

EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, Aug. 13, 2022, Minutes

Adopted Amendments to the Valuation Manual (Attachment One)

Adopted Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves (AG 53) (Attachment Two)

Adopted the Pet Insurance Model Act (Attachment Three)

Adopted Revisions to the “Other Health” MCAS Data Call and Definitions (Attachment Four)

Adopted the Homeowners MCAS Digital Claim Interrogatories and Lawsuit Data Elements and Definitions (Attachment Five)

Adopted the PPA MCAS Digital Claim Interrogatories and Lawsuit Data Elements and Definitions (Attachment Six)

Adopted the Addition of AU Data Elements, Interrogatories, and Definitions into the Life MCAS (Attachment Seven)

Adopted the Regulatory Considerations Applicable to (But Not Exclusive to) Private Equity (PE) Insurers (Attachment Eight)

Adopted the List of Jurisdictions that Recognize and Accept the Group Capital Calculation (GCC) (Attachment Nine)

Report on States’ Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Ten)

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Contents.doc

Draft Pending Adoption

Draft: 8/25/22

Executive (EX) Committee and Plenary
Portland, Oregon
August 13, 2022

The Executive (EX) Committee and Plenary met in Portland, OR, Aug. 13, 2022. The following Committee and Plenary members participated: Dean L. Cameron, Chair (ID); Chlora Lindley-Myers, Vice Chair (MO); Andrew N. Mais, Vice President (CT); Jon Godfread, Secretary-Treasurer (ND); David Altmaier, Most Recent Past President (FL); Lori K. Wing-Heier (AK); Mark Fowler (AL); Alan McClain represented by Russ Galbraith (AR); Evan G. Daniels (AZ); Ricardo Lara (CA); Michael Conway (CO); Trinidad Navarro (DE); John F. King (GA); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard represented by Victoria Hastings (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Anita G. Fox represented by Karin Gyger (MI); Grace Arnold (MN); Mike Chaney represented by David Browning (MS); Troy Downing (MT); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Marlene Caride (NJ); Barbara D. Richardson (NV); Adrienne A. Harris represented by Sumit Sud (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Elizabeth Kelleher Dwyer (RI); Michael Wise represented by Diane Cooper (SC); Larry D. Deiter (SD); Cassie Brown represented by Jamie Walker (TX); Jon Pike (UT); Scott A. White (VA); Kevin Gaffney (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek (WI); Allan L. McVey represented by Erin K. Hunter (WV); and Jeff Rude (WY).

1. Received the Report of the Executive (EX) Committee

Director Cameron reported that the Executive (EX) Committee met Aug. 11 and adopted the Aug. 10 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Committee adopted its June 21 report, which included the following action: 1) received an update on the NAIC's 2022 financials and an overview of preliminary work on the 2023 budget; 2) approved the Catastrophe Modeling Center of Excellence (COE) Fiscal Impact Statement; 3) approved the Variable Annuity Model Office Fiscal Impact Statement; and 4) received an update on the Enterprise Resource Planning (ERP) project.

The Committee adopted the reports of its task forces: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Long-Term Care Insurance (EX) Task Force; and 4) the Special (EX) Committee on Race and Insurance.

The Committee approved the Request for NAIC Model Law Development to amend the *Property and Casualty Insurance Guaranty Association Model Act* (#540).

The Committee also approved the Request for NAIC Model Law Development to draft the new Insurance Consumer Privacy Protection Model Law.

The Committee adopted the revisions to the NAIC Consumer Participation Plan of Operation.

The Committee received a status report on the NAIC *State Ahead* strategic plan implementation.

The Committee received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) the *Mortgage Guaranty Insurance Model Act* (#630); 3) the *Nonadmitted Insurance Model Act* (#870); and 4) the new Pet Insurance Model Act.

Draft Pending Adoption

The Committee heard reports from the National Insurance Producer Registry (NIPR) and the Interstate Insurance Product Regulation Commission (Compact).

2. Adopted by Consent the Committee, Subcommittee, and Task Force Minutes of the Spring National Meeting

Director Lindley-Myers made a motion, seconded by Commissioner Donelon, to adopt by consent the committee, subcommittee, and task force minutes of the Spring National Meeting. The motion passed unanimously.

3. Received the Report of the Life Insurance and Annuities (A) Committee

Director French reported that the Life Insurance and Annuities (A) Committee met Aug. 11. During this meeting, the Committee adopted its July 20 minutes, which included the following action: 1) adopted nine *Valuation Manual* amendments; and 2) adopted *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53).

The Committee received an update from the Accelerated Underwriting (A) Working Group. The Working Group continues to collaborate with other NAIC groups as it works on developing regulatory guidance for state insurance regulators related to accelerated underwriting (AU) in life insurance, and it plans to meet in October to continue work on its goals.

The Committee adopted the report of the Annuity Suitability (A) Working Group, including its July 25 minutes. The Working Group continues to work on a frequently asked questions (FAQ) document about the safe harbor/comparable standards provision in the revised *Suitability in Annuity Transactions Model Regulation* (#275), which added a best interest standard of conduct for insurers and producers.

The Committee adopted the report of the Life Actuarial (A) Task Force. In particular, the Task Force is considering limited, targeted revisions to the *Life Insurance Illustrations Model Regulation* (#582) to address the need for the Task Force to make continual changes to the indexed universal life (IUL) illustration actuarial guideline to address product features causing aggressive illustrations.

The Committee also agreed to have the Life Insurance Online Guide (A) Working Group focus on updating life insurance information on the NAIC website. State insurance regulators interested in participating in the Working Group can contact Jennifer Cook (NAIC).

The Committee received an update from Workstream Four of the Special (EX) Committee on Race and Insurance that it plans to schedule future presentations on marketing in underserved communities from the agent perspective.

4. Adopted the Amendments to the *Valuation Manual*

Director French reported on nine *Valuation Manual* amendments for consideration. The package of amendments was adopted by the Life Insurance and Annuities (A) Committee on July 20. The *Valuation Manual* amendments provide technical clarifications and guidance to existing requirements in the *Valuation Manual*.

Director French noted that amendment 2022-04 names the Secured Overnight Financing Rate (SOFR) as the official replacement to the London Interbank Offered Rate (LIBOR) for the calculation of swap spreads, and it establishes a methodology for the NAIC to set short-term and long-term swap spreads. LIBOR will cease to be published by mid-2023.

Draft Pending Adoption

Director French made a motion, seconded by Commissioner Mulready, to adopt the amendments to the *Valuation Manual* (Attachment One). The motion was adopted by 46 jurisdictions, representing 93.84% of the applicable premiums written. Director Cameron confirmed that the vote satisfied the requirements to amend the *Valuation Manual*. The motion passed.

5. Adopted Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves (AG 53)

Director French reported that the new AG 53 is part of an NAIC effort regarding the oversight of the increase in private equity (PE) and complex assets in the life insurance industry.

AG 53 was adopted by the Life Actuarial (A) Task Force on June 16 and the Life Insurance and Annuities (A) Committee on July 20. Beginning April 2023, state insurance regulators will receive additional documentation and analysis related to PE and complex assets supporting life insurance business.

Director French made a motion, seconded by Commissioner Donelon, to adopt AG 53 (Attachment Two). The motion passed unanimously.

6. Received the Report of the Health Insurance and Managed Care (B) Committee

Commissioner Mulready reported that the Health Insurance and Managed Care (B) Committee met Aug. 11 and adopted its Spring National Meeting minutes.

The Committee adopted the report of the Consumer Information (B) Subgroup, which has not met since March 22. However, in June, the Subgroup chair and a few Subgroup members conducted focus groups with a small number of states to gather information on consumer engagement strategies they find effective. The first focus group completed its work June 13, and the second focus group completed its work July 8. They are preparing summaries of the focus groups and expect to share them with the full Subgroup and interested parties within the next few months.

The Committee adopted its subgroup, working group, and task force reports and their interim minutes.

The Committee heard a panel presentation on efforts to create state-based health insurance exchanges and why states should establish them.

The Committee heard discussion on Medicaid redeterminations following the end of the COVID-19 public health emergency (PHE). The presentation provided an overview of the PHE, including the authorities at play in the COVID-19 pandemic at the federal and state level. The presentation also highlighted important dates state insurance regulators need to keep in mind related to the end of the PHE. The presentation discussed 10 fundamental actions for states to prepare for the unwinding at the end of the PHE, including creating a comprehensive state unwinding operational plan and coordinating with state, tribal, and federal government partners.

The Committee heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on recent activities of interest to the Committee, including the steps the CCIIO is taking to prepare for the eventual end of the COVID-19 PHE and the Medicaid redetermination process.

The Committee also: 1) heard a federal legislative and regulatory update, including an update on the implementation of the federal No Surprises Act (NSA); 2) received an update on the Pharmacy Benefit Manager

Draft Pending Adoption

Regulatory Issues (B) Subgroup's work; and 3) received an update on the Special (EX) Committee on Race and Insurance Workstream Five's work.

7. Received the Report of the Property and Casualty Insurance (C) Committee

Mr. Galbraith reported that the Property and Casualty Insurance (C) Committee met Aug. 12. During this meeting, the Committee adopted its Aug. 1 and Spring National Meeting minutes, which included adoption of the Pet Insurance Model Act.

The Committee adopted the reports of its task forces and working groups: the Casualty Actuarial and Statistical (C) Task Force, the Surplus Lines (C) Task Force, the Title Insurance (C) Task Force, the Workers' Compensation (C) Task Force, the Cannabis Insurance (C) Working Group, the Catastrophe Insurance (C) Working Group, the Terrorism Insurance Implementation (C) Working Group, and the Transparency and Readability of Consumer Information (C) Working Group.

The Committee also: 1) heard a report on cyber insurance data contained within the Cybersecurity and Identity Theft Supplement. The Committee will release a written report that contains alien surplus lines data later this year; 2) heard a federal update; 3) heard an update on the Collaboration Forum on Algorithmic Bias; 4) heard an overview of the member visit to the Insurance Institute for Business and Home Safety (IBHS). IBHS research and messaging materials are available for use by state insurance regulators; and 5) discussed its charge related to parametric insurance. The Committee will hear future presentations and begin to gather research to create an outline for a white paper.

8. Adopted the Pet Insurance Model Act

Mr. Galbraith reported that the Property and Casualty Insurance (C) Committee released the white paper, *A Regulator's Guide to Pet Insurance* in April 2019. After its release, the Committee asked the Pet Insurance (C) Working Group to discuss the potential development of a model law that would address regulatory concerns in the pet insurance industry described in the white paper.

The Working Group was officially tasked with drafting a model in August 2019, and the Working Group has held 26 meetings since then with active participation from industry, consumer representatives, producers, and veterinarian groups.

The Pet Insurance Model Act covers required definitions and disclosures, as well as regulations for policy conditions, sales practices for wellness programs, and producer training.

The Working Group held comment periods and had extensive discussion on all the major issues. Of note, the Pet Insurance Model Act includes several consumer protections related to policy renewals, required disclosures of waiting periods, policy limits, conditions, and benefit schedules. The Pet Insurance Model Act requires disclosure language when a preexisting condition exists. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which the claim is being made. The Pet Insurance Model Act discusses wellness programs and prohibits a pet insurer from marketing a wellness program as pet insurance or requiring the purchase of a wellness program. Finally, while the Working Group decided that the Pet Insurance Model Act was not the appropriate place to decide the type of license required to sell pet insurance, state insurance regulators wanted to ensure producers are trained on the specific features of pet insurance products before selling those products.

The Pet Insurance Model Act was adopted by the Working Group and the Committee ahead of the 2021 Fall National Meeting, but there were concerns about language in the producer training section that could cause

Draft Pending Adoption

unintended consequences to producer licensing and reciprocity, so it was sent back to the Working Group for revision. After discussions about those concerns, the Working Group adopted the Pet Insurance Model Act with revisions to the Producer Training section, including required training topics for pet insurance producers and language that allows training requirements to be satisfied by substantially similar requirements in another state.

Mr. Galbraith made a motion, seconded by Commissioner Schmidt, to adopt the Pet Insurance Model Act (Attachment Three). The motion passed with New York abstaining.

9. Received the Report of the Market Regulation and Consumer Affairs (D) Committee

Commissioner Pike reported that the Market Regulation and Consumer Affairs (D) Committee met Aug. 12. During this meeting, the Committee adopted its July 15 minutes, which included the following action: 1) adopted a revised charge to delete a reference to the System for Electronic Rates & Forms Filing (SERFF) Advisory Board (SAB) because it was disbanded at the Spring National Meeting; 2) adopted a revised charge of the Producer Licensing (D) Task Force to appoint a new Adjuster Licensing (D) Working Group to review adjuster licensing reciprocity and uniformity issues rather than the Task Force; 3) adopted a new “Other Health” Market Conduct Annual Statement (MCAS) Data Call and Definitions; 4) adopted revisions to the Homeowners MCAS to add digital claim interrogatories and lawsuit data elements and definitions; 5) adopted revisions to the Private Passenger Auto (PPA) MCAS to add digital claim interrogatories and lawsuit data elements and definitions; and 6) adopted revisions to the Life MCAS to add AU data elements, interrogatories, and definitions.

The Committee adopted revisions to the *Market Regulation Handbook*. These edits included: 1) revisions to Chapter 1 to encourage market regulators to coordinate with a company’s domestic financial regulator to obtain information related to the company’s group capital calculations (GCCs), liquidity stress test (LST) results, corporate governance, and Own Risk and Solvency Assessment (ORSA); 2) revisions to Exam Standard 1 of marketing and sales in Chapter 20 to add the *Insurance Holding Company System Regulatory Act* (#440) to the list of NAIC models to reference for guidance; and 3) revisions to Chapter 21 to include references to the *Real Property Lender-Placed Insurance Model Act* (#631).

The Committee also adopted a new Mental Health Parity chapter to the *Market Regulation Handbook*. This chapter will provide updated examination guidelines in response to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) compliance analysis requirements for non-quantitative treatment limitations (NQTLs), which were amended at the federal level in 2021.

The Committee adopted the “Recommendations for the Incorporation of Artificial Intelligence in the NAIC Market Information Systems.” The report recommends that artificial intelligence (AI) should be contemplated in the context of a long-range plan, beginning with repairing known issues with existing data and employing more rigorous traditional statistical techniques to assess the predictive accuracy of analytical tools. Subsequently, state insurance regulators can consider the potential collection of data appropriate to AI.

The Committee adopted the “Guidelines for Amending the NAIC Uniform Applications.” These guidelines will be used for the review and adoption of substantive changes to the NAIC’s Uniform Licensing Applications in support of the NAIC and NIPR mission of maintaining stable and consistent NAIC Uniform Applications for producer licensing.

The Committee adopted the Antifraud Plan Repository Workflow. This workflow will serve as the template for the creation of a centralized filing system for insurers to report their antifraud plans to state insurance departments and eliminate the need for multiple state filings of the same plan.

The Committee adopted the reports of its task forces and working groups: the Antifraud (D) Task Force, the Market Information Systems (D) Task Force, the Producer Licensing (D) Task Force, the Advisory Organization Examination

Draft Pending Adoption

Oversight (D) Working Group, the Market Analysis Procedures (D) Working Group, the Market Conduct Annual Statement Blanks (D) Working Group, the Market Conduct Examination Guidelines (D) Working Group, the Market Regulation Certification (D) Working Group, and the Speed to Market (D) Working Group.

The Committee heard a presentation on dark patterns on websites, which are website designs created to intentionally mislead consumers into making unintended choices.

10. Adopted the Market Conduct Annual Statement (MCAS) Items

Commissioner Pike reported that on July 15, the Market Regulation and Consumer Affairs (D) Committee adopted a new MCAS blank and changes to three current MCAS blanks.

- “Other Health” MCAS Data Call and Definitions

First are revisions to the “Other Health” MCAS Data Call and Definitions. With the adoption of this blank, the MCAS now collects underwriting, claims, complaint, and marketing information on health plans not subject to the federal Affordable Care Act (ACA). Those health plans include: 1) accident only; 2) accidental death and dismemberment; 3) specified disease and critical illness; 4) hospital and other indemnity; and 5) hospital/surgical and other expense.

The data on these plans is divided into those sold directly to individuals, sold through associations, and sold through employer groups. Much like previous MCAS blanks, this blank is divided into five sections; i.e., Interrogatories, Underwriting, Claims, Consumer Complaints and Lawsuits, and Marketing. In combination with the Health MCAS blank, which collects data on plans subject to the ACA, and the Short-Term Limited-Duration (STLD) MCAS blank, most of the health insurance marketplace will now be subject to MCAS reporting.

- Revised HO and PPA MCAS Blanks

Commissioner Pike noted that that there was a typo in the PPA Data Call and Definitions that has been corrected. In the lawsuit definition, it referenced Homeowners instead of PPA.

The changes to the Homeowners Data Call and Definitions and the PPA Data Call and Definitions are identical.

Last year, the Market Regulation and Consumer Affairs (D) Committee adopted data elements to collect information on digital claims. This year, it added two interrogatories about digital claim handling, including asking companies to identify all the vendors that provide third-party data and algorithms used in digital claim handling.

Additionally, the Committee adopted changes for reporting lawsuits in the Homeowners and PPA Data Call and Definitions. Historically, only claims-related lawsuits were reported. An additional reporting category was created to capture non-claims-related lawsuits. This change required edits to the lawsuit definition.

- Revised Life MCAS Blank

The Life MCAS Data Call and Definitions was edited to include the reporting of AU data. A new section was added to the interrogatories to capture basic information related to the products subject to AU, as well as the types of data the company uses in its AU.

Schedule 1C includes data elements for which a company must provide both AU information and non-AU information. This reporting is required on individual life cash value products and individual life non-cash value products.

Draft Pending Adoption

The addition of AU to the Life Insurance MCAS blank was completed after the Accelerated Underwriting (A) Working Group finished its work on its educational paper. However, the definition developed by the Working Group did not work for MCAS filing purposes. For this reason, the MCAS definition references the definition adopted by the Working Group and notes that the MCAS definition is a subset of the definition contained in the Working Group's 2022 NAIC educational paper on the topic.

Commissioner Pike made a motion, seconded by Commissioner Clark, to adopt the revisions to the "Other Health" MCAS Data Call and Definitions (Attachment Four); the Homeowners MCAS digital claim interrogatories and lawsuit data elements and definitions (Attachment Five); the PPA MCAS digital claim interrogatories and lawsuit data elements and definitions (Attachment Six); and the addition of AU data elements, interrogatories, and definitions into the Life MCAS (Attachment Seven). The motion passed with New York abstaining.

11. Received the Report of the Financial Condition (E) Committee

Commissioner White reported that the Financial Condition (E) Committee met Aug. 12. During this meeting, the Committee: 1) adopted its July 21, May 23, and Spring National Meeting minutes, which included the following action: a) approved a Request for NAIC Model Law Development to amend Model #540; b) adopted the "Regulatory Considerations Applicable (But Not Exclusive) to PE Owned Insurers"; c) adopted the "List of Jurisdictions that Recognize and Accept the GCC"; and d) adopted a memorandum of support for work performed because of the low interest rate environment and ongoing pressure from certain assets.

The Committee adopted agenda item 2021-21: Related Party Reporting, with an effective date of Dec. 31. This item incorporates new reporting requirements for investment transactions with related parties and includes clarifications to *Statement of Statutory Accounting Principles (SSAP) No. 25—Affiliates and Other Related Parties* and *SSAP No. 43R—Loan-Backed and Structured Securities* to make it clear that the existing affiliate definition applies to all types of entities, including securitizations.

The Committee adopted agenda item 2021-22BWG with an effective date of Dec. 31. These revisions add a new reporting requirement in the investment schedules for investment transactions with related parties. For all investments, except those on Schedule A—Real Estate, reporting entities will report a code to identify the type of related party involvement. Investments that do not have any related party involvement will also be identified with a specific code.

The Committee adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force, the Capital Adequacy (E) Task Force, the Examination Oversight (E) Task Force, the Financial Stability (E) Task Force, the Group Capital Calculation (E) Working Group, the Group Solvency Issues (E) Working Group, the Mutual Recognition of Jurisdictions (E) Working Group, the National Treatment and Coordination (E) Working Group, the Receivership and Insolvency (E) Task Force, the Reinsurance (E) Task Force, and the Valuation of Securities (E) Task Force.

The Committee heard a presentation from the Federal Reserve on its Supervisory Framework.

Note: Items adopted within the Financial Condition (E) Committee's task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial—will be considered for adoption by the Executive (EX) Committee and Plenary through the Financial Condition (E) Committee's technical changes report process. Pursuant to this process, which was adopted by the NAIC in 2009, a listing of the various technical changes will be sent to NAIC members shortly after completion of the National Meeting, and the members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

Draft Pending Adoption

12. Adopted the “Regulatory Considerations Applicable to (But Not Exclusive to) PE Owned Insurers”

Commissioner White reported that the Financial Stability (E) Task Force of the Financial Condition (E) Committee, charged the Macroprudential (E) Working Group with coordinating all NAIC efforts related to PE ownership of insurers.

The Working Group developed a list of 13 considerations that may result in changes to existing regulatory requirements. These 13 considerations relate to activities frequently, but not exclusively, attributed to PE firms. The list was adopted by the Task Force, and since then, the Working Group has proposed ways to address the 13 considerations. This includes specific referrals to various NAIC committee groups. This plan was adopted by the Task Force on June 27 and by the Committee on July 21.

Commissioner White made a motion, seconded by Commissioner Donelon, to adopt the “Regulatory Considerations Applicable to (But Not Exclusive to) PE Insurers” (Attachment Eight). The motion passed unanimously.

13. Adopted the “List of Jurisdictions that Recognize and Accept the GCC”

Commissioner White reported that on Dec. 9, 2020, the Executive (EX) Committee and Plenary adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), which established the GCC framework.

The revisions specifically provide that the requirements to file the NAIC’s GCC apply to U.S.-based groups, while a group headquartered outside of the U.S. is exempt from the GCC (subject to limited exceptions) if its groupwide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction.

The “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement) establish this mutual recognition process for European Union (EU) and United Kingdom (UK) groups, and the *Process for Evaluating Qualified and Reciprocal Jurisdictions* does this for groups in a handful of other jurisdictions.

After the GCC framework was adopted, the Mutual Recognition Jurisdictions (E) Working Group developed the “List of Jurisdictions that Recognize and Accept the GCC” to exempt groups within those jurisdictions from the GCC.

The list has been through public exposure, and there were no comments. It will be updated at least annually.

Commissioner White made a motion, seconded by Commissioner Altmaier, to adopt the “List of Jurisdictions that Recognize and Accept the GCC” (Attachment Nine). The motion passed unanimously.

14. Received the Report of the Financial Regulation Standards and Accreditation (F) Committee

Director Wing-Heier reported that the Financial Regulation Standards and Accreditation (F) Committee met Aug. 9 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Alaska, Iowa, Minnesota, and Ohio.

Draft Pending Adoption

The Committee also met Aug. 10 in open session to adopt its Spring National Meeting minutes.

The Committee adopted an update to the examination coordination guidelines recommended by the Financial Examiners Handbook (E) Technical Group. The update ensures consistency between the *Financial Condition Examiners Handbook* and the accreditation guidelines and clarifies coordination for examinations that are part of a holding company group with insurers domiciled in multiple states.

The Committee adopted the recommendation that the 2021 revisions to Model #440 and Model #450 are acceptable for accreditation but not required. The revisions address the continuation of essential services through affiliated intercompany agreements with an insurer that is placed into receivership.

The Committee adopted updates to the Preamble of the *Accreditation Program Manual* to reference VM-21, Requirements for Principle-Based Reserves for Variable Annuities. The revisions reference how captives that reinsure variable annuity (VA) business are addressed in the accreditation standards.

15. Received the Report of the International Insurance Relations (G) Committee

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Aug. 10 and adopted its July 21 and Spring National Meeting minutes.

The Committee heard a presentation on the Federal Reserve Board's (FRB's) Insurance Policy Advisory Committee (IPAC) paper on the insurance capital standard (ICS). The presentation described the analysis undertaken by the IPAC, the potential impact of the ICS and the IPAC's recommended revisions to the ICS, and its conclusions.

The Committee heard an update on recent activities and priorities of the International Association of Insurance Supervisors (IAIS), including: 1) a review of recent committee meetings and the annual Global Seminar; 2) an update on the targeted jurisdictional assessments (TJAs) as part of the implementation of the holistic framework; 3) the comparability assessment process for the aggregation method (AM); and 4) upcoming activities related to climate; diversity, equity, and inclusion (DE&I); operational resilience; cyber; and liquidity metrics.

The Committee heard an update on international activities, including: 1) recent and upcoming meetings, events, and speaking engagements with international regulators; 2) the upcoming Fall 2022 International Fellows Program; 3) upcoming meetings and participation in workstreams at the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee; and 4) a review of recent working group meetings of the Sustainable Insurance Forum (SIF).

16. Received the Report of the Innovation, Cybersecurity, and Technology (H) Committee

Commissioner Birrane reported that the Innovation, Cybersecurity, and Technology (H) Committee met Aug. 10. During this meeting, the Committee adopted its Spring National Meeting minutes, which included the following action: 1) adopted structural and charge revisions; 2) adopted its working group reports; 3) received a report on the Casualty Actuarial and Statistical (C) Task Force predictive model review process; 4) discussed various committee-level projects, including: a) the creation of a new Collaboration Forum that will serve as a platform for multiple NAIC committees to work together to identify and address foundational issues and develop a common framework; b) the development of a portal or library of resources related to innovation, cybersecurity, data and consumer privacy, and technology; and c) the creation of a forum to facilitate the training and education of state insurance regulators on innovation and technology topics, SupTech issues, and potential ways data and technology might affect the insurance sector in the future; and 5) received an update on the implementation of

Draft Pending Adoption

the *Insurance Data Security Model Law* (#668) and *Unfair Trade Practices Act* (#880) revised language specific to rebating.

The Committee approved the Request for NAIC Model Law Development from the Privacy Protections (H) Working Group to draft a new model law with the proposed title, the Insurance Consumer Privacy Protection Model Law, to replace the *NAIC Insurance Information and Privacy Protection Model Act* (#670) and the *Privacy of Consumer Financial and Health Information Regulation* (#672).

The Committee adopted the reports of its task forces and working groups: the Big Data and Artificial Intelligence (H) Working Group, the Cybersecurity (H) Working Group, the E-Commerce (H) Working Group, the Innovation in Technology and Regulation (H) Working Group, and the Privacy Protections (H) Working Group.

The Committee received an update on its projects, including the proposed Innovations, Cybersecurity, and Technology (ICT)-Hub and Collaboration Forum on Algorithmic Bias Fly-In.

At the conclusion of the Committee meeting and as a part of the Collaboration Forum on Algorithmic Bias panel, the Committee members heard presentations entitled, “Approaches Companies Are or Can Implement to Manage and Mitigate the Risk of Unintended Bias and Illegal Discrimination When Developing and Using AI/ML” from Dale Hall, Managing Director of Research for the Society of Actuaries (SOA); Tulsee Doshi, Head of Product for Responsible AI & Human Centered Technology at Google and an Advisor of Lemonade; and Daniel Schwarcz, a professor at the University of Minnesota.

17. Received a Report on the States’ Implementation of NAIC-Adopted Model Laws and Regulations

Director Cameron referred attendees to the written report for updates on the states’ implementation of NAIC-adopted model laws and regulations (Attachment Ten).

Having no further business, the Executive (EX) Committee and Plenary adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/8-Plenary

LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date	Page Number
2020-12	VM-01, VM-20, VM-21, VM-31	Create consistency between CDHS determination in VM-20 and VM-21. Revise hedge modeling to only require CDHS if modeling future hedging reduces the reserves under VM-20 or TAR under VM-21.	6/9/22	3
2021-11	VM-21, section 12 and various others	Add a section for other assumptions requirement in VM-21 which covers general guidance and requirements for assumptions, and expense assumptions.	2/3/22	22
2021-12	VM-21 Section 6.B.3.a.v, VM-21 Section 6.C.4, VM-21 Section 6.C.10, VM-21 Section 6.C.11	Correct CSMP reference and clarify requirements for VA contracts with no minimum guaranteed benefits in Additional Standard Projection Amount in VM-21 Section 6.C. These three prescribed assumptions are Partial Withdrawal, Account Value Depletion, and Other Voluntary Contract Termination.	12/8/21	33
2021-13	VM-20 Sect. 9.C.6.e, VM-20 Sect. 9.C.7, VM-31 Sect. 3.D.3.o.	It has been observed that adding the prescribed mortality margins for some Life/LTC combination products cause modeled reserves to decrease rather than increase.	11/4/21	40
2022-01	VM-20 Section 8.C.18	Clarifying the Valuation Manual treatment of the per-reinsurance ceded reserve and the reserve credit for retrocessions	3/10/22	44
2022-02	VM-31	Revise language and add an explicit cross-reference to the VM-21 section since it has further details on how to demonstrate compliance	3/31/22	47
2022-03	VM-20, VM-21, VM-31	General cleanup, including updating cross-references, better consistency between VM-20 and VM-21, where reasonable, and making clarifying edits.	3/31/22	49
2022-04	VM-20 Section 9.F.8, App 2.F, App 2.G	LIBOR transition to the Secured Overnight Financing Rate (SOFR) - Updated VM-20 prescribed swap spreads guidance to facilitate the LIBOR transition to SOFR.	6/30/22	55
2022-05	VM-51 App 1, App 4	Add dividend plan code & Covid-19 indicator; change field identifier; correct Appendix 1 reference.	5/12/22	61

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 1 Valuation Manual Chart.pdf

Actuarial Guideline LIII

APPLICATION OF THE VALUATION MANUAL FOR TESTING THE ADEQUACY OF LIFE INSURER RESERVES

Background

The *NAIC Valuation Manual (VM-30)* contains actuarial opinion and supporting actuarial memorandum requirements, including requirements for asset adequacy analysis. Regulators have observed a lack of uniform practice in the implementation of asset adequacy analysis. The variety of practice in incorporating the risk of complex assets into testing does not provide regulators comfort as to reserve adequacy. Examples of complex assets are structured securities, including asset-backed securities and collateralized loan obligations, as well as assets originated by the company or affiliated or contracted entity. An initial increase of this activity has been noted in support of general account annuity blocks; however, recent activity was noted in other life insurer blocks.

This Guideline is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy analysis performed by life insurers. In particular, this Guideline:

- (1) Helps identify reserve adequacy and claims-paying ability in moderately adverse conditions, including conditions negatively impacting cash flows from complex assets;
- (2) Clarifies elements to consider in establishing margins on asset-related assumptions;
- (3) Ensures recognition that higher expected gross returns from assets are, to some extent, associated with higher risk, and that assumptions fit reasonably within the risk-return spectrum;
- (4) Requires sensitivity testing regarding complex assets supporting life insurer business;
- (5) Identifies expectations in practice regarding the valuation of complex assets within asset adequacy analysis;
- (6) Reflects that while complex assets tend to have higher uncertainty regarding timing and amount of cash flows than more traditional investments, because complex assets are difficult to classify, and the regulatory concern is regarding the projected net yields and cash flows from those assets, the focus of the analysis requirements will be on assets categorized as high-yielding; and
- (7) Requires additional documentation of investment fee income relationships with affiliated entities or entities close to the company.

Text

1. Effective Date

This Guideline shall be effective for asset adequacy analysis of the reserves reported in the December 31, 2022 Annual Statement and for the asset adequacy analysis of the reserves reported in all subsequent Annual Statements.

Guidance note: It is anticipated that the requirements contained in this Guideline will be incorporated into VM-30 at a future date, effective for a future valuation year. Requirements in the Guideline will cease to apply to annual statutory financial statements when the corresponding or replacement VM-30 requirements become effective.

2. Scope

This Guideline shall apply to all life insurers with:

- A. Over \$5 billion of general account actuarial reserves (from Exhibits 5, 6, 7, and 8 of the Annual Statement) and non-unitized separate account assets or
- B. Over \$100 million of general account actuarial reserves (from Exhibits 5, 6, 7, and 8 of the Annual Statement) and non-unitized separate account assets and over 5% of supporting assets (selected for asset adequacy analysis) in the category of Projected High Net Yield Assets, as defined in Section 3.F.

Actuarial reserve amounts are included in the amounts in A and B whether directly written or assumed through reinsurance and are determined before any reinsurance ceded credit.

The Guideline applies to assets supporting liabilities tested in the asset adequacy analysis except it does not apply to unitized separate account assets or policy/contract loans.

3. Definitions

- A. Equity-like Instruments. Assets that include the following:
 - i. Any assets that, for purposes of risk-based capital C-1 reporting, are in the category of common stock, i.e., have a 30% or higher risk-based capital charge.
 - ii. Any assets that are captured on Schedule A or Schedule BA of the Annual Statement.
 - iii. Bond funds.
- B. Fair Value. The price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, consistent with methodology of fair value, as reported in the Annual Statement.

- C. Net Market Spread. For each asset grouping, shall mean the spread over comparable Treasury bonds that equates the fair value as of the valuation date with modeled cash flows, less the default assumption used in asset adequacy analysis.

Market conventions and other approximations are acceptable for the purposes of this definition.

- D. Investment Grade Net Spread Benchmark. The applicable spread found in Appendix I using the weighted average life (WAL) of the associated non-Equity-like Instrument.
- E. Guideline Excess Spread. The net spread derived by subtracting the Investment Grade Net Spread Benchmark from the Net Market Spread for non-Equity-like Instruments. Investment expenses shall be excluded from this calculation.
- F. Projected High Net Yield Assets. Currently held or reinvestment assets that are either:
- i. An Equity-like Instrument assumed to have higher value at projection year 10 or later than under an assumption of annual total returns, before the deduction of investment expenses, of 4% for the first 10 projection years after the valuation date followed by 5% for projection year 11 and after. Aggregation shall be done at a level of granularity that is consistent with or more granular than how the assets are grouped, i.e., compressed, in the asset adequacy analysis model, or
 - ii. Assets other than Equity-like Instruments where the assumed Guideline Excess Spread is higher than zero. In addition:
 - (a) Aggregation of the comparison between the assumed Net Market Spread from each asset and the Investment Grade Net Spread Benchmark shall be done at a level of granularity that is consistent with or more granular than how the assets are grouped, i.e., compressed, in the asset adequacy analysis model.
 - (b) For applicable assets that do not have an explicit WAL or term to maturity, the Appointed Actuary shall disclose the method used to determine the appropriate WAL used for comparing to the Investment Grade Net Spread Benchmark.
 - (c) For purposes of the comparison between the assumed Net Market Spread from each asset and the Investment Grade Net Spread Benchmark, investment expenses shall be excluded.
 - iii. The following asset types can be excluded from the scope of requirements in sections 4.A.ii through 5:
 - (a) Cash or cash equivalents,
 - (b) Treasuries and agency bonds, and
 - (c) Public non-convertible, fixed-rate corporate bonds with no or immaterial callability.

4. Asset Adequacy Considerations and Documentation Expectations

A. **Net return and risk documentation.**

- i. For all assets, either currently held or in assumed reinvestments, provide:
 - (a) Identification of the assumed gross asset yield and the key components (for example, default and investment expenses) deducted to arrive at the assumed net asset yield.
 - (b) Explanation of any future reinvestment strategy assumptions that materially differ from current practices.
- ii. For Projected High Net Yield Assets, either currently held or in assumed reinvestments, provide:
 - (a) A detailed explanation describing the relationship between the expected gross returns from these assets and the risk. It shall also include, for the aspect of any higher expected gross returns not assumed to be associated with higher risk, an explanation of how overperforming assets with expected returns lying outside the risk-return spectrum can be assumed to persist and be available for reinvestments throughout the projection period in moderately adverse conditions.
 - (b) Commentary on how assumptions on assets with risk factors leading to substantial volatility of returns, as identified through sensitivity testing or other means, contain an appropriate margin to reflect the uncertainty in the timing and amounts of asset cash flows.
 - (c) Identification of the extent to which Projected High Net Yield Assets are supporting major product categories, e.g., individual fixed annuities and pension risk transfers.
 - (d) Explanation of rationale for materially changing or not changing complex-asset-based assumptions from the prior year's analysis.

B. **Model rigor.** Where significant risks associated with complex, Projected High Net Yield Assets are not adequately captured with traditional modeling techniques, more rigorous modeling of those risks should occur.

- i. Where necessary to adequately reflect the risk:
 - (a) Multi-scenario testing of those risks specific to complex assets should be performed. For example, investments that may provide a higher expected return in part due to limited information, niche skill sets, or other factors may require

unique scenarios (for instance to adequately capture credit or liquidity risk) to fully encompass potential sources of loss.

- (b) Asset cash flows should be appropriately projected to reflect anticipated liquidity under adverse conditions. If such model aspects are not developed, sufficient additional conservatism to reflect this risk shall be applied.
 - (c) To the extent that the process for modeling or otherwise evaluating the risks is complex, and the potential for disconnect between reality and modeling increases, an additional margin to assumption(s) should be applied. Any such margin shall be applied in the direction of asset adequacy analysis results being less favorable.
 - (d) The full distribution of risk associated with complex assets should be considered.
- ii. An Appointed Actuary may use simplifications, approximations, and modeling efficiency techniques if the Appointed Actuary can demonstrate that the use of such techniques does not make asset adequacy analysis results more favorable. These techniques may be less appropriate if the amount of complex, high-yielding assets becomes a higher percentage of total assets.

Guidance note: Actuarial Standards of Practice (ASOPs), including ASOP No. 7 and No. 56 contain additional guidance on the use of models in the analysis of cash flows.

- C. **Fair Value determination.** In asset adequacy analysis, when an asset is projected to be available for sale, a Fair Value of that asset is established, based on the projected market conditions. Fair Value should only be determined internally (by the insurance or investment management company) when the market-based value of the asset or similar asset cannot be obtained or expected to be obtained in a projected scenario.
 - i. When the Fair Value of a material portion of supporting assets is determined internally, the actuarial memorandum shall contain a step-by-step description of the approach used to calculate the Fair Value of such assets.
 - ii. Provide the total Fair Value of assets that have values determined internally.
 - iii. When the Fair Value of a material portion of assets is determined internally, a sensitivity test should be performed (and the impact on asset adequacy analysis results presented) assuming a haircut to internally derived Fair Values that the Appointed Actuary deems reasonable given the commensurate level of anticipated uncertainty.
- D. **Non-publicly traded assets.** For non-publicly traded assets originated by the company, within the company's group, or within an entity closely tied to a company's group (inclusive of the company's investment manager), provide the following:
 - i. Documentation of practices to help ensure accurate valuation of those assets.

- ii. The total Fair Value of such assets.
- iii. To the extent the contractual agreement affects the investment income revenue streams included in the asset adequacy analysis, disclose in detail applicable contractual agreements and revenue sharing, e.g., performance fees, between the entity responsible for providing investment or other types of services and the insurer.

Also, assumed net cash flows from assets should be net of all explicit or implicit fees or expenses, such as origination fees, as well as reflective of other asset-related risks including credit risk, illiquidity risk, and other market risks.

- E. **Investments expenses (fees).** Assumed investment expenses, whether paid to an external asset manager or to internal investment management staff, as well as additional expenses that are directly attributable to the specific investments, should be commensurate with the expected expenses in light of the complexity of the assets.
- F. **Reinsurance modeling.** Related to reinsurance, relevant communications and disclosures, for instance commentary on collectability and counterparty risk, should be presented in the memorandum.

Guidance note: Section 4.F is consistent with the standard laid out in ASOP No. 11 – Reinsurance Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports.

- G. **Borrowing.** Please identify if any borrowing is modeled besides to address very short-term liquidity needs. Also, verify borrowing and reinvestment rates to ensure that projections are not materially benefiting from arbitrage advantages.

5. Sensitivity Tests and Attribution Analysis related to Assumptions on Projected High Net Yield Assets

A. Sensitivity testing

- i. Perform and disclose, separately for (a) and (b), the asset adequacy analysis results from the following sensitivity tests:

- (a) For reinvestment assets other than Equity-like Instruments, assume the Net Market Spreads (before deduction of investment expenses) for Projected High Net Yield Assets do not exceed the Investment Grade Net Spread Benchmark and apply the test to a baseline of a level Treasury rate scenario.

For the purposes of limiting the Net Market Spreads at the Investment Grade Net Spread Benchmark, Projected High Net Yield Assets may be aggregated together but shall not include any assets that are not Projected High Net Yield Assets.

- (b) For reinvestment assets that are Equity-like Instruments, assume annual total returns, before the deduction of investment expenses, of 4% for the first 10 projection years after the valuation date followed by 5% for projection year 11 and after.

- ii. Strict technical compliance for each asset may not be practical for reasons such as model limitations. Professional judgment should be applied to produce sensitivity testing results that are consistent with the spirit of the test. A variety of alternative methods may be acceptable. Appropriate explanation and justification should be provided for the method that was employed.
 - iii. Sensitivity testing for the purpose of this Guideline does not reflect commentary on moderately adverse conditions, but the volatility and impact demonstrated from the testing should be contemplated in Section 4.A.ii.(b) considerations.
- B. For Projected High Net Yield Assets for non-Equity-like Instruments either currently held or in assumed reinvestments, perform and disclose the following attribution analysis steps at the asset type level associated with the templates in Section 6:
- i. State the assumed Guideline Excess Spread.
 - ii. Estimate the proportion of the Guideline Excess Spread attributable to the following factors:
 - (a) Credit risk
 - (b) Illiquidity risk
 - (c) Deviations of current spreads from long-term spreads defined in Appendix 1
 - (d) Volatility and other risks (identify and describe these risks in detail)
 - iii. Provide commentary on the results of Section 5.B.ii. Also, where judgment is applied, provide supporting rationale of how the expected return in excess of the Investment Grade Net Spread Benchmark is estimated.

Guidance note: a best-efforts approach is expected for the year-end 2022 attribution analysis

6. Reporting, Review, and Templates

Guidance note: The NAIC Valuation Analysis (E) Working Group (VAWG) shall serve as a resource in the targeted review of asset adequacy analysis related to modeling of business supported with Projected High Net Yield Assets. VAWG shall provide periodic reports identifying outliers and concerns regarding the analysis to help inform regulators on the effectiveness of the Guideline in meeting the seven objectives stated in the Background section.

- A. The documentation, sensitivity test results, and attribution analysis referenced above are to be incorporated as a separate, easily identifiable section of the actuarial memorandum required by VM-30 or as a standalone document, with a due date of April 1 following the applicable valuation date. The domiciliary commissioner may approve a later due date for companies seeking a hardship extension. The separate section or standalone document shall be available to other state insurance commissioners in

which the company is licensed upon request to the company. The confidentiality and information provisions in state adoptions of NAIC Model 820 regarding the actuarial memorandum are applicable to the separate section or standalone document required by this Guideline.

B. Sample templates (to be adopted by the Life Actuarial Task Force):

- i. Asset types – will be categorized when the templates are completed.
- ii. Template for the asset summary.
- iii. Template for components of net asset yield for various asset classes, with separate tables to be provided for initial assets and reinvestment assets.
- iv. Template for sensitivity test aspects for Projected High Net Yield Assets that are fixed-income.
- v. Template for sensitivity test results for Projected High Net Yield Assets.
- vi. Template for attribution analysis, with separate tables to be provided for initial assets and reinvestment assets for Projected High Net Yield Assets.

Appendix I – Investment Grade Net Spread Benchmark

WAL (Weighted Avg Life)	Investment Grade Net Spread Benchmark (in bps)
1-10	170
11-20	175
21-30	185

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 2 AG 53.pdf

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC's Executive Committee is required. The NAIC's Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: ☒ New Model Law or ☐ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Pet Insurance (C) Working Group

2. NAIC staff support contact information:

Aaron Brandenburg
abrandenburg@naic.org
816 783 8271

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

Pet Insurance Model Law. This model would define a regulatory structure related to pet insurance, including issues such as producer licensing, policy terms, coverages, claims handling, premium taxes, disclosures, arbitration, and preexisting conditions.

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or ☐ No (Check one)

If yes, please explain why: Interested parties agree that there is ambiguity within regulation of the pet insurance market and having a more defined and consistent regulatory structure will improve the market and benefit consumers. The NAIC Paper, A Regulators' Guide to Pet Insurance, the Pet Insurance (C) Working Group and the Producer White Licensing (D) Task Force have previously discussed some of these ambiguities in the regulation of the market.

b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

☒ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: The NAIC White Paper, "A Regulator's Guide to Pet Insurance" has provided the background for the Working Group to understand the issues and begin to draft a model.

6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No

PET INSURANCE MODEL LAW

New Model - Draft: 7/21/2022

Adopted by Pet Insurance (C) Working Group – 7/21/2022

Adopted by Property and Casualty Insurance (C) Committee – 8/1/2022

Table of Contents

Section 1.	Short Title
Section 2.	Scope and Purpose
Section 3.	Definitions
Section 4.	Disclosures
Section 5.	Policy Conditions
Section 6.	Sales Practice for Wellness Programs
Section 7.	Insurance Producer Training
Section 8.	Regulations
Section 9.	Violations

Section 1. Short Title

This Act shall be known as the “Pet Insurance Act.”

Section 2. Scope and Purpose

- A. The purpose of this Act is to promote the public welfare by creating a comprehensive legal framework within which Pet Insurance may be sold in this state.
- B. The requirements of this Act shall apply to Pet Insurance policies that are issued to any resident of this state, and are sold, solicited, negotiated, or offered in this state, and policies or certificates that are delivered or issued for delivery in this state.
- C. All other applicable provisions of this state’s insurance laws shall continue to apply to Pet Insurance except that the specific provisions of this Act shall supersede any general provisions of law that would otherwise be applicable to Pet Insurance.

Section 3. Definitions

If a pet insurer uses any of the terms in this Act in a policy of pet insurance, the pet insurer shall use the definition of each of those terms as set forth herein and include the definition of the term(s) in the policy. The pet insurer shall also make the definition available through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.

Nothing in this Act shall in any way prohibit or limit the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions defined below.

As used in this Act:

- A. “Chronic condition” means a condition that can be treated or managed, but not cured.
- B. “Congenital anomaly or disorder” means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.
- C. “Hereditary disorder” means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

- D. “Orthopedic” refers to conditions affecting the bones, skeletal muscle, cartilage, tendons, ligaments, and joints. It includes, but is not limited to, elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments. It does not include cancers or metabolic, hemopoietic, or autoimmune diseases.
- E. “Pet insurance” means a property insurance policy that provides coverage for accidents and illnesses of pets.
- F. “Preexisting condition” means any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:
 - (1) A veterinarian provided medical advice;
 - (2) The pet received previous treatment; or
 - (3) Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

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

- G. “Renewal” means to issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.
- H. “Veterinarian” means an individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.
- I. “Veterinary expenses” means the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by a veterinarian.
- J. “Waiting period” means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.
- K. “Wellness program” means a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. If any wellness program [insert language from state statute or regulation that defines the trigger for insurance contracts, which might include language such as: [undertakes to indemnify another], or [pays a specified amount upon determinable contingencies] or [provides coverage for a fortuitous event]], it is transacting in the business of insurance and is subject to the insurance code. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being “the business of insurance,” unless other indications of insurance also exist.

Section 4. Disclosures

- A. A pet insurer transacting pet insurance shall disclose the following to consumers:
 - (1) If the policy excludes coverage due to any of the following:
 - (a) A preexisting condition;
 - (b) A hereditary disorder;
 - (c) A congenital anomaly or disorder; or
 - (d) A chronic condition.
 - (2) If the policy includes any other exclusions, the following statement: “Other exclusions may apply. Please refer to the exclusions section of the policy for more information.”

- (3) Any policy provision that limits coverage through a waiting or affiliation period, a deductible, coinsurance, or an annual or lifetime policy limit.
 - (4) Whether the pet insurer reduces coverage or increases premiums based on the insured's claim history, the age of the covered pet or a change in the geographic location of the insured.
 - (5) If the underwriting company differs from the brand name used to market and sell the product.
- B. Right to Examine and Return the Policy.
- (1) Unless the insured has filed a claim under the pet insurance policy, pet insurance applicants shall have the right to examine and return the policy, certificate or rider to the company or an agent/insurance producer of the company within fifteen (15) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason,
 - (2) Pet insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. The following free look statement or language substantially similar shall be included:

"You have 15 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office or you may return it to the agent/insurance producer that you bought it from as long as you have not filed a claim. You must return it within 15 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued."
- C. A pet insurer shall clearly disclose a summary description of the basis or formula on which the pet insurer determines claim payments under a pet insurance policy within the policy, prior to policy issuance and through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.
- D. A pet insurer that uses a benefit schedule to determine claim payment under a pet insurance policy shall do both of the following:
- (1) Clearly disclose the applicable benefit schedule in the policy.
 - (2) Disclose all benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.
- E. A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall do both of the following:
- (1) Include a usual and customary fee limitation provision in the policy that clearly describes the pet insurer's basis for determining usual and customary fees and how that basis is applied in calculating claim payments.
 - (2) Disclose the pet insurer's basis for determining usual and customary fees through a clear and conspicuous link on the main page of the pet insurer or pet insurer's program administrator's website.
- F. If any medical examination by a licensed veterinarian is required to effectuate coverage, the pet insurer shall clearly and conspicuously disclose the required aspects of the examination prior to purchase and disclose that examination documentation may result in a preexisting condition exclusion.

- G. Waiting periods and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.
- H. The pet insurer shall include a summary of all policy provisions required in Subsections (A) through (G), inclusive, in a separate document titled “Insurer Disclosure of Important Policy Provisions.”
- I. The pet insurer shall post the “Insurer Disclosure of Important Policy Provisions” document required in Subsection (H) through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.
- J. In connection with the issuance of a new pet insurance policy, the pet insurer shall provide the consumer with a copy of the “Insurer Disclosure of Important Policy Provisions” document required pursuant to Subsection (H) in at least 12-point type when it delivers the policy.
- K. At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall include a written disclosure with the following information, printed in 12-point boldface type:
 - (1) The [insert state insurance department]’s mailing address, toll-free telephone number and website address.
 - (2) The address and customer service telephone number of the pet insurer or the agent or broker of record.
 - (3) If the policy was issued or delivered by an agent or broker, a statement advising the policyholder to contact the broker or agent for assistance.
- L. The disclosures required in this section shall be in addition to any other disclosure requirements required by law or regulation.

Section 5. Policy Conditions

- A. A pet insurer may issue policies that exclude coverage on the basis of one or more preexisting conditions with appropriate disclosure to the consumer. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.
- B. A pet insurer may issue policies that impose waiting periods upon effectuation of the policy that do not exceed 30 days for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited.
 - (1) A pet insurer utilizing a waiting period permitted in Subsection 5B shall include a provision in its contract that allows the waiting periods to be waived upon completion of a medical examination. Pet insurers may require the examination to be conducted by a licensed veterinarian after the purchase of the policy.
 - (2)
 - (a) A medical examination under Subsection 5B(1) shall be paid for by the policyholder, unless the policy specifies that the pet insurer will pay for the examination.
 - (b) A pet insurer can specify elements to be included as part of the examination and require documentation thereof, provided the specifications do not unreasonably restrict a consumer’s ability to waive the waiting periods in Subsection 5B.
 - (3) Waiting periods, and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.
- C. A pet insurer must not require a veterinary examination of the covered pet for the insured to have their policy renewed.

- D. If a pet insurer includes any prescriptive, wellness, or non-insurance benefits in the policy form, then it is made part of the policy contract and must follow all applicable laws and regulations in the insurance code.
- C. An insured's eligibility to purchase a pet insurance policy must not be based on participation, or lack of participation, in a separate wellness program.

Section 6. Sales Practices for Wellness Programs

- A. A pet insurer and/or producer shall not do the following:
 - (1) Market a wellness program as pet insurance;
 - (2) Market a wellness program during the sale, solicitation, or negotiation of pet insurance.
- B. If a wellness program is sold by a pet insurer and/or producer:
 - (1) The purchase of the wellness program shall not be a requirement to the purchase of pet insurance.
 - (2) The costs of the wellness program shall be separate and identifiable from any pet insurance policy sold by a pet insurer and/or producer.
 - (3) The terms and conditions for the wellness program shall be separate from any pet insurance policy sold by a pet insurer and/or producer.
 - (4) The products or coverages available through the wellness program shall not duplicate products or coverages available through the pet insurance policy; and
 - (5) The advertising of the wellness program shall not be misleading and shall be in accordance with Subsection 6B of this Model.
 - (6) A pet insurer and/or producer shall clearly disclose the following to consumers, printed in 12-point boldface type:
 - (a) That wellness programs are not insurance.
 - (b) The address and customer service telephone number of the pet insurer or producer or broker of record.
 - (c) The [insert state insurance department]'s mailing address, toll-free telephone number, and website address.
- C. Coverages included in the pet insurance policy contract described as "wellness" benefits are insurance.

Section 7. Insurance Producer Training

- A. An insurance producer shall not sell, solicit, or negotiate a pet insurance product until after the producer is appropriately licensed and has completed the required training identified in Subsection C of this Section.
- B. Insurers shall ensure that its producers are trained under Subsection C of this Section and that its producers have been appropriately trained on the coverages and conditions of its pet insurance products.
- C. The training required under this subsection shall include information on the following topics:
 - (1) Preexisting conditions and waiting periods;
 - (2) The differences between pet insurance and noninsurance wellness programs;
 - (3) Hereditary disorders, congenital anomalies or disorders and chronic conditions and how pet insurance policies interact with those conditions or disorders; and

(4) Rating, underwriting, renewal and other related administrative topics.

D. The satisfaction of the training requirements of another state that are substantially similar to the provisions of Subsection C shall be deemed to satisfy the training requirements in this state.

Section 8. Regulations

The commissioner may promulgate rules and regulations to administer this Act.

Section 9. Violations

Violations of this Act shall be subject to penalties pursuant to [insert state administrative code].

PROJECT HISTORY - 2022

PET INSURANCE MODEL LAW (#633)

1. Description of the Project, Issues Addressed, etc.

Development of the Pet Insurance Act. This model addresses required disclosures, definitions, policy conditions, sales practices for wellness programs, and producer training requirements.

2. Name of Group Responsible for Drafting the Model and States Participating

Pet Insurance (C) Working Group

Participating states: Virginia, Chair; California, Co-Chair; Alaska; Arkansas; Connecticut; District of Columbia; Louisiana; Maryland; Massachusetts; Missouri; Pennsylvania; Rhode Island; Utah; Vermont; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

Authorized by a charge from the Property and Casualty Insurance (C) Committee on March 28, 2019. The Working Group adopted the Request for NAIC Model Law Development on June 27, 2019, and the Property and Casualty Insurance (C) Committee adopted it on July 18, 2019. The Executive (EX) Committee and Plenary adopted the Request for NAIC Model Law Development on Aug. 6, 2019.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

Drafted by the full membership of the Pet Insurance (C) Working Group. Also participating in the drafting process were: the American Property Casualty Insurance Association (APCIA); the American Veterinarian Medical Association (AVMA); the Center for Economic Justice (CEJ); the Center for Insurance Research (CIR); the Chubb Group, Companion Protect, Mars Veterinary Health; Nationwide Insurance Group; North American Pet Health Insurance Association (NAPHIA); Trupanion; and Unum Life Insurance Company.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

A draft model law was presented to the Working Group on Oct. 1, 2019. The Working Group exposed Sections 1–4 for a public comment period on Oct. 1, 2019. It met to discuss Sections 1–4 on Nov. 7, 2019; Dec. 19, 2019; Feb. 19, 2020; March 5, 2020; and July 16, 2020.

The Working Group exposed Sections 5–6 for a public comment period on July 16, 2020. It met to discuss Sections 5–6 on Sept. 30, 2020, and Oct. 21, 2020.

The Working Group exposed Sections 7–9 for a public comment period on Sept. 30, 2020. It met to discuss Sections 7–9 on Nov. 6, 2020; Nov. 24, 2020; and Feb. 18, 2021.

The Working Group met to discuss open issues in the model on March 4, 2021; March 26, 2021; April 29, 2021; May 19, 2021; June 10, 2021; June 24, 2021; July 8, 2021; July 22, 2021; and July 29, 2021. It adopted a draft model on Aug. 4, 2021. The Working Group held additional meetings to discuss issues in the model on Sept. 8, 2021, and Oct. 7, 2021. The Working Group adopted the revised draft model on Oct. 21, 2021. The Property and Casualty Insurance (C) Committee adopted the draft model on Nov. 10, 2021. Before its consideration at the Joint Meeting of Executive (C) Committee and Plenary during the Fall National Meeting, there were concerns about the producer training section. The model was sent back to the Working Group for review. The Working Group met June 7, 2022 and July 21, 2022 to revise the language in Section 7. The model was adopted by the Working Group on July 21, 2022. The model was adopted by the Property and Casualty Insurance (C) Committee on August 1, 2022.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Free Look Period – There was discussion that a free look period would offer a better understanding for consumers with a newer product like pet insurance. Many state insurance regulators commented that the free look period was not necessary or actuarial sound. The inclusion of this free look period in the California pet insurance law was requested by industry and supported by many interested parties. State insurance regulators adopted language that insurers can implement a maximum 15-day free look period in which consumers can examine and return the policy for a full refund if no claim has been made on the policy.

Renewals – State insurance regulators wanted clear language added to the model that would not allow a condition that was covered under a policy to be considered a preexisting condition—and, therefore, excluded from coverage—on subsequent policy renewals. While industry did indicate that it would like the ability to issue one-year policies that do not offer a renewal and could then use a preexisting exclusion for a previously covered condition, state insurance regulators stated that these policies would not be considered a renewal and, therefore, the added language would not affect industry's ability to sell these types of policies.

Waiting Period – Some state insurance regulators took issue with the allowance of a waiting period for certain conditions as proposed by the industry. State insurance regulators adopted the allowance of a 30-day waiting period for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited.

Wellness Plans – There was discussion about whether wellness plans should be considered insurance or if those plans should be allowed to cover services that could be covered in insurance plans. State insurance regulators adopted a new section of the model to outline sales practices for wellness plans that are sold by licensed insurance entities. Wellness plans that are not sold by licensed entities and do not provide insurance coverage are not regulated by insurance departments and are not addressed in this model.

Licensing – Several state insurance regulators questioned the inclusion of licensing requirements in the model. After discussion with the Producer Licensing (D) Task Force, the licensing section was removed from the model. The Working Group adopted guidelines for producer training requirements.

Producer Training – Regulators in several states wanted to ensure that the language around producer training did not infringe on the work of the Producer Licensing (D) Task Force. They also wanted to make sure the model appropriately addressed reciprocity in states that had different but substantially similar training requirements.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 3 Pet Insurance Model.pdf

Adopted by the Executive (EX) Committee and Plenary, Aug. 13, 2022

Adopted by the Market Regulation and Consumer Affairs (D) Committee, July 15, 2022

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Line of Business: Other Health Insurance

Reporting Period: January 1, 2023 through December 31, 2023

Filing Deadline: June 30, 2024

Contact Information

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

Schedule 1 - Interrogatories

1-01	Are you currently marketing these products in this jurisdiction?	Yes/No
1-02	Do the products you are reporting on in response to this blank include closed or frozen blocks of business?	Yes/No
1-03	If yes, list the closed or frozen blocks of business?	Comment
1-04	Number of Other Health products offered to residents in this state	Number
1-05	For products reported to this MCAS jurisdiction, list the states where your Other Health products are filed (provide SERFF tracking number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product, and describe the basis for not filing.	Comment
1-06	For products reported to this MCAS jurisdiction, does the company issue these Other Health products through associations/trusts?	Yes/No
1-07	If yes, list the associations/trusts	Comment
1-08	If yes, do you have a contractual relationship with any association/trust?	Comment
1-09	If yes, please identify which associations/trusts	Comment
1-10	If yes, does the contract allow any association/trust to market the product?	Yes/No
1-11	If yes, please identify which associations/trusts	
1-12	If yes, does the contract allow any association/trust to collect policy or contract premiums?	Yes/No
1-13	If yes, does the contract allow any association/trust to collect and pay commissions?	Yes/No
1-14	If yes, please identify which associations/trusts	Comment
1-15	If yes, does the contract allow any association/trust to adjudicate claims?	Yes/No
1-16	if yes, please identify which associations/trusts	Comment

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

1-17	Has the company filed the associations by-laws and articles of incorporation in their state of domicile?	Yes/No
1-18	Has the company filed the association by-laws and articles of incorporation and policy forms in the situs state of the association?	Yes/No
1-19	If yes please provide the state, and the SERFF tracking number, if applicable	Comment
1-20	Has the company filed the association by-laws and articles of incorporation in the filing state?	Yes/No
1-21	Has the company filed the certificate of insurance in the filing state, if applicable?	Yes/No
1-22	Does the company contract with third-party administrators for administrative services related to Other Health products?	Yes/No
1-23	If yes, does the company issue Other Health products through administrators/TPAs?	Yes/No
1-24	If yes, how many administrators/TPAs?	Number
1-25	If yes, list the TPAs and provide their respective National Producer Number (NPN), if required by the state	Comment
1-26	If yes, does your company contract claims services related to Other Health products?	Yes/No
1-27	If yes, does your company contract complaints-related services related to Other Health products?	Yes/No
1-28	If yes, does your company contract medical underwriting services related to Other Health products?	Yes/No
1-29	If yes, does your company contract pricing services related to Other Health products?	Yes/No
1-30	If yes, does your company contract producer appointment services related to Other Health products?	Yes/No
1-31	If yes, does your company contract marketing, advertisement, or lead generation, services related to Other Health products?	Yes/No
1-32	If yes, does your company contract policyholder services related to Other Health products?	Yes/No
1-33	If yes, does your company contract premium collection services related to Other Health products?	Yes/No
1-34	Does your company audit third parties to whom you have delegated responsibilities?	Yes/No
1-35	If yes, please provide frequency of audits	Comment
1-36	Does your company distribute its product through independent agents?	Yes/No
1-37	Does your company distribute its products through captive agents?	Yes/No
1-38	Does your company distribute its products through its employees?	Yes/No
1-39	Does the company use pre-existing condition exclusions?	Yes/No
1-40	If yes, identify which products	Comment

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

1-41	Does the company contract with producers to collect premium or bind coverage on behalf of the company?	Yes/No
1-42	For fees that are included in reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.	Comment
1-43	For fees not included in the reported premium, identify what fees are charged to applicants and policyholders/certificate holders. Do not include commissions.	Comment
1-44	Additional state specific comments (optional)	Comment

Products

Product Identifiers	Explanation of Product Identifiers
Individual H-AO	Accident Only. Purchased by an individual
Individual ADD	Accidental Death and Dismemberment. Purchased by an individual
Individual SD	Specified Disease-Limited Benefit/Critical Illness. Purchased by an individual
Individual H-H/OI	Hospital/Other Indemnity. Purchased by an individual
Individual H-HSME	Hospital/Surgical/Medical Expense. Purchased by an individual
Association H-AO	Accident Only. Purchased through an association/trust
Association ADD	Accidental Death and Dismemberment. Purchased through an association/trust
Association SD	Specified Disease-Limited Benefit/Critical Illness. Purchased through an association/trust
Association H-H/OI	Hospital/Other Indemnity. Purchased through an association/trust
Association H-HSME	Hospital/Surgical/Medical Expense. Purchased through an association/trust
Employer Group H-AO	Accident Only. Purchased through an employer group
Employer Group ADD	Accidental Death and Dismemberment. Purchased through an employer group
Employer Group SD	Specified Disease-Limited Benefit/Critical Illness. Purchased through an employer group
Employer Group H-H/OI	Hospital/Other Indemnity. Purchased through an employer group

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Employer Group H-HSME	Hospital/Surgical/Medical Expense. Purchased through an employer group
----------------------------------	---

Schedule 2 – Policy/Certificate Administration

2-1	Net written premium
2-2	Earned premiums for reporting year
2-3	Number of policies/certificates in force at the beginning of the period
2-4	Number of covered lives on policies/certificates in force at the beginning of the period
2-5	Number of new policy/certificate applications/enrollments received during the period
2-6	Number of new policy/certificates issued during the period
2-7	Number of new policies/certificates denied during the period
2-8	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-9	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder during the period
2-10	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the period
2-11	Number of policies/certificates cancelled during the free look period
2-12	Number of covered lives on policies/certificates cancelled at the initiation of the policyholder/certificate holder during the free look period during the period
2-13	Number of policy/certificate terminations and cancellations due to non-payment of premium during the period
2-14	Number of covered lives on policies/certificates cancelled by the company due to non-payment of premium during the period
2-15	Number of policies/certificates cancelled by the company for any reason other than non-payment of premium during the period
2-16	Number of rescissions during the period
2-17	Number of covered lives impacted on terminations and cancellations initiated by the policyholder/certificate holder
2-18	Number of covered lives impacted on terminations and cancellations due to non-payment
2-19	Number of covered lives impacted by rescissions
2-20	Number of policies/certificates in force at the end of the period
2-21	Number of covered lives on policies/certificates in force at the end of the period

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Schedule 3 – Claims Administration (Including Pharmacy)

3-1	Number of claims pending at the beginning of the period
3-2	Number of claims received (include non-clean claims)
3-3	Total number of claims denied, rejected or returned
3-4	Number of denied, rejected, or returned as non-covered or maximum benefit exceeded
3-5	Number of denied, rejected, or returned as subject to pre-existing condition exclusion
3-6	Number denied, rejected, or returned due to failure to provide adequate documentation
3-7	Number denied, rejected, or returned due to being within the waiting period (do not answer for ADD products)
3-8	Number of denied, rejected, or returned (in whole or in part) because maximum \$ limit exceeded
3-9	Number of claims pending at end of the period
3-10	Median number of days from receipt of claim to decision for denied claims
3-11	Average number of days from receipt of claim to decision for denied claims
3-12	Median number of days from receipt of claim to decision for approved claims
3-13	Average number of days from receipt of claim to decision for approved claims
3-14	Number of claims paid
3-15	Aggregate dollar amount of paid claims during the period
3-16	Number of claims where the claims payment was reduced by premium owed
3-17	Dollar amount of claims payments applied to unpaid premiums.

Schedule 4 – Consumer Complaints and Lawsuits

4-1	Number of complaints received by Company (other than through the DOI)
4-2	Number of complaints received through DOI
4-3	Number of complaints resulting in claims reprocessing
4-4	Number of lawsuits open at beginning of the period
4-5	Number of lawsuits opened during the period
4-6	Number of lawsuits closed during the period
4-7	Number of lawsuits closed during the period with consideration for the consumer
4-8	Number of lawsuits open at end of the period

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Schedule 5 – Marketing and Sales

5-1	Number of individual applications/enrollments pending at the beginning of the period
5-2	Number of individual applications/enrollments denied during the period for any reason
5-3	Number of individual applications/enrollments denied during the period - health status or condition
5-4	Number of individual applications/enrollments approved during the period
5-5	Number of individual applications/enrollments pending at the end of the period
5-6	Number of applications/enrollments received via phone (audio only) (only answer for individual products)
5-7	Number of applications/enrollments received in person or via video application (e.g., Zoom, WebEx) (only answer for individual products)
5-8	Number of applications/enrollments received online (electronically) (only answer for individual products)
5-9	Number of applications/enrollments received by mail during the period (only answer for individual products)
5-10	Number of applications/enrollments received by any other method during the period (only answer for individual products)
5-11	Commissions paid during reporting period (dollar amount of commissions incurred during the period)
5-12	Unearned commissions returned to company on policies/certificates sold during the period

Participation Requirements: All companies licensed and reporting at least \$50,000 of other health insurance premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Report by Residency: This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situated.

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

General Definitions:

Other Health - Health insurance forms that are not subject to the Affordable Care Act (ACA). For this MCAS blank, they are Health-Accident Only; Health - Accidental Death and Dismemberment; Health-Specified Disease-Limited Benefit/Critical Illness; Health - Hospital/Other Indemnity; and Health - Hospital/Surgical/Medical Expense

Health-Accident Only - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability (not disability income), or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident

Health-Accidental Death and Dismemberment - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

Health-Specified Disease-Limited Benefit/Critical Illness - An insurance contract that pays benefits for the diagnosis and/or treatment of a specifically named disease, diseases, or critical illness. Benefits can be paid as expense incurred, per diem, or a principle sum.

Health-Hospital/Other Indemnity - An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred.

Health-Hospital/Surgical/Medical Expense - An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition.

Association/Trust – For purposes of this MCAS blank, a non-employer group that offers benefits to its members (does not include banks or credit unions).

Individual Product - Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State's department of insurance.

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

National Producer Number (NPN) - This is a specific number provided by National Insurance Producers Registry (NIPR) to individuals and most business entities that are listed in the NIPR's Producer Database (PDB).

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

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Policyholder/Certificate holder – Refers to the individual or member who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association/trust)

Policyholder Service - A company's activities relating to servicing its policyholders which includes, but is not limited to, notice/billing, disclosures, premium refunds and coverage questions.

Schedule 2 Definitions (Policy/Certificate Administration):

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

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

Schedule 3 Definitions (Claims Administration):

Claim – Provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Duplicate claims should not be reported.

For the purposes of this Market Conduct Annual Statement, a "Claim" includes any such request or demand, even those with incomplete or inadequate documentation and those made by an individual not eligible or covered under the policy against which the claim is made.

Communications with an insurer that are not explicit claims as per the definition above should not be reported on this MCAS. Such communications could include general queries regarding policy provisions, potential coverage, events reported for "information only", or other communications for which a clear request or demand for payment has not been made.

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

If a claim is reopened, treat the reopened claim as a new and distinct claim apart from the original claim. For reopened claims, the claim determination time period is measured from the date the claim was re-opened to the date a benefit determination is made.

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

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

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

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

Schedules 4 Definitions (Consumer Complaints and Lawsuits):

Complaint - any written communication that expresses dissatisfaction with a specific person or entity. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose. A complaint should be reported to the state where the policyholder resides.

Include:

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

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

For purposes of reporting lawsuits for Other Health Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;

Other Health Insurance Market Conduct Annual Statement

Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

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

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

Schedule 5 Definitions (Marketing and Sales)

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

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 4 MCAS OtherHealth.pdf

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
 Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group, May 26, 2022
 Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
 Proposed Additions in Blue Text/Proposed Deletions in Red Text*

Line of Business: Homeowners

Reporting Period: January 1, 2023 through December 31, 2023

Filing Deadline: April 30, 2024

Contact Information

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

Schedule 1—Interrogatories

ID	Description	Comment
1-01	Were there policies in-force during the reporting period that provided Dwelling coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Personal Property coverage?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Liability coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Loss of Use coverage?	Yes/No
1-06	Was the Company still actively writing policies in the state at year end?	Yes/No
1-07	Does the Company write in the non-standard market?	Yes/No
1-08	If yes, what percentage of your business is non-standard?	Comment
1-09	If yes, how is non-standard defined?	Comment
1-10	Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No	Yes/No
1-11	If yes, add additional comments	Comment
1-12	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-13	If yes, add additional comments	Comment
1-14	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment
1-15	Does the company use Managing General Agents (MGAs)?	Yes/No

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

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

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

***Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)**

Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment

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

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

ID	Description
2-23	Number of claims open at the beginning of the period
2-24	Number of claims opened during the period
2-25	Number of claims closed during the period, with payment
2-26	Number of claims closed during the period, without payment
2-27	Number of claims open at the end of the period
2-28	Median days to final payment

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

2-29	Number of claims closed with payment within 0-30 days
2-30	Number of claims closed with payment within 31-60 days
2-31	Number of claims closed with payment within 61-90 days
2-32	Number of claims closed with payment within 91-180 days
2-33	Number of claims closed with payment within 181-365 days
2-34	Number of claims closed with payment beyond 365 days
2-35	Number of claims closed without payment within 0-30 days
2-36	Number of claims closed without payment within 31-60 days
2-37	Number of claims closed without payment within 61-90 days
2-38	Number of claims closed without payment within 91-180 days
2-39	Number of claims closed without payment within 181-365 days
2-40	Number of claims closed without payment beyond 365 days
2-39	Number of lawsuits open at beginning of the period
2-40	Number of lawsuits opened during the period
2-41	Number of lawsuits closed during the period
2-42	Number of lawsuits open at end of period
2-43	Number of lawsuits closed with consideration for the consumer.

Schedule 3—Homeowners Underwriting Activity

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

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

3-53	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-54	Number Of Complaints Received Directly From Any Person or Entity Other than the DOI

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

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

Schedule 4– Lawsuit Activity

Reporting Breakdown

Dwelling (includes – Other Structures)	Claim related lawsuits
Personal Property	
Liability	
Medical Payments	
Loss of Use	
Non-claim Related Lawsuits	Non-claim related lawsuits

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

Schedule 4– Homeowners Attestation

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

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

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

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

Definitions:

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

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

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

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.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

Report cancellations separately for:

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

Exclude:

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

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

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

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

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

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

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

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:

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

- 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.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

- 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.

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).

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

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

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

Digital Claim Handling Process Level of Detail Breakdown:

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

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

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

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

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

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

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

Calculation Clarification:

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

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

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

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

Include:

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

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:

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

- 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 – ~~A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.~~ An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

Exclude:

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, **interpleader actions**, and declaratory judgment actions filed **or brought** by an insurer.
- **Arbitrations, mediation, appraisal, or any other form of dispute resolution not brought in a court of law.**

Calculation Clarification:

- ~~• Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each / claimant / coverage combination, regardless of the number of actual suits filed.~~
- ~~• One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.~~
- ~~• One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage.~~
- ~~• Lawsuits should be reported in the state in which the claim was reported on this statement.~~

For purposes of reporting lawsuits for Homeowner products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer as a defendant.
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- With the exception of class action lawsuits, report a lawsuit with two or more complainants as one lawsuit.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

- With the exception of class action lawsuits, report a lawsuit in the jurisdiction in which the policy was issued.
- Report claim related lawsuits broken out by coverage as outlined in the schedule.
- Report non-claim related lawsuits in aggregate as outlined in the schedule.

Treatment of Class Action Lawsuits:

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

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

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

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

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

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

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

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

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

Exclude:

- Subrogation payments.

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.

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

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

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

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

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

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

$$\text{Median Days to Final Payment} = (5 + 6)/2 = 5.5$$

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

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

Closing Time # of Claims

< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

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

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

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

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

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

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

Exclude:

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

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

Include:

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

Exclude:

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

Calculation Clarification:

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

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

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

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

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

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.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 5 MCAS HomeownerDataCallDefinitions.pdf

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
 Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
 Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
 Proposed Additions in Blue Text/Proposed Deletions in Red Text*

Line of Business: Private Passenger Auto

Reporting Period: January 1, 2023 through December 31, 2023

Filing Deadline: April 30, 2024

Contact Information

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

Schedule 1—Interrogatories

ID	Description	Comments
1-01	Were there policies in-force during the reporting period that provided Collision coverage?	Yes/No
1-02	Were there policies in-force during the reporting period that provided Comprehensive/Other Than Collision coverage?	Yes/No
1-03	Were there policies in-force during the reporting period that provided Bodily Injury coverage?	Yes/No
1-04	Were there policies in-force during the reporting period that provided Property Damage coverage?	Yes/No
1-05	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?	Yes/No
1-06	Were there policies in-force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?	Yes/No
1-07	Were there policies in-force during the reporting period that provided Medical Payments coverage?	Yes/No
1-08	Were there policies in-force during the reporting period that provided Combined Single Limits coverage?	Yes/No
1-09	Were there policies in-force during the reporting period that provided Personal Injury Protection coverage?	Yes/No
1-10	Was the Company still actively writing policies in the state at year end?	Yes/No
1-11	Does the Company write in the non-standard market?	Yes/No
1-12	If yes, what percentage of your business is non-standard?	Percentage
1-13	If yes, how is non-standard defined?	Comment

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

1-14	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-15	If yes, add additional comments	Comment
1-16	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-17	If yes, add additional comments	Comment
1-18	How does company treat subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim)? Re-open original claim/open new claim	Comment
1-19	Does the company use Managing General Agents (MGAs)?	Yes/No
1-20	If yes, list the names of the MGAs.	Comment
1-21	Does the company use Third Party Administrators (TPAs)?	Yes/No
1-22	If yes, list the names of the TPAs.	Comment
1-23	Does the company use telematics or usage-based data?	Yes/No
1-24	Does the company use digital claim settlement?	Yes/No
1-25	If yes, list the names of the vendors providing third-party data and algorithms used in the digital claim settlement process.	Comment
1-26	Claims Comments	Comment
1-27	Underwriting Comments	Comment

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

Coverages

Coverages	Reported also at the Digital Claim Handling Process Level of Detail*
Collision	X
Comprehensive/Other Than Collision	X
Bodily Injury	
Property Damage	X
Uninsured Motorists and Underinsured Motorists (UMBI)	
Uninsured Motorists and Underinsured Motorists (UMPD)	X
Medical Payments	
Combined Single Limits	
Personal Injury Protection	

*** Includes Digital Claims, Hybrid Claims and Non-Digital Claims (Applies only to claims related data elements)**

Additionally, an "All" breakout will be included for the reporting of Median Days to Final Payment.

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

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

ID	Description
2-28	Number of claims open at the beginning of the period
2-29	Number of claims opened during the period
2-30	Number of claims closed during the period, with payment
2-31	Number of claims closed during the period, without payment.
2-32	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.
2-33	Number of claims remaining open at the end of the period

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

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

Schedule 3—Private Passenger Auto Underwriting

ID	Description
3-52	Number of autos which have policies in-force at the end of the period
3-53	Number of policies in-force at the end of the period
3-54	Number of new business policies written during the period
3-55	Dollar amount of direct premium written during the period
3-56	Number of Company-Initiated non-renewals during the period
3-57	Number of cancellations for non-pay or non-sufficient funds
3-58	Number of cancellations at the insured's request
3-59	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-60	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

3-61	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-62	Number of complaints received directly from any person or entity other than the DOI

Schedule 4—Private Passenger Auto Attestation

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

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

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

ID	Description
4-63	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
4-64	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
4-65	Overall Comments for the Period

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

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

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
 - 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.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 6 MCAS DataCallPPADigitalClaimsLawsuits.pdf

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

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.

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

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

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.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

- 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.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

Include:

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

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

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

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

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

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

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

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

coverages (wage, funeral, death, medical, etc) that would correspond to first party coverages in the applicable participating states should be included.

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

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

Calculation Clarification:

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

Example:

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

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

Digital Claim Handling Process Level of Detail Breakdown:

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

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

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

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

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

Direct Written Premium - The total amount of direct written premium for all policies 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 – ~~A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.~~ An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

Exclude:

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit legal activity or litigation filed by an insurer, including, but not limited to: request to compel an independent medical examination, an examination under oath, **interpleader actions**, and declaratory judgment actions filed **or brought** by an insurer.

Calculation Clarification:

- ~~• Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each claimant / coverage combination, regardless of the number of actual lawsuits filed.~~
- ~~• One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.~~
- ~~• One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage. If the lawsuit is seeking damages for bodily injury and property damage, one lawsuit should be reported for each of the two coverages.~~
- ~~• Lawsuits should be reported in the state in which the claim is reported on this statement.~~

For purposes of reporting lawsuits for Private Passenger Auto products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer as a defendant.
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred.
- With the exception of class action lawsuits, report a lawsuit with two or more complainants as one lawsuit.
- With the exception of class action lawsuits, report a lawsuit in the jurisdiction in which the policy was issued.
- Report claim related lawsuits broken out by coverage as outlined in the schedule.
- Report non-claim related lawsuits in aggregate as outlined in the schedule.

Treatment of class action lawsuits:

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

Lawsuits Closed During the Period with Consideration for the Consumer—A lawsuit closed during the reporting period in which a court order, jury verdict, or

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

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

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

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

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

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

Exclude:

- Subrogation payments should not be included.

Calculation Clarification / Example:

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

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

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

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

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

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

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

$$\text{Median Days to Final Payment} = (5 + 6)/2 = 5.5$$

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

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

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

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

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

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

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

Property & Casualty Market Conduct Annual Statement

Private Passenger Auto Data Call & Definitions

Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text

Exclude:

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

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

Include:

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

Exclude:

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

Calculation Clarification:

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

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

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.

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

*Digital Claims Edits other than Interrogatories Adopted by D Committee and MCAS Blanks WG in 2021
Lawsuit & Digital Claims Interrogatory Edits Adopted by MCAS Blanks (D) Working Group May 26, 2022
Lawsuit & Digital Claims Interrogatory Edits Adopted by Market Regulation and Consumer Affairs (D) Committee, July 15, 2022
Proposed Additions in Blue Text/Proposed Deletions in Red Text*

- 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.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 6 MCAS DataCallPPADigitalClaimsLawsuits.pdf

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

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

Reporting Period: January 1, 2023 through December 31, 2023

Filing Deadline: April 30, 2024

Contact Information

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

Life and Annuity Product Types

Product Identifiers	Explanation of Product Identifiers
ICVP	Individual Life Cash Value Products (Includes Variable Life, Universal Life, Variable Universal Life, Term Life with Cash Value, Whole Life, & Equity Index Life)
INCVP	Individual Life Non-Cash Value Products (Any life insurance policy that does not contain a cash value element)
IIFA	Individual Indexed Fixed Annuities
IOFA	Individual Other Fixed Annuities
IIVA	Individual Indexed Variable Annuities
IOVA	Individual Other Variable Annuities

In addition, some data elements are broken out by Accelerated Underwriting vs. Other than Accelerated Underwriting.

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

Schedule 1A—Life Interrogatories

ID	Description	Comments
----	-------------	----------

Interrogatories General

1A-01	Individual Life Cash Value – Does the company have data to report for this product type?	Yes/No
1A-02	Individual Life Non-Cash Value – Does the company have data to report for this product type?	Yes/No
1A-03	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.)	Yes/No
1A-04	If yes, add additional comments	Comment
1A-05	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.)	Yes/No
1A-06	If yes, add additional comments	Comment
1A-07	Does the company use third party administrators (TPAs) for purposes of supporting the individual life business being reported?	Yes/No
1A-08	If yes, provide the names and functions of each TPA.	Comment
1A-09	Did the company use MCAS accelerated underwriting during the reporting period? If yes, complete the MCAS Accelerated Underwriting interrogatories.	Yes/No

Interrogatories MCAS Accelerated Underwriting

1A-10	Did the company use MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, or 3-Both Cash Value and Non-Cash Value products	1/2/3
1A-11	Did the company utilize Application Data as inputs in its MCAS accelerated underwriting algorithm (excluding application data used only for purposes of identifying a consumer to obtain third-party data) for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-12	Did the company utilize Medical Data in its MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-13	If 1, 2 or 3, list the data categories and sources of data	Comment

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

	<i>associated with Medical Data</i>	
1A-14	Did the company utilize FCRA compliant non-medical third-party data in its MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-15	If 1, 2 or 3, list the data categories and sources of data associated with FCRA compliant non-medical third-party data	Comment
1A-16	Did the company utilize other non-medical third-party data in its MCAS accelerated underwriting for 1-Cash Value, 2-Non-Cash Value, 3-Both Cash Value and Non-Cash Value products or 4-Not used?	1/2/3/4
1A-17	If 1, 2 or 3, list the data categories and sources of data associated with other non-medical third-party data	Comment

Interrogatories Comments

1A-18	Individual Life Cash Value comments	Comment
1A-19	Individual Life Non-Cash Value comments	Comment

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

ID	Description
1B-20	Number of New Replacement Policies Issued During the Period (Include only the number of replacement insurance policies issued)
1B-21	Number of Internal Replacements Issued During the Period
1B-22	Number of External Replacements of Unaffiliated Company Policies Issued During the Period.
1B-23	Number of External Replacements of Affiliated Company Policies Issued During the Period.
1B-24	Number of Policies Replaced Where Age of Insured at Replacement was <65 (Only applies to ICVP)
1B-25	Number of Policies Replaced Where Age of Insured at Replacement was Age 65 and Over (Only applies to ICVP)
1B-26	Number of Policies Surrendered Under 2 Years from Policy Issue (Only applies to ICVP)
1B-27	Number of Policies Surrendered Between 2 Years and 5 Years of Policy Issue (Only applies to ICVP)
1B-28	Number of Policies Surrendered Between 6 Years and 10 Years of Policy Issue (Only applies to ICVP)
1B-29	Number of Policies Surrendered More Than 10 Years from Policy Issue (Only applies to ICVP)
1B-30	Total Number of Policies Surrendered During the Period (Only applies to ICVP)

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

1B-31	Number of Policies Surrendered with a Surrender Fee (Only applies to ICVP)
1B-32	Number of Policies Issued During the Period where age of insured at issue was <65 (Only applies to ICVP)
1B-33	Number of Policies Issued During the Period where age of insured at issue was Age 65 and over (Only applies to ICVP)
1B-34	Number of Complaints Received Directly from Any Person or Entity Other than the DOI
1B-35	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)
1B-36	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)
1B-37	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)
1B-38	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)
1B-39	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)
1B-40	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)
1B-41	Number of Death Claims Denied, Resisted or Compromised During the Period
1B-42	Number of Death Claims Closed with Payment During the Period, which Occurred within the Contestability Period
1B-43	Number of Death Claims Denied During the Period, which Occurred within the Contestability Period
1B-44	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)
1B-45	Number of Lawsuits Open at the Beginning of the Period
1B-46	Number of Lawsuits Opened During the Period
1B-47	Number of Lawsuits Closed During the Period

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

1B-48	Number of Lawsuits Closed During the Period with Consideration for the Customer
1B-49	Number of Lawsuits Open at the End of the Period

Schedule 1C—Individual Life Cash Value (ICVP) and Non-Cash Value (INCVP) Products with MCAS Accelerated Underwriting vs. Other Than MCAS Accelerated Underwriting Breakout

1C-50	Total Number of New Policies Issued by the Company During the Period
1C-51	Number of Policies Applied for During the Period
1C-52	Number of Free Looks During the Period
1C-53	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)
1C-54	Dollar Amount of Direct Premium During the Period
1C-55	Dollar Amount of Insurance Issued During the Period (Face Amount)
1C-56	Dollar Amount of Insurance In-Force at the End of the Period (Face Amount)

Schedule 2A—Annuity Interrogatories

ID	Description	Comments
2A-01	Individual Indexed Fixed Annuities – Does the company have data to report for this product type?	Yes/No
2A-02	Individual Other Fixed Annuities – Does the company have data to report for this product type?	Yes/No
2A-03	Individual Indexed Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-04	Individual Other Variable Annuities – Does the company have data to report for this product type?	Yes/No
2A-05	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
2A-06	If yes, add additional comments	Comment
2A-07	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
2A-08	If yes, add additional comments	Comment
2A-09	Does the company use third party administrators (TPAs) for purposes of supporting the individual annuity business being reported?	Yes/No

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

2A-10	If yes, provide the names and functions of each TPA.	Comment
2A-11	Individual Fixed Annuities comments	Comment
2A-12	Individual Variable Annuities comments	Comment

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)
Proposed Additions in Blue Text

Schedule 2B—Individual Indexed Fixed Annuities (IIFA), Individual Other Fixed Annuities (IOFA), Individual Indexed Variable Annuities (IIVA), and Individual Other Variable Annuities (IOVA)

ID	Description
2B-13	Number of New Replacement Contracts Issued During the Period (Include only the number of replacement annuity contracts issued)
2B-14	Number of Internal Replacement Contracts Issued During the Period
2B-15	Number of External Replacements of Unaffiliated Company Contracts Issued During the Period.
2B-16	Number of External Replacements of Affiliated Company Contracts Issued During the Period.
2B-17	Number of Contracts Replaced Where Age of Annuitant at Replacement was < 65
2B-18	Number of Contracts Replaced Where Age of Annuitant at Replacement was 65 to 80
2B-19	Number of Contracts Replaced Where Age of Annuitant at Replacement was > 80
2B-20	Number of New Immediate Contracts Issued During the Period
2B-21	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was < 65
2B-22	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was 65 to 80
2B-23	Number of New Deferred Contracts Issued During the Period Where Age of Annuitant was > 80
2B-24	Total Number of New Deferred Contracts Issued by the Company During the Period
2B-25	Number of Contracts Surrendered Under 2 Years from Issuance
2B-26	Number of Contracts Surrendered Between 2 Years and 5 Years of Issuance
2B-27	Number of Contracts Surrendered Between 6 years and 10 Years of Issuance
2B-28	Number of Contracts Surrendered Over 10 Years from Issuance
2B-29	Total Number of Contracts Surrendered During the Period
2B-30	Total Number of Contracts Surrendered with a Surrender Fee
2B-31	Number of Contracts Applied for During the Period
2B-32	Number of Free Looks During the Period
2B-33	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)
2B-34	Dollar Amount of Annuity Considerations During the Period
2B-35	Number of Complaints Received Directly From Any Person or Entity Other than the DOI
2B-36	Number of Lawsuits Open at the Beginning of the Period
2B-37	Number of Lawsuits Opened During the Period
2B-38	Number of Lawsuits Closed During the Period
2B-39	Number of Lawsuits Closed During the Period with Consideration for the Customer
2B-40	Number of Lawsuits Open at the End of the Period

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

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:

MCAS Accelerated Underwriting - For this MCAS, data should be reported as Accelerated Underwriting when artificial intelligence and/or machine learning which utilizes, in whole or in part, Other Non-medical Third-party Data and/or FCRA Compliant Non-medical Third-party Data in the underwriting of life insurance; including when used in combination with Application Data or Medical Data.

MCAS Accelerated Underwriting is a subset of Life insurance Accelerated Underwriting as defined in a 2022 NAIC educational paper on the topic. That broader definition is:

Accelerated Underwriting¹ - Accelerated underwriting is the use of big data, artificial intelligence, and machine learning to underwrite life insurance in an expedited manner. The process generally uses predictive models and machine learning algorithms to analyze applicant data, which may include the use of nontraditional, non-medical data, provided either by the applicant directly or obtained through external sources. The process is typically used to replace all or part of traditional underwriting in life insurance and to allow some applications to have certain medical requirements waived, such as paramedical exams and fluid collection.

Data utilized in accelerated underwriting algorithms:

- **Application data:** Information provided by or on behalf of the consumer in response to questions on the application for insurance, including any supplemental application forms, including medical information provided on the application.
- **Medical data:** Medical information related to the consumer and collected from third parties with the authorization of the consumer, such as but not limited to health records and prescription records.
- **FCRA Compliant non-medical third-party data:** Non-medical data related to the consumer that is provided by a consumer reporting agency in a consumer report that is subject to the Fair Credit Reporting Act (FCRA) requirements and protections. Examples – 1) category of data is a motor vehicle report, and the source of the data is a state department of motor vehicles or a third-party vendor, 2) category of data is consumer credit information and the source of the data is Experian or TransUnion.

¹ Source: Accelerated Underwriting (AU) Educational Report by the NAIC Accelerated Underwriting (A) Working Group, 2022

Market Conduct Annual Statement Life & Annuities Data Call & Definitions

(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

- **Other non-medical third-party data:** Any non-medical data not reported in the three categories listed above. Examples – 1) category of non-medical third-party data is social media and the source of those data is Facebook or Carpe Data, 2) category is facial analytics and the source is a video interview application used by insurer.

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.

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

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

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.

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

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

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.

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

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;
- 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.)

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

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.

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.

Market Conduct Annual Statement
Life & Annuities Data Call & Definitions
(Adopted by the MCAS Blanks (D) Working Group 5/26/2022)

Proposed Additions in Blue Text

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.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 7 MCAS LifeAnnuityAdditionAccelerated.pdf

Adopted by the Financial Condition (E) Committee July 21, 2022.

Adopted by the Financial Stability (E) Task Force and Macroeconomic (E) Working Group, June 27, 2022.

Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers

A summary of currently identified regulatory considerations follows with no consideration of priority or importance (green underlined font indicates current or completed work by another NAIC committee group). Most of these considerations are not limited to PE owned insurers and are applicable to any insurers demonstrating the respective activities. A summary of the regulatory process has been added to this document since it is being used by individuals less familiar with the state insurance regulatory system, and the results of regulator discussions on how to move forward have been added to specific considerations in blue font. The proposed regulator responses are exposed for a 45-day comment period.

State insurance regulators monitor the solvency of each legal entity insurer, including assessing risks from the broader holding company when an insurer is part of a group, making use of routinely required disclosures, both public, such as the statutory financial statements, and confidential, such as the Risk-Based Capital (RBC) supplemental filing and Holding Company form filings. Regulators also use many analysis and examination tools and procedures for each insurer and/or insurance group. Regulatory responses to the analysis and examination work depend upon the results of those reviews. One specific area of solvency monitoring work focuses on potential acquisitions of a US legal entity insurer, involving a Form A filing. In 2013, guidance was added to the NAIC Financial Analysis Handbook for Form A reviews when a private equity owner was involved, although these considerations are not limited to PE acquisitions. The guidance provides examples of stipulations, both limited time and continuing, regulators could use when approving the acquisition to address solvency concerns, as well as for use in ongoing solvency monitoring. Examples follow:

Limited Time Stipulations:

- Requiring RBC to be maintained at a specified amount above company action level/trend test level. Because capital serves as a buffer that insurers use to absorb unexpected losses and financial shocks, this would better protect policyholders.
- Requiring quarterly RBC reports rather than annual reports as otherwise required by state law.
- Prohibiting any dividends, even ordinary.
- Requiring a capital maintenance agreement or prefunded trust account.
- Enhancing the scrutiny of operations, dividends, investments, and reinsurance by requiring material changes in plans of operation to be filed with the commissioner (including revised projections), which, at a minimum, would include affiliated/related party investments, dividends, or reinsurance transactions to be approved prior to such change.
- Requiring a plan to be submitted by the group that allows all affiliated agreements and affiliated investments to be reviewed, despite being below any materiality thresholds otherwise required by state law. A review of agreements between the insurer and affiliated entities may be particularly helpful to verify there are no cost-sharing agreements that are abusive to policyholder funds assessment.

Continuing Stipulations:

- Requiring prior commissioner approval of material arms-length, non-affiliated reinsurance treaties or risk-sharing agreements.

- Requiring notification within 30 days of any change in directors, executive officers or managers, or individuals in similar capacities of controlling entities, and biographical affidavits and such other information as shall reasonably be required by the commissioner.
- Requiring filing of additional information regarding the corporate structure, controlling individuals, and other operations of the company.
- Requiring the filing of any offering memoranda, private placement memoranda, any investor disclosure statements or any other investor solicitation materials that were used related to the acquisition of control or the funding of such acquisition.
- Requiring disclosure of equity holders (both economic and voting) in all intermediate holding companies from the insurance company up to the ultimate controlling person or individual but considering the burden on the acquiring party against the benefit to be received by the disclosure.
- Requiring the filing of audit reports/financial statements of each equity holder of all intermediate holding companies but considering the burden on the acquiring party against the benefit to be received by the disclosure.
- Requiring the filing of personal financial statements for each controlling person or entity of the insurance company and the intermediate holding companies up to the ultimate controlling person or company. Controlling person could include for example, a person who has a management agreement with an intermediate holding company.

Among many other concepts, regulators are considering the need for any additional stipulations, if there are some stipulations that should be required instead of used subjectively, and use of some stipulations beyond the Form A acquisition process (e.g., for insurers acquired in the past).

RRC Comments “In a Form A transaction” (7 bullet points) – Suggest including these in the referrals to the NAIC Group Solvency Issues (E) Working Group and the NAIC Risk-Focused Surveillance (E) Working Group for consideration when addressing Consideration numbers 1, 2, 4 and 5.

1. Regulators may not be obtaining clear pictures of risk due to holding companies structuring contractual agreements in a manner to avoid regulatory disclosures and requirements. Additionally, affiliated/related party agreements impacting the insurer’s risks may be structured to avoid disclosure (for example, by not including the insurer as a party to the agreement).

Regulator discussion results:

- Refer this item to the NAIC Group Solvency Issues (E) Working Group. Items discussed:
 - Instead of requiring for all Form A acquisitions to provide additional disclosures, structure an optional disclosure requirement that can be used when unresolved regulatory concerns exist with the acquisition. For example:
 - Disclosures to allow regulators to assess the goal of the potential owner in acquiring the insurer, how the potential owner will be paid and in what amounts, and the ability of the potential owner to provide capital support as needed.
 - Copies of disclosures provided to the potential owner’s investors.
 - Provide training as needed to states with less experience reviewing complex Form A transactions and refer those states to more experienced states for live help.

- These options include highlighting the need to use external expertise for complex transactions, especially to understand non-U.S. affiliations and when assessing multiple complex Form A applications, and at the expense of the Form A applicant.

AIC Comment (recommended 2 items) – Suggest including this recommendation in the referral to the NAIC Group Solvency Issues (E) Working Group for its work on Consideration #1.

- Recommendation: The Working Group should assess, among other items: (i) the need to provide regulatory certainty *vis a vis* when and on what basis additional disclosures could be required; and (ii) whether the additional disclosures would extend approval timelines. We believe such items are critical to insurers being able to access the capital markets effectively and efficiently.
2. Control is presumed to exist where ownership is $\geq 10\%$, but control and conflict of interest considerations may exist with less than 10% ownership. For example, a party may exercise a controlling influence over an insurer through Board and management representation or contractual arrangements, including non-customary minority shareholder rights or covenants, investment management agreement (IMA) provisions such as onerous or costly IMA termination provisions, or excessive control or discretion given over the investment strategy and its implementation. Asset-management services may need to be distinguished from ownership when assessing and considering controls and conflicts.

Regulator discussion results:

- Refer this item to the NAIC Group Solvency Issues (E) Working Group. Regulators recognized the integral connection of the first two considerations. Items discussed:
 - An emphasis on training and providing detailed examples to address the complexity and creativity involved in some of these Form A agreements and holding company structures.
 - It is not practical to get copies of operating agreements from every entity in a group to assess control impacts to the insurers. Consider ways of better targeting the pertinent agreements to assess, including a potential list of questions about less than 10% owners for use when considering Form A applications and/or ongoing analysis.
 - Consider if Form B (Insurance Holding Company System Annual Registration Statement) disclosure requirements should be modified to address these considerations.

AIC Comment (2 primary concerns) – Suggest asking the AIC to follow the work of the NAIC Group Solvency Issues (E) Working Group on Consideration #2 and make comments on specific recommendations if needed.

- Concerns: The 10% presumption of control needs to remain; and contractual terms contained in service agreements that are negotiated on an arm's length basis are not sufficient to convey the power to direct or cause the direction of an insurer, so long as they are subject to the ultimate supervision and control by the insurer.
3. The material terms of the IMA and whether they are arm's length or include conflicts of interest—including the amount and types of investment management fees paid by the insurer, the termination provisions (how difficult or costly it would be for the insurer to terminate the IMA) and the degree of discretion or control of the investment manager over investment guidelines, allocation, and decisions.

Regulator discussion results:

- Refer this item to the NAIC Risk-Focused Surveillance (E) Working Group. Regulators recognized similar dynamics to the first two considerations, but this Working Group was selected because it is already currently focused on a project involving affiliated agreements and Form D filings. Items discussed:
 - Consider training and examples, such as unique termination clauses and use of sub-advisors with the potential for additive fees, and strategies to address these.
 - This included addressing pushback on obtaining sub-advisor agreements as Form D disclosures and some optional disclosures for the Form A.
 - Given the increasing prevalence of bespoke agreements, does it make sense to tie this work in to the work of the NAIC Valuation of Securities (E) Task Force and/or the NAIC Securities Valuation Office? If yes, how best to do so?
 - Surplus Notes and appropriate interest rates given their special regulatory treatment, including whether floating rates are appropriate; follow any Statutory Accounting Principles (E) Working Group projects related to this topic and provide comments needed.

RRC Comments “With respect to an Investment Management Agreement (IMA)” (3 bullet points) - Suggest including these in the referral to the NAIC Risk-Focused Surveillance (E) Working Group for Consideration #3.

AIC Comments on “Conflict of Interest, Fees, Termination” (3 individual comments) – Suggest including these comments in the referral to the NAIC Risk-Focused Surveillance (E) Working Group for its work on Consideration #3.

4. Owners of insurers, regardless of type and structure, may be focused on short-term results which may not be in alignment with the long-term nature of liabilities in life products. For example, investment management fees, when not fair and reasonable, paid to an affiliate of the owner of an insurer may effectively act as a form of unauthorized dividend in addition to reducing the insurer’s overall investment returns. Similarly, owners of insurers may not be willing to transfer capital to a troubled insurer.
 - a. Life Actuarial (A) Task Force (LATF) work addresses this – helping to ensure the long-term life liabilities (reserves) and future fees to be paid out of the insurer are supported by appropriately modeled assets.

Regulator discussion results:

- In addition to LATF’s work, refer this item to the NAIC Risk-Focused Surveillance (E) Working Group, as it is already looking at some of this work related to affiliated agreements and fees. Items discussed:
 - Capital maintenance agreements, suggesting guidance for the appropriate entities to provide them and considering ways to make them stronger.
5. Operational, governance and market conduct practices being impacted by the different priorities and level of insurance experience possessed by entrants into the insurance market without prior insurance experience, including, but not limited to, PE owners. For example, a reliance on TPAs due to the acquiring firm’s lack of expertise may not be sufficient to administer the business. Such practices could lead to lapse, early surrender, and/or exchanges of contracts with in-the-money guarantees and other important policyholder coverage and benefits.

- a. The NAIC Financial Analysis Handbook includes guidance specific to Form A consideration and post approval analysis processes regarding PE owners of insurers (developed previously by the Private Equity Issues (E) Working Group).

Regulator discussion results:

- Regulators considered referring this consideration to the NAIC Risk-Focused Surveillance (E) Working Group but opted to keep developing more specific suggestions for now. Items discussed:
 - o Consider optional Form A disclosures and guidance for less experienced states; review EU conduct of business language and consider if similar concepts would help target the optional use.
 - o Consider more detailed guidance for financial examinations.
 - o Besides just inexperience, the consideration also includes intentional actions that ignore known concerns to achieve owner's results; might need to consider Market Conduct group(s).
6. No uniform or widely accepted definition of PE and challenges in maintaining a complete list of insurers' material relationships with PE firms. (UCAA (National Treatment WG) dealt with some items related to PE.) This definition may not be required as the considerations included in this document are applicable across insurance ownership types.

Regulator discussion results:

- Regulators do not believe a PE definition is needed, as the considerations are activity based and apply beyond PE owners.
7. The lack of identification of related party-originated investments (including structured securities). This may create potential conflicts of interests and excessive and/or hidden fees in the portfolio structure, as assets created and managed by affiliates may include fees at different levels of the value chain. For example, a CLO which is managed or structured by a related party.
- a. An agenda item and blanks proposal are being re-exposed by SAPWG. Desire for 2022 year-end reporting to include disclosures identifying related-party issuance/acquisition.

Regulator discussion results:

- Regulators are comfortable the SAPWG's work is sufficient as a first step since it involves code disclosures to identify various related party issues. They also recognize that existing and/or referred work at the Risk-Focused Surveillance (E) Working Group may address some items in this consideration. Once regulators work with these SAPWG disclosures and other regulatory enhancement, further regulatory guidance may be considered as needed.
8. Though the blanks include affiliated investment disclosures, it is not easy to identify underlying affiliated investments and/or collateral within structured security investments. Additionally, transactions may be excluded from affiliated reporting due to nuanced technicalities. Regulatory disclosures may be required to identify underlying related party investments and/or collateral within structured security investments. This would include, for example, loans in a CLO issued by a corporation owned by a related party.
- a. An agenda item and blanks proposal are being re-exposed by SAPWG. The concept being used for investment schedule disclosures is the use of code indicators to identify the role of

the related party in the investment, e.g., a code to identify direct credit exposure as well as codes for relationships in securitizations or similar investments.

Regulator discussion results:

- Like the previous consideration, regulators are looking forward to using these code disclosures to help target areas for further review. However, specific to CLO/structured security considerations, regulators support a referral to the Examination Oversight (E) Task Force. Specific items discussed include:
 - o Since investors in CLOs obtain monthly collateral reports, regulators should consider asking for such reports when concerns exist regarding a company's potential exposure to affiliated entities within their CLO holdings.
 - o Regulators would like to have more information regarding the underlying portfolio companies affiliated with a CLO manager to help quantify potential exposure between affiliates and related parties.
 - o Regulators request NAIC staff to consider their ability to provide tools and/or reports to help regulators target CLOs/structured securities to consider more closely.

RRC Comments on "collateralized loan obligations (CLOs)" (2 bullets) – Suggest including these in the referrals to the NAIC Examination Oversight (E) Task Force and the NAIC Risk-Focused Surveillance (E) Working Group for Consideration numbers 7, 8 and 9, but also sending to the NAIC Statutory Accounting Principles (E) Working Group for its existing work related to these Considerations.

9. Broader considerations exist around asset manager affiliates (not just PE owners) and disclaimers of affiliation avoiding current affiliate investment disclosures. A new Schedule Y, Pt 3, has been adopted and is in effect for year-end 2021. This schedule will identify all entities with greater than 10% ownership – regardless of any disclaimer of affiliation - and whether there is a disclaimer of control/disclaimer of affiliation. It will also identify the ultimate controlling party.
 - a. Additionally, SAPWG is developing a proposal to revamp Schedule D reporting, with primary concepts to use principles to determine what reflects a qualifying bond and to identify different types of investments more clearly. For example, D1 may include issuer credits and traditional ABS, while a sub-schedule of D1 could be used for additional disclosures for equity-based issues, balloon payment issues, etc. This is a much longer-term project, 2024 or beyond.

Regulator discussion results:

- Regulators recognize the new Schedule Y, Part 3, will give them more insights for owners of greater than 10%, but it does not provide insights for owners of less than 10%. However, regulators also recognize that existing and/or referral work of the Risk-Focused Surveillance (E) Working Group may help with some of this dynamic. Additionally, since the SAPWG 2022 code project and its longer-term Schedule D revamp project will help provide further disclosures that will assist with this consideration, regulators are comfortable waiting to see if further regulatory guidance is needed after using the resulting disclosures and other enhancements from these projects.
 - o Specific to owners of less than 10%, regulators discussed the April 19, 2022, Insurance Circular Letter No. 5 (2022) sent by the New York Department of Financial Services to all New York domiciled insurers and other interested parties. This letter highlights that avoiding the levels deemed presumption of control, e.g., greater than 10% ownership, does not create a safe harbor from a control determination and the related regulatory

requirements. The circular letter was distributed to all MWG members and interested regulators.

10. The material increases in privately structured securities (both by affiliated and non-affiliated asset managers), which introduce other sources of risk or increase traditional credit risk, such as complexity risk and illiquidity risk, and involve a lack of transparency. (The NAIC Capital Markets Bureau continues to monitor this and issue regular reports, but much of the work is complex and time-intensive with a lot of manual research required. The NAIC Securities Valuation Office will begin receiving private rating rationale reports in 2022; these will offer some transparency into these private securities.)
 - a. LATF's exposed AG includes disclosure requirements for these risks as well as how the insurer is modeling the risks.
 - b. SVO staff have proposed to VOSTF a blanks proposal to add market data fields (e.g., market yields) for private securities. If VOSTF approves, a referral will be made to the Blanks WG.

Regulator discussion results:

- Regulators focused on the need to assess whether the risks of these investments are adequately included in insurers' results and whether the insurer has the appropriate governance and controls for these investments. Regulators discussed the potential need for analysis and examination guidance on these qualifications.
- To assist regulators in identifying concerns in these investments, regulators expressed support for the VOSTF proposal to obtain market yields to allow a comparison with the NAIC Designation. Once such data is available, regulators ask NAIC staff to develop a tool or report to automate this type of initial screening. Also, regulators again recognized the SAPWG Schedule D revamp work will help in identifying other items for initial screening.
- The regulators discussed LATF's exposed AG, noting the Actuarial Memorandum disclosures that would be required for these privately structured securities along with the actuarial review work, and recognizing how those would be useful for analysts and examiners when reviewing these investments. Additionally, the Valuation and Analysis (E) Working Group would be able to serve as a resource for some of these insights for states without in house actuaries.
- As a result of the above discussions, regulators agreed to a referral to the Examination Oversight (E) Task Force to address the disclosures that will be available from LATF's exposed AG. They agreed to wait for any further work or referral until they have an opportunity to work with the results of the VOSTF proposal and the SAPWG Schedule D revamp project.

RRC Comments on "privately structured securities" (2 bullets, 1 with 2 sub-bullets) – Suggest including these in the referral to the NAIC Examination Oversight (E) Task Force for Consideration #10 but also sending to the NAIC Valuation of Securities (E) Task Force for its existing work related to this Consideration.

AIC Comment on "Privately Structured Securities" (6 bullets) – Suggest asking the AIC to follow the work of the NAIC Examination Oversight (E) Task Force and the NAIC Valuation of Securities (E) Task Force and provide comments on specific recommendations if needed.

RRC Comment on the work by the NAIC Life Actuarial (A) Task Force (LATF) – Suggest adopting this recommendation as an addition to the Regulatory Discussion results and sending the referral.

- Recommendation: Since reserves are not intended to capture tail risk, refer this item to the NAIC RBC Investment Risk and Evaluation (E) Working Group and monitor the Working Group's progress.

11. The level of reliance on rating agency ratings and their appropriateness for regulatory purposes (e.g., accuracy, consistency, comparability, applicability, interchangeability, and transparency).
 - a. VOSTF has previously addressed and will continue to address this issue. A small ad hoc group is forming (key representatives from NAIC staff, regulators, and industry) to develop a framework for assessing rating agency reviews. This will be a multi-year project, will include discussions with rating agencies, and will include the inconsistent meanings of ratings and terms.

Regulator discussion results:

- Regulators agreed to monitor the work of the ad hoc group in lieu of any specific recommendations at this time. Recognizing this will likely be a multi-year project, regulators reserve the right to raise specific concerns that may arise as the various NAIC committee groups work to address this list of considerations.

12. The trend of life insurers in pension risk transfer (PRT) business and supporting such business with the more complex investments outlined above. ([Enhanced reporting in 2021 Separate Accounts blank](#) will specifically identify assets backing PRT liabilities.) Considerations have also been raised regarding the RBC treatment of PRT business.

- a. [LATF has exposed an Actuarial Guideline](#) to achieve a primary goal of ensuring claims-paying ability even if the complex assets (often private equity-related) did not perform as the company expects, and a secondary goal to require stress testing and best practices related to valuation of non-publicly traded assets (note – LATF’s considerations are not limited to PRT). [Comment period for the 2nd exposure draft ends on May 2.](#)

Regulator discussion results:

- Regulators focused on the need to have disclosures on the risks to the General Account from the Separate Account PRT business – for guarantees but also reporting/tracking when the Separate Account is not able to support its own liabilities. Regulators noted the need to address the differences between buy in PRT transactions and buy out.
 - Regulators are comfortable LATF is addressing the reserve considerations. To address the disclosure considerations, regulators support sending a referral to the Statutory Accounting Principles (E) Working Group since regulators suggested it be an item in the Notes to Financial Statements. (Regulators noted it might help to discuss such disclosure concepts with LATF’s Valuation Manual 22 (A) Working Group.)
 - While the exposed AG is not limited to PRT, and general disclosures may be helpful, regulators recognized additional and/or more specific disclosures may be needed for PRT business.
- b. Review applicability of Department of Labor protections resulting for pension beneficiaries in a PRT transaction.

Regulator discussion results:

- Regulators discussed concerns regarding potential differences between the pension benefit and the group annuity benefit in the PRT transaction.

- Regulators directed NAIC staff to further research this item for the MWG to address in the near future, including potential discussions with Department of Labor representatives.
- c. Review state guaranty associations' coverage for group annuity certificate holders (pension beneficiaries) in receivership compared to Pension Benefit Guaranty Corporation (PBGC) protection.
 - i. NOLHGA provided 2016 study of state guaranty fund system vs. PBGC.

Regulator discussion results:

- Regulators recognized the difficulty in comparing the state guaranty system to the Pension Benefit Guarantee Corporation, as detailed in the NOLHGA study. However, they agreed policyholders should appreciate the benefit of having solvency regulators actively monitoring and working with the insurance companies in an attempt to prevent the need for any guaranty fund usage, as standard corporations holding pension liabilities have significantly less regulatory oversight.
 - Regulators found the NOLHGA study responsive to this consideration, thus they suggested no further action.
- d. "Considerations have also been raised regarding the RBC treatment of PRT business."
- Regulator discussion results:**
- Regulators recognized the work of the Longevity Risk Transfer (LRT) Subgroup of the Life Risk-Based Capital (E) Working Group covers PRT business. A new LRT charge was included in the 2021 Life Risk-Based Capital (LRBC) formula. Regulators agreed the results of this new charge should be monitored.
 - While regulators agreed to follow the work of the LRT Subgroup, they suggested no further action at this time.

13. Insurers' use of offshore reinsurers (including captives) and complex affiliated sidecar vehicles to maximize capital efficiency, reduce reserves, increase investment risk, and introduce complexities into the group structure.

- a. LATF's exposed AG was modified to require the company to provide commentary on reinsurance collectability and counterparty risk in the asset adequacy analysis memorandum. The original concept of requiring life insurers to model the business itself even if it uses these mechanisms to share/transfer risk was deferred to allow time to consider and address concerns over potential violations with EU/UK covered agreements and the 2019 revisions to NAIC Models 785 and 786.

Regulator discussion results:

- Regulators held candid conversations about the need to understand why insurers are using these types of offshore reinsurers. If there are problems in the U.S. regulatory system that are driving insurers to utilize offshore reinsurers (e.g., "excess" reserves), we should know of those problems so we can consider if there are appropriate changes to make.
- If there are other drivers, per the common theme in the regulators' review of this list of considerations, there isn't a presumption that the use of these transactions is categorically bad. Rather, there is a need to understand the economic realities of the transactions so the regulators can effectively perform their solvency monitoring responsibilities.

- Regulators discussed the potential concept of additional Holding Company Act requirements if these are affiliated reinsurers, disclosing the insurer benefits (reserves, capital, etc.).
- Regulators deferred specifying action on this item at this time, instead noting the desire to have meetings with industry representatives using these transactions and regulators from some of the offshore jurisdictions to gain more insights.

Northwestern Mutual Comment (2 cautions) – Suggest including these cautions as part of the MWG’s future discussions and work for this Consideration.

- Caution: Reinsurance transactions can and often do serve a valuable function by reallocating risk. However, offshore reinsurance can also result in lower total reserves and capital, reduced state regulatory oversight, and diminished stakeholder transparency from what would be required by the statutory accounting and risk-based capital requirements the NAIC has established to protect policyholders in the United States.
 - Caution: Without progress and action on the item pertaining to offshore reinsurance, the Working Group’s progress on other MWG Considerations could further incentivize even more utilization of offshore reinsurance transactions and undercut the NAIC’s efforts to close other solvency regulatory gaps domestically. In the long run, a system that encourages companies to transfer business to a related offshore entity in order to alter their reserves and capital from uniform standards diminishes the strength of reserve and capital regulation in the United States. If capital standards are deemed to be too conservative in the US, they should be addressed transparently and uniformly through the NAIC and not through the alternate means of offshore reinsurance.
- **Additional regulator discussion result:**
 - Similar to the result of discussions for the 13th consideration, regulators expressed a desire to meet with various industry representatives to discuss the incentives behind private equity ownership of insurers and conversely the concerns other industry members may have with such ownership. Regulators believe the insights from these conversations will benefit their ability to monitor and, when necessary, contribute to the work occurring in the various NAIC committee groups regarding these considerations.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 8 PE Insurers.pdf



Adopted by the Executive (EX) Committee and Plenary, Aug. 13, 2022

Adopted by the Financial Condition (E) Committee, July 21, 2022

Adopted by the Mutual Recognition of Jurisdictions (E) Working Group, June 29, 2022

NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation

Reciprocal Jurisdictions (Model #440, Section 4L(2)(c))

Jurisdiction	Group-Wide Supervisor	Effective Date	Model #440, Section 4L(2)(e) Determination Explanatory Note
Member States of the European Union	Respective Member State Supervisory Authorities	January 1, 2022	
United Kingdom (UK)	Prudential Regulation Authority of the Bank of England (PRA)	January 1, 2022	
Bermuda	Bermuda Monetary Authority (BMA)	January 1, 2022	
Japan	Financial Services Agency (FSA)	January 1, 2022	
Switzerland	Financial Market Supervisory Authority (FINMA)	January 1, 2022	

Recognize and Accept Jurisdictions (Model #440, Section 4L(2)(d))

Jurisdiction	Group-Wide Supervisor	Effective Date	Model #440, Section 4L(2)(e) Determination Explanatory Note
None currently			

Group Capital Calculation. On December 9, 2020, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implement the Group Capital Calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person for the purposes of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC's GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions detailed in the [Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation](#)) if its groupwide supervisor "recognizes and accepts" the GCC for U.S. groups doing business in that jurisdiction.

List of Jurisdictions that Recognize and Accept the GCC. The Mutual Recognition of Jurisdictions (E) Working Group will evaluate non-U.S. jurisdictions in accordance with the "Recognize and Accept" Process. A list of "Recognize and Accept" Jurisdictions is published through the NAIC committee process. Sections 21D and 21E of Model #450 provide a general framework for how the process to identify "Recognize and Accept" Jurisdictions will work and specifically contemplates the development of a list of such jurisdictions through the NAIC Committee Process.

NAIC Listing Process. Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

- (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction "recognizes the U.S. state regulatory approach to group supervision and group capital" (Model #440, Section 4L(2)(c)); or
- (b) If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

Evaluation of Reciprocal Jurisdictions. Under Section 4L(2)(c) of Model #440, Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital are exempt from the GCC. Because a "recognize and accept" evaluation by the Mutual Recognition of Jurisdictions (E) Working Group is already part of the Reciprocal Jurisdiction review process, all Reciprocal Jurisdictions designated by the NAIC through that review process are also automatically designated as "Recognize and Accept" Jurisdictions. Likewise, in view of the terms of the EU and UK Covered Agreements, all EU Member States and the UK are automatically designated "Recognize and Accept" Jurisdictions. If there is a material change to the terms of the U.S.-EU or U.S.-UK Covered Agreement, or if the United States enters into a new covered agreement with one or more non-U.S. jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will consider, and will consult with FIO and USTR regarding, whether and how the applicability of the procedures in this document may apply.

Prudential Oversight and Solvency Monitoring. Section 4L(2)(e) of Model #440 directs a lead state commissioner to require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system based in a “Recognize and Accept” Jurisdiction if, after any necessary consultation with other supervisors or officials, the commissioner deems such a “subgroup” calculation to be appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 provides that to assist with such a determination, the “Recognize and Accept” List will also identify whether a listed jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that jurisdiction. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and may include an explanatory note in cases where a simple “Yes” or “No” response does not adequately describe the jurisdiction’s requirements. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.

The specific details of the GCC Recognize and Accept process can be found in the [Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation](#).

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 9 GCC List of Jurisdictions.pdf

Date: 07/29/22

State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Amendments to the *Unfair Trade Practices Act (#880)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. Nine jurisdictions have enacted the revisions to this model.

Life Insurance and Annuities (A) Committee

- Amendments to the *Annuity Disclosure Model Regulation (#245)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. NAIC staff are not aware of any activity regarding this model.
- Amendments to the *Suitability in Annuity Transactions Model Regulation (#275)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020, conference call. 27 jurisdictions have enacted the revisions to the model.
- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. 16 jurisdictions have adopted the revisions to this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the *Health Maintenance Organization Model Act (#430)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Five jurisdictions have enacted this model.
- Amendments to the *Insurance Holding Company System Regulatory Act (#440)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. 22 jurisdictions have adopted the revisions to this model.
- Amendments to the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Six jurisdictions have adopted the revisions to this model.

Property and Casualty Insurance (C) Committee

- Adoption of the *Real Property Lender-Placed Insurance Model Act (#631)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. NAIC staff are not aware of any activity regarding this model.

Financial Condition (E) Committee

- Amendments to the *Credit for Reinsurance Model Law (#785)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019, conference call. 52 jurisdictions have enacted this model.
- Amendments to the *Credit for Reinsurance Model Regulation (#786)*—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019, conference call. 48 jurisdictions have enacted this model.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Summer National Meeting/Att 10 StatusAdoptedModels.pdf