewed

___  Applicable statutes, rules and regulations
___  New business application
___  All underwriting information obtained
___  Company underwriting guidelines and bulletins
___  Declination procedures
___  Agency agreements and correspondence with producers
___  Riders or extensions of coverage
___  Interoffice memoranda and company minutes
___  Policy specifications page
___  Underwriter’s file or notes on a system log

Others Reviewed

___  _________________________________
___  _________________________________

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Limited Long-Term Care Insurance Model Act (#642)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness (#888)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper
Review Procedures and Criteria

Ensure the file documentation adequately supports the decisions made:
- The application should be complete and signed;
- Determine when, and under what conditions the company requires motor vehicle reports, inspection reports, credit reports, Medical Information Bureau (MIB) or other medical physician reports or other underwriting information to confirm exposure or premium basis;
- Determine if the file contains the necessary information to support the classification, rating and selection decision made; and
- Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable statutes, rules and regulations.

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state’s definition of unfair discrimination.

Determine if the company is following its underwriting guidelines, and that the guidelines conform to applicable statutes, rules and regulations, including, but not limited to:
- The insurer shall obtain one of the following prior to issuance of a policy or certificate to an applicant aged 80 or older:
  - A report of physical examination;
  - An assessment of functional capacity;
  - An attending physician’s statement; or
  - Copies of medical records.
- All applications for limited long-term care, except policies issued on a guaranteed-issue basis, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant; and
- If an application for limited long-term care coverage contains a question regarding whether the applicant has had medication prescribed by a physician, the company shall also ask the applicant to list the medication.

Determine if the company underwriting guidelines have been filed, where applicable.

Review interoffice memoranda for evidence of anti-competitive behavior, collusive practices or improper replacement tactics.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each office being examined.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination. Companies may not permit discrimination between individuals of the same class and equal health status.

Ensure that underwriting requirements are not applied in an unfairly discriminatory manner.

Review guaranteed-issue criteria to ensure correct handling.

Review policy provisions for skilled nursing care to ensure that no restrictions are placed on the proper level of care; i.e., the company does not provide only skilled nursing care or does not provide more coverage for skilled care in a facility than coverage for lower levels of care.

Verify that the questions on applications are sufficiently clear and applicable to the coverage being requested.

Verify that Medical Information Bureau (MIB) information is not used as the sole basis for an underwriting decision.
Companies may not refuse to insure, continue to insure or limit coverage based on:

- Sex;
- Marital status;
- Race;
- Religion;
- National origin;
- Physical or mental impairment (except where based on sound actuarial principles or actual or reasonably anticipated experience);
- Blindness or partial blindness only* (however, all other conditions, including the underlying cause of the blindness or partial blindness, are subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person); and
- Abuse status.

*Note: Review individual state statutes, rules and regulations that may provide that an insurer may not refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness.

Many jurisdictions have enacted legislation regarding subjects of abuse. Examiners should be familiar with their statutes, rules and regulations in this area.

Examine new business applications for the required fraud statement.
H. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.
### Standard 1

**CLAIMS**

*Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.*

**Apply to:** All limited long-term care products

**Priority:** Essential

**Documents to be Reviewed**

- Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- Company claim procedure manuals
- Claim training manuals
- Internal company claim audit reports
- Insured’s requests (if applicable)
- Claim bulletins and procedure manuals
- Company claim forms manual
- Claim files

**Others Reviewed**

- 
- 

**NAIC Model References**

- *Insurance Fraud Prevention Model Act* (#680)
- *Limited Long-Term Care Insurance Model Act* (#642)
- *Unfair Claims Settlement Practices Act* (#880)
- *Unfair Life, Accident and Health Claims Settlement Practices Model Regulation* (#903)
- *Limited Long-Term Care Insurance Model Regulation* (#643)

**Review Procedures and Criteria**

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether standards comply with state statutes. Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner.

Determine if claim handling meets applicable statutes, rules and regulations, including:

- Correct payees and addresses; and
- Correct benefit amounts.
Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

If a claim under a limited long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

- Provide a written explanation of the reasons for the denial; and
- Make available all information directly related to the denial.

Determine if the insurer is in compliance with proper payment of “clean claims,” as defined in applicable state statutes, rules and regulations. Verify that the insurer pays clean claims within 30 business days after receipt of a clean claim. For claims that do not fall within the category of a clean claim, verify that the insurer has sent a written notice acknowledging the date of receipt of the claim and containing one of the following provisions within 30 business days:
  - The insurer has declined to pay all or part of the claim and the specific reason(s) for denial; or
  - That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

Verify that the insurer has paid clean claims within 30 business days after receipt of all requested additional information, or has sent a written notice that the insurer has declined to pay all or part of the claim within 30 days. The notice should specify the specific reason(s) for denial.

If, upon review of insurer clean claim payment practices, an examiner determines that an insurer has failed to comply with clean claim requirements, verify that the insurer has paid interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the receipt of the claim or, in the event the insurer has requested additional information, upon receipt of all requested additional information.

Verify that the insurer has included interest payable in any late reimbursement without requiring the individual who filed the original claim to make any additional claim for such interest.

It is an unfair practice to settle, or attempt to settle, a claim on the basis of an application that was materially altered without the consent of the insured.

Confirm that a monthly report is issued to the policyholder whenever limited long-term care benefits are issued through acceleration of death benefit provisions of a life insurance product.

Confirm that mandatory nonforfeiture benefits are offered.

Determine that eligibility for the payment of benefits is based on a deficiency in the ability to perform not more than 3 of the activities of daily living (ADLs) or the presence of cognitive impairment.

Ensure that determination of deficiency is not more restrictive than:

- Requiring the hands-on assistance of another person to perform the prescribed ADLs; and
- For a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

Ensure that licensed or certified professionals, such as physicians, nurses or social workers, perform assessments of ADLs and cognitive impairment.
**POLICY IN FORCE STANDARDIZED DATA REQUEST**

**Property/Casualty Line of Business**

**Inland Marine**

**Contents:** This file should be downloaded from the company system(s) and contain one record for each inland marine policy issued in [applicable state] which was in force at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

**Uses:** Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or termination of inland marine policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state(s) licensing information to ensure proper producer licensure

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<th>Field Name</th>
<th>Start</th>
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<td>InceptDt</td>
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<td>Inception date of the policy [MM/DD/YYYY]</td>
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<tr>
<td>EffDt</td>
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<tr>
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<tr>
<td>PdDt</td>
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<td>D</td>
<td></td>
<td>Date policy was paid to before cancellation [MM/DD/YYYY]</td>
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<tr>
<td>CanTerDt</td>
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<td>10</td>
<td>D</td>
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<td>Date policy cancelled/terminated [MM/DD/YYYY]</td>
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<tr>
<td>CanReqDt</td>
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<td>D</td>
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<td>Date cancellation requested, if applicable [MM/DD/YYYY]</td>
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<td>CanTer</td>
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<td>Who cancelled the coverage C=Consumer or I=Insurer</td>
</tr>
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<td>Reason for cancellation/termination of coverage (i.e., lapse, underwriting reasons, change of risk, nonpayment) If codes are used, provide a list of codes along with their meanings</td>
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<td>RfndDt</td>
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<td>RefMthd</td>
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<td>Refund method (i.e. 90%, prorata, etc.) If codes are used, provide a list of codes along with their meanings</td>
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<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
</tr>
</tbody>
</table>
CLAIMS STANDARDIZED DATA REQUEST  
Property & Casualty Line of Business  
Inland Marine

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of inland marine claims within the scope of the examination.
- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted; and
- Cross-reference to state (s) licensing information to ensure proper adjuster licensure.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Start</th>
<th>Length</th>
<th>Type</th>
<th>Decimals</th>
<th>Description</th>
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<td>COL</td>
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<td>Cause of loss (water, hail, theft, fire, etc.)</td>
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<td>Insured street address) (location)</td>
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<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
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<td>ClmStat</td>
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<td>Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded</td>
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<td>D</td>
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<td>Date company or its producer acknowledged the claim [MM/DD/YYYY]</td>
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<tr>
<td>DtClmFrm</td>
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<td>D</td>
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<td>Date claim forms sent to insured [MM/DD/YYYY]</td>
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<td>D</td>
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<td>Date of written notice to insured regarding incomplete investigation [MM/DD/YYYY]</td>
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<td>DepTkn</td>
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<td>Was depreciation taken? (Y/N)</td>
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<tr>
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<td>Amount of recoverable depreciation taken</td>
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<td>Amount of recoverable depreciation paid</td>
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<td>Amount of interest paid, if applicable</td>
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<td>D</td>
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<td>Date company received subrogation refund [MM/DD/YYYY]</td>
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<td>Amount of deductible reimbursed to insured</td>
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<td>D</td>
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<td>Date deductible refunded to insured [MM/DD/YYYY]</td>
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<tr>
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<td></td>
<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
</tr>
</tbody>
</table>

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