

Draft: 7/1/20

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, May 27, May 21 and May 20 minutes. 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.

W:\National Meetings\2020\Summer\Cmte\D\MCAS WG\0624 Meeting.docx

Draft Homeowner MCAS Clarification for Discussion

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

- (3-45) Number of dwelling fire policies in force at the end of the period.
 - Include dwelling policies that meet the definition of a dwelling policy as defined within this document. This would typically include policies written on forms DP-1, DP-2 and DP-3.
- (3-46) Number of homeowner policies in force at the end of the period.
 - Include homeowner policies that meet the definition of a homeowner policy as defined within this document. This would typically include policies written on forms HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8.
- (3-47) Number of tenant/renter/condo policies in force at the end of the period.
 - Include tenant/renter/condo policies that meet the definition of a tenant/renter/condo policy as defined within this document. This would typically include policies written on forms HO-4 and HO-6.
- (3-48) Number of all other residential property policies in force at the end of the period.
 - Include other policies that meet the specifics of MCAS reporting, but that do not fall into one of the categories requested in questions 3-45, 3-46 and 3-47. If your company only write policies that fall into the forms specified for questions 3-45, 3-46 and 3-47, this number may be 0.



Comments for the Center for Economic Justice
To the NAIC Market Conduct Annual Statement Blanks Working Group
Proposed Revisions to Life, Annuity, Auto and Homeowners MCAS Reporting
May 18, 2020

The Center for Economic Justice (CEJ) submits the following comments and recommendation for improvements to MCAS data collection, generally, and for the auto, homeowners, life and annuities lines of business, specifically.

Pandemic Has Revealed Inadequacy of Insurance Market Regulation Data Collection

The pandemic has further exposed the inadequacy of regulatory data collection for market surveillance and market regulation. Regulators have not had and will not have relevant data for monitoring market outcomes for over a year from the outbreak of the pandemic. And even when the data become available – too late for timely, meaningful action – the data will be so aggregated that analysis of specific product markets will not be possible.

The absence of timely and meaningful regulatory data for market analysis and market surveillance contrasts with that for financial analysis and financial surveillance. Financial regulators receive insurer financial data on a quarterly basis so significant changes in, say, the first quarter 2020 can be identified by late May. Financial regulators have granular data on insurer investments – equities, derivatives, bonds – and, consequently, are able to assess the impact on insurers of financial danger in other industries. For example, if residential or commercial mortgage delinquencies spike, financial regulators can review insurer holdings in these instruments and assess the likely impact on insurer financial condition. And financial regulators collect data on a more granular product basis – whether that be the many lines of business for property casualty or the many products lines for life insurance and annuities.

Market regulators have found themselves unequipped to address the sudden excessive rates of many lines of business for which risk exposure has changed virtually overnight, such as the drop in cars on the road and miles driven for personal and commercial auto or the impact of business closings on various commercial lines of business. At the same time, market regulators

are also unable to assess the potential spike in claims for other lines of business. Have new COVID19-related health insurance claims been greater or less than the reduction in non-COVID19 claims due to shutdown of non-essential procedures? As insurers transition rapidly to remote claims settlement in personal auto insurance and remote underwriting for life insurance and annuities – among other rapid digital transformation of the insurance industry – how will regulators assess consumer outcomes in a timely fashion?

The pandemic has emphasized the need for significant improvements in insurance market surveillance data:

1. More frequent data collection – move to quarterly MCAS reporting;
2. More granular product market data collection for life insurance and annuities;
3. Current lawsuit data elements and definitions for auto, homeowners, life and annuities; and
4. Accelerated underwriting definition, interrogatories and data elements for life.

Quarterly Data Collection -- Applicable to All MCAS Lines of Business

One of the major problems with MCAS data collection is that it has largely become part of an audit-style approach to market regulation instead of better helping transform market regulation from auditing to analytics. MCAS has become part of an annual assessment of insurers, instead of a resource of more advanced analytics. As a result, regulators have, in the past, discounted the usefulness of quarterly MCAS reporting – too much data to use and too difficult to fit into the current processes for using MCAS data.

Simply stated, quarterly MCAS reporting is required for market regulators to have the data necessary to meaningfully monitor insurance markets and consumer outcomes in a timely fashion. If quarterly reporting were in place, regulators would have information on 20q1 consumer outcomes by the end of May 2020 and 20q2 outcomes by the end of August 2020. Instead, with current MCAS annual reporting, regulators will have 20q1 and 20q2 data by the end of August **2021** – far too late to be useful to respond to rapidly changing market condition in the Spring of 2020. Consider the difference between getting travel insurance MCAS data on a quarterly basis versus an annual basis.

In the past, regulators have viewed quarterly MCAS reporting as more work for the states. This need not and should not be the case. First, even with no changes to how MCAS is incorporated in to annual review, quarterly data reporting does not interfere. A state can continue to use MCAS the way it currently does with any particular four-quarter period's worth of data. Second, no matter how much regulators may want to employ advanced analytics, the absence of necessary data will always preclude such efforts. While Tableau is a useful tool for presenting and viewing and analyzing MCAS data, Tableau can only do so much with annual data.

Finally, there is no structural impediment or significant burden on insurers to report MCAS on a quarterly basis – whether to the NAIC for financial quarterly statements or to statistical agents and advisory organization for premium and claim experience data. Like other reports to statistical agents, insurers program their data systems to produce the required reports – whether financial or statistical – for the relevant experience period at the required due date. After more than a decade of reporting some lines of business, insurers are surely capable of producing MCAS reports on a quarterly basis without significant increases in burden on insurers.

CEJ recommendation: All MCAS lines of business should transition to quarterly reporting as soon as NAIC capabilities permit.

More Granular Lines of Business for Life Insurance and Annuities

CEJ has written extensively in past comments about the need for more granular product line reporting for life insurance and annuities.

The current MCAS provides for life insurance reporting broken out by cash-value products and non-cash value products. This means that the following product categories are reported in one coverage – cash-value products:

- Term life with cash value
- Universal Life – with and without secondary guarantees
- Indexed Universal Life – with and without secondary guarantees
- Variable Life – with and without secondary guarantees
- Variable Universal Life – with and without secondary guarantees
- Whole Life

Non-Cash Life includes:

- Term Life
- Pre-Need
- Final Expense

Within the current MCAS cash and non-cash value categories, these products are significantly different and sold in significantly different markets. Without breaking out these product categories, market analysis is irreparably compromised because problems in one product market can be masked by being combined in larger overall experience. Further, comparisons across companies are compromised because of different relative weights in a company's portfolio of the different products.

For annuities, the current MCAS provides for reporting of fixed and variable: Fixed annuity products include:

- Immediate Fixed Annuity
- Deferred Fixed Annuity
- Qualified Longevity Annuity Contract
- Multi-year Guaranteed Annuity
- Indexed Annuities

Variable annuities include:

- Variable Annuity
- Buffered Annuity
- Contingent Deferred Annuity

Again, products with the current two categories are significantly different and are sold in different markets. As with the life MCAS, the lack of product break-out in the annuity MCS compromises market analysis and effectively eliminates market surveillance capability.

ACLI Proposal Not Serious or Useful

The ACLI proposes, in its May 12, 2020 letter that additions to the Life and Annuity MCAS be limited four interrogatories – two for complaints and two for surrenders – for three products – indexed annuities, variable annuities and university (sic) life. ACLI writes, with no apparent attempt at irony or absurd jest:

ACLI observes that, while there might be more granular data of interest for each line which perhaps might be justifiably requested, it might be desirable to establish a presumption against gathering additional data, at least initially. This is because: (1) additional data imposes additional costs and administrative burdens on each insurance company and (2) more granular data may mislead regulators into misapprehending a company's market or business operation.

The ACLI proposal is simply not credible for several reasons. First, it is overly-aggregated data – the absence of more granular data – that causes failures in market analysis. The limited data elements suggested by ACLI will guarantee the very thing ACLI fears – “mislead regulators into misapprehending a company's market or business operation.

Second, the purposes of more granular data collection are several – to answer questions and concerns already known, to answer questions and concerns not yet contemplated and to permit the use of advanced analytics, like data mining, to discover new insights. ACLI’s proposal seeks to keep MCAS in the dark ages – as an auditing tool and not as the raw material for improved market analysis and surveillance.

Third, ACLI convenient leaves out other product markets that have been the source of market problems, including indexed universal life, fails to distinguish products within the stated groups and fails to identify new, complex products like buffered annuities.

Fourth, the disparate treatment of these three product categories from traditional MCAS reporting means an absence of regulator ability for data quality control and accuracy. MCAS reporting is structured to ensure complete and accurate experience reporting. With the ACLI proposal, there is no way to assess the accuracy or completeness of the responses to the four interrogatories.

Fifth, industry claims of administrative burdens are without empirical support and are overstated. Industry reports financial experience by granular product categories. There is an initial expense to program the new reports that take the same experience and reporting it in, say, 12 categories instead of four categories. ACLI also fails to mention the cost benefits of more granular reporting, including fewer reporting errors requiring interaction with the NAIC and state regulators and fewer false positives in MCAS ratios requiring explanation and interaction with regulators.

CEJ Recommendation: Change MCAS Life and Annuity reporting from the current four coverage categories to the following – unless noted otherwise, all are individual products

- Term life with cash value
- Universal Life
- Indexed Universal Life
- Variable Life
- Variable Universal Life
- Whole Life
- Term Life with no cash value
- Pre-Need
- Final Expense
- Other Life
- Immediate Fixed Annuity
- Deferred Fixed Annuity
- Qualified Longevity Annuity Contract
- Multi-year Guaranteed Annuity
- Indexed Annuities
- Variable Annuity
- Buffered Annuity
- Individual or Group Contingent Deferred Annuity
- Other Annuity

Additional Data Elements – Lawsuits – Auto, Home, Life and Annuity

The most recent MCAS lines of business – private flood, disability, long-term care, lender-placed – include five data elements for suits:

1. Number of lawsuits open at beginning of the period
2. Number of lawsuits opened during the period
3. Number of lawsuits closed during the period
4. **Number of lawsuits closed during the period with consideration for the consumer**
5. Number of lawsuits open at end of period

The current private passenger auto and homeowners MCASs include data elements 1, 2, 3 and 5, but not data element 4. The current life and annuity MCAS s contain no data elements for lawsuits.

CEJ Recommendation: The following lawsuit data elements and definitions be included in the private passenger auto, homeowners, life and annuity MCASs with the data definitions used for these data elements in the private flood, disability, lender-placed and long-term care MCASs.

1. Number of lawsuits open at beginning of the period
2. Number of lawsuits opened during the period
3. Number of lawsuits closed during the period
4. **Number of lawsuits closed during the period with consideration for the consumer**
5. Number of lawsuits open at end of period

Additional Data Elements – Accelerated Underwriting – Life Insurance

Life insurers started utilizing accelerated underwriting a few years ago – the use of non-medical data sources to create algorithms for underwriting and pricing. These data sources have included consumer credit data, social media, facial analytics and more. Some of the data sources used by insurers are not subject to the disclosure and consumer protection provisions of the Fair Credit Reporting Act. While accelerated underwriting holds the promise of faster decision-making and broader access, the use of black-box algorithms with little or no regulatory oversight also raises the potential for unfair and unfairly discriminatory treatment of applicants and policyholders. To enable regulators to monitor the effects of accelerated underwriting, we the following additional definition and data elements for MCAS life insurance:

Definition: 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.

Interrogatories:

- Does the company use accelerated underwriting for life insurance? Y/N
- If the company uses accelerated underwriting for life insurance, for what product categories is it used?
- If the company uses accelerated underwriting for life insurance, list the data sources used and vendors supplying data or algorithms.

Data Elements:

For data elements 1B-19 through 1B-27, replicate each data element for accelerated underwriting experience. For example, in addition to current 1B-20:

1B-20A: Total Number of New Policies Issued By the Company during the Period Utilizing Accelerated Underwriting.

CEJ Recommendation: Add Data Elements, Interrogatories and Definition to the Life MCAS for Accelerated Underwriting.



Comments for the Center for Economic Justice

To the NAIC Market Conduct Annual Statement Blanks Working Group

Proposed Revisions to Auto and Homeowners MCAS Reporting

May 25, 2020

The Center for Economic Justice submits the following recommendations for changes to the private passenger auto and homeowners MCAS interrogatories, coverages, data elements and definitions. The proposals are substantively identical for both lines of insurance. In keeping with the process utilized by the working group to review each line of business separately, CEJ presents our recommendations separately for private passenger auto and for homeowners.

Recommendations for Changes to Homeowners MCAS

1. Add lawsuit data element for lawsuits settled with consideration for the consumer and utilized the most current lawsuit data definitions as used in the long-term care, disability, private flood and lender-placed MCAS and recently adopted for the life and annuity MCAS.

This is the action recently taken by the MCAS Blanks WG for the Life/Annuity MCAS to promote greater consistency and uniformity.

2. Add interrogatories regarding use of third-party administrators.

This is the action recently taken by the MCAS Blanks WG for the Life/Annuity MCAS to promote greater consistency and uniformity.

3. Break Claims Data Elements 2-17 through 2-34 into Digital Claims Settlement and Other Than Digital Claims Settlement *for Dwelling and Personal Property Coverages Only*.

Description and Rationale: CEJ recommends splitting claims data experience between digital claims settlement and other than digital claims settlement. Digital claims settlement, sometimes referred to as virtual claims handling, refers to loss appraisal not involving a human on-site inspection of the property, but based on digital information, including, for example, photos taken by the insured or claimant or photos taken by a plane or drone or information provided by sensors or cameras within or near the property. We propose this additional break-out of claims only the dwelling and personal property coverages.

The purposes of segregating digital-only from human-involved claims settlements are, one, to assess the outcomes for consumers from digital-only claims settlement; and, two, to ensure that significant differences between digital-only and other than digital-only claim settlements are not masked by aggregate reporting. For example, one of the advertised benefits

of digital claims settlement is speed of settlement. If digital claims settlements are significantly faster than other-than-digital-only claims settlements, the aggregated claims data would mask these differences.

Definition:

Digital Claim Settlement means a claim involving a loss appraisal utilizing digital information only with no human on-site visual inspection or appraisal by the insurance company or independent adjuster of the vehicle or property. Examples of digital claim settlement include, but are not limited to, claim settlements based on photos taken by a claimant or insured or photos taken by a plane or drone or data provided by in-vehicle or in-property sensors with no in-person inspection or appraisal by the insurance company or independent adjuster.

Other Than Digital Claims Settlement means any claim other than a Digital Claim Settlement claim

Data Elements: The proposed change can be accommodated by creating two claims experience columns each for Dwelling and Personal Property coverages only for the claims activity data elements 2-17 through 2-34. The table below illustrates this approach.

ID	Description HOMEOWNERS MCAS	Digital Claims Settlement	Other Than Digital Claims Settlement
2-17	Number of claims open at the beginning of the period		
2-18	Number of claims opened during the period		
2-19	Number of claims closed during the period, with payment		
2-20	Number of claims closed during the period, without payment		
2-21	Number of claims open at the end of the period		
2-22	Median days to final payment		
2-23	Number of claims closed with payment within 0-30 days		
2-24	Number of claims closed with payment within 31-60 days		
2-25	Number of claims closed with payment within 61-90 days		
2-26	Number of claims closed with payment within 91-180 days		

2-27	Number of claims closed with payment within 181-365 days		
2-28	Number of claims closed with payment beyond 365 days		
2-29	Number of claims closed without payment within 0-30 days		
2-30	Number of claims closed without payment within 31-60 days		
2-31	Number of claims closed without payment within 61-90 days		
2-32	Number of claims closed without payment within 91-180 days		
2-33	Number of claims closed without payment within 181-365 days		
2-34	Number of claims closed without payment beyond 365 days		

4. Break “Number of Company-Initiated Non-Renewals During the Period” into
- a. Non-Renewals Based In Whole or In Part on Claims History;
 - b. Non-Renewals Based on Catastrophe Risk Exposure
 - c. Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information
 - d. All Other Company Initiated Non-Renewals

Description and Rationale: Insurers may non-renew a policy for a variety of reasons, each of which tells a different story about the insurer and/or the market. Market analysis would be significantly improved by segregating out company-initiated non-renewals for some of these different reasons. These additions are particularly relevant given new types of catastrophe risk exposure evaluations – e.g. wildfire – and the use of new algorithms based on non-insurance personal consumer information to assess customer lifetime value.

The current definitions include:

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.

New Definitions

Company-Initiative Non-Renewals Based in Whole or In Part on Claims History during the Period means a non-renewal initiated by the company based entirely or in part on the policyholder's claims history. For example, if the company-initiated non-renewal was based in part on claims history and in part on a change in credit score, report the non-renewal here.

Company-Initiative Non-Renewals Based on Catastrophe Risk Exposure during the Period means a non-renewal initiated by the company based entirely on an assessment of the policyholder's catastrophe risk exposure.

Company-Initiative Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information during the Period means a non-renewal initiated by the company based entirely on an algorithm or rule used by the company and based on non-insurance personal consumer information. Examples of such algorithms include a credit-based insurance score, a consumer lifetime value score or a consumer propensity for fraud score.

All Other Company-Initiative Non-Renewals during the Period means non-renewal initiated by the company for any other reason than the other three company-initiated non-renewal data elements.

Recommendations for Changes to Private Passenger Auto MCAS

1. Add lawsuit data element for suits settled with consideration for the consumer and the most current lawsuit data definitions used in the long-term care, disability, private flood and lender-placed MCAS and recently adopted for the life and annuity MCAS.

This is the action recently taken by the MCAS Blanks WG for the Life/Annuity MCAS to promote greater consistency and uniformity.

2. Add interrogatories regarding use of third-party administrators.

This is the action recently taken by the MCAS Blanks WG for the Life/Annuity MCAS to promote greater consistency and uniformity.

3. Break Claims 2-21 through 2-38 into Digital Claims Settlement and Other Than Digital Claims Settlement for Property Damage, Collision and Comprehensive Coverages Only.

CEJ recommends splitting claims data experience between digital claims settlement and other than digital claims settlement. Digital claims settlement, sometimes referred to as virtual claims handling, refers to loss appraisal not involving a human on-site inspection of the vehicle or property, but based on digital information, including, for example, photos taken by the insured or claimant or photos taken by a plane or drone or information provided by sensors or cameras within or near the property or site of the accident. We propose this break-out only for property damage and physical damage coverages.

The purposes of segregating digital-only from human-involved claims settlements are, one, to assess the outcomes for consumers from digital-only claims settlement; and, two, to ensure that significant differences between digital-only and other than digital-only claim settlements are not masked by aggregate reporting. For example, one of the advertised benefits of digital claims settlement is speed of settlement. If digital claims settlements are significantly faster than other-than-digital-only claims settlements, the aggregated claims data would mask these differences.

Definition:

Digital Claim Settlement means a claim involving a loss appraisal utilizing digital information only with no human on-site visual inspection or appraisal by the insurance company or independent adjuster of the vehicle or property. Examples of digital claim settlement include, but are not limited to, claim settlements based on photos taken by a claimant or insured or photos taken by a plane or drone or data provided by in-vehicle or in-property sensors with no in-person inspection or appraisal by the insurance company or independent adjuster.

Other Than Digital Claims Settlement means any claim other than a Digital Claim Settlement claim

Data Elements: The proposed change can be accommodated by creating two coverage columns for Dwelling and Personal Property only for the claims activity data elements 2-21 through 2-38.

ID	Description	Digital Claims Settlement	Other Than Digital Claims Settlement
2-21	Number of claims open at the beginning of the period		
2-22	Number of claims opened during the period		
2-23	Number of claims closed during the period, with payment		
2-24	Number of claims closed during the period, without payment		

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

4. Break “Number of Company-Initiated Non-Renewals During the Period” into
- a. Non-Renewals Based In Whole or In Part on Claims History;
 - b. Non-Renewals Based on Catastrophe Risk Exposure
 - c. Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information
 - d. All Other Company Initiated Non-Renewals

Description and Rationale: Insurers may non-renew a policy for a variety of reasons, each of which tells a different story about the insurer and/or the market. Market analysis would be significantly improved by segregating out company-initiated non-renewals for some of these different reasons. These additions are particularly relevant given new types of catastrophe risk exposure evaluations – e.g. flooding – and the use of new algorithms based on non-insurance personal consumer information to assess customer lifetime value.

Definitions: The current definitions include:

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.

New Definitions

Company-Initiative Non-Renewals Based in Whole or In Part on Claims History during the Period means a non-renewal initiated by the company based entirely or in part on the policyholder’s claims history. For example, if the company-initiated non-renewal was based in part on claims history and in part on a change in credit score, report the non-renewal here.

Company-Initiative Non-Renewals Based in Whole or In Part on Catastrophe Risk Exposure during the Period means a non-renewal initiated by the company based entirely on an assessment of the policyholder’s catastrophe risk exposure.

Company-Initiative Non-Renewals Based on Changes in Credit Score or Other Algorithm Utilizing Non-Insurance Personal Consumer Information during the Period means a non-renewal initiated by the company based entirely on an algorithm or rule used by the company and based on non-insurance personal consumer information. Examples of such algorithms include a credit-based insurance score, a consumer lifetime value score or a consumer propensity for fraud score.

All Other Company-Initiative Non-Renewals during the Period means non-renewal initiated by the company for any other reason than the other three company-initiated non-renewal data elements.