NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft date: 5/10/23

Virtual Meeting

MARKET CONDUCT ANNUAL STATEMENT BLANKS (D) WORKING GROUP
Monday, May 22, 2023
1:00 – 2:00 p.m. ET / 12:00 – 1:00 p.m. CT / 11:00 a.m. – 12:00 p.m. MT / 10:00 – 11:00 a.m. PT

ROLL CALL

Erica Weyhenmeyer, Chair	Illinois	Hermoliva Abejar	Nevada
Rebecca Rebholz, Vice Chair	Wisconsin	Leatrice Geckler	New Mexico
Maria Ailor	Arizona	Guy Self	Ohio
Crystal Phelps/Teri Ann Mecca	Arkansas	Gary Jones/August Hall/ Karen Veronikis	Pennsylvania
Scott Woods	Florida		
Scott Sanders/Elizabeth Nunes	Georgia	Rachel Moore/ Gwendolyn McGriff	South Carolina
Shannon Lloyd	Kansas		
Lori Cunningham	Kentucky	Larry D. Deiter/Candy Holbrook	South Dakota
Mary Kwei	Maryland	Shelli Isiminger	Tennessee
Mary Lou Moran	Massachusetts	Shelley Wiseman	Utah
Jeff Hayden	Michigan	Melissa Gerachis/Will Felvey	Virginia
Paul Hanson	Minnesota	John Haworth	Washington
Jennifer Hopper/Teresa Kroll	Missouri	Letha Tate	West Virginia
Martin Swanson	Nebraska		

NAIC Support Staff: Teresa Cooper/Hal Marsh

AGENDA

1. Consider Adoption of its April 6 minutes—*Erica Weyhenmeyer (IL)* — Attachment 1

2. Consider Adoption of the Pet Market Conduct Annual Statement (MCAS) Data Call and Definitions—*Erica Weyhenmeyer (IL)* — Attachment 2

3. Discuss Any Other Matters Brought Before the Working Group —*Erica Weyhenmeyer (IL)*

4. Adjournment

© 2023 National Association of Insurance Commissioners

Draft: 04/17/23

Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
April 6, 2023

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met April 6, 2023. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Vice Chair (WI); Tolanda Coker (AZ); Scott Woods (FL); Tia Taylor (GA); Shannon Lloyd (KS); Lori Cunningham (KY); Mary Lou Moran (MA); Jeffrey Hayden (MI); Jo LeDuc (MO); Martin Swanson (NE); Leatrice Geckler (NM); Karen Veronikis (PA); Rachel Moore (SC); Shelli Isiminger (TN); Melissa Gerachis (VA); John Haworth (WA); and Letha Tate (WV). Also participating were: Matt Gendron (RI).

1. Discuss Market Conduct Annual Statement (MCAS) Participation Requirements

Rebholz stated the first agenda item is to discuss the MCAS Participation Requirements document. She said NAIC staff received a question related to a sentence in the document and they have asked for insight from the Working Group. The document has been updated through the years to accommodate new lines of business and thresholds established for the new lines of business. There is one sentence in the document that is being questioned. The entire bulleted item reads as follows, "Each company in a holding company system must file separately for each state in which it does business. Data for the members of a group or insurance holding company cannot be combined into a single filing for the purposes of this project. Data must be reported separately for each group member unless it involves only inter-company arbitration." The last sentence is in question.

Rebholz asked the working group members and other state regulators if anyone recalls the intent or meaning of the sentence. Hearing no response, Rebholz asked for a motion to remove the sentence from the Participation Requirements document. Haworth moved and Geckler seconded to have the sentence removed.

Birnbaum (Center for Economic Justice – CEJ) suggested that the first part of the sentence to be eliminated was still wanted "Data must be reported separately for each group member" and only the last part of the sentence should be deleted "unless it involves only inter-company arbitration" as that was the confusing part. Rebholz acknowledged that Birnbaum made a fair point and asked for thoughts from the group. Rebholz went on to say that the line right before the sentence in question says "Data for the members of a group or insurance holding company cannot be combined into a single filing…" and asked Birnbaum if that met the need of saying that companies must report separately. Birnbaum conceded the point and stated he had no objections to deleting the sentence. Hearing no further discussion, the motion passed unanimously.

2. Hear a Pet Subject Matter Expert (SME) Group Update

Rebholz asked Matt Gendron (RI) to provide an update on the work being done to create the PET MCAS Reporting Blank and definitions.

Gendron stated that the SME Group has been working for several months, meeting every other week, and has decided to start meeting weekly. There are five or six Regulators who are attending every call. There are consumer representatives that are on most of the calls and several trade associations and insurance company professionals helping to flush out details and put specificity into the interrogatories and schedules. Gendron identified that there are several schedules in the draft Pet MCAS reporting blank. He said the work was being done in tandem with both Regulators, keeping in mind what they need, and also keeping in mind the potential of

© 2023 National Association of Insurance Commissioners

creating cost for insurers which will be passed on to consumers. He said the SME Group is trying to be circumspect in their requests. Gendron stated he was happy to take any questions.

Rebholz thanked Gendron and asked the group if there were any questions. No questions were asked.

3. Review the Other Health Data Element

Rebholz reviewed an adopted data element for the Other Health MCAS that is to be reported for the 2023 data year. Rebholz identified that NAIC staff has received questions related to claims question 3-80 and its intent. The data element in question reads, “Aggregate dollar amount of paid claims during the period”. Rebholz said Mary Kay Rodriguez (WI) led the SME group in developing the Other Health MCAS. Rodriguez was consulted and it is proposed that the proper wording should be “Total dollar amount of paid claims during the period”. Where the word “Total” replaces the word “Aggregate”. Rebholz said this edit is outside the date guidelines for updates to MCAS reporting, but the intent here is not being changed. We are asking for the wording to be edited for clarity only. No comments were made regarding the proposed wording change.

Haworth made a motion to replace the word “Aggregate” with “Total” so that the sentence reads “Total dollar amount of claims paid during the period.” Isiminger seconded the motion. The motion passed unanimously.

4. Hear an Update on MCAS Filings

Rebholz reminded state regulators to be on the lookout for MCAS waiver and extension requests. She recommended that those responsible for decisioning MCAS waivers and extensions set up Personalized Information Capture System (PICS) events so they will receive notification of the requests as they are submitted through the MCAS application. Rebholz said any questions about how to set up PICS events, can be directed to Hal Marsh (NAIC) or Teresa Cooper (NAIC). Rebholz said state regulators can also view extension and waiver requests using the Extension and Waiver Tableau dashboard that can be accessed through iSite+. This year the extension process has been updated to provide companies with two-week intervals for requesting extensions. This was done at the request of the Market Analysis Procedures (D) Working Group. Companies will now be able to submit more than one extension request, but each request will be limited to a two-week period. Filings are coming in as anticipated. All lines of business except Health and Short Term Limited Duration (STLD) will be due April 30th. Health is due May 31st and STLD is due June 30th.

5. Discuss Any Other Matters Brought Before the Working Group

Rebholz asked if there were any other items to be brought before the working group. No additional items were brought forward.

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

SharePoint/Market Regulation - Home/D Working Groups/MCAS Blanks WG/2023/WG Mtg 0406/MCAS Blanks WG Minutes April 6.docx

© 2023 National Association of Insurance Commissioners

Line of Business: Travel

Reporting Period: January 1, 2024 through December 31, 2024

Filing Deadline: April 30, 2025

Contact Information

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

Schedule 1 – Interrogatories

ID	Description	Comment
1-01	Did the company conduct any business related to individual pet insurance policies during the period?	Yes/No
1-02	Did the company conduct any business related to group pet insurance policies during the period?	Yes/No
1-03	Did the company conduct any stand-alone pet Wellness Insurance business during the reporting period?	Yes/No
1-04	Did the company conduct any Accident & Illness, Accident only, or Illness only pet insurance business during the reporting period?	Yes/No
1-05	Did the company conduct any pet insurance business during the reporting period that does not fit into the following categories: Wellness Only, Accident & Illness, Accident only, or Illness only?	Yes/No
1-06	If yes, describe the other types of pet insurance business conducted during the reporting period.	Comment
1-07	On which annual statement line(s) of business on the state page of the statutory annual statement does the company report pet insurance experience?	Comment
1-08	Was the company still actively marketing or writing pet insurance in the jurisdiction at the end of the reporting period?	Yes/No
1-09	Has the company had a significant event/business strategy change that would affect data for this reporting period?	Yes/No
1-10	If yes, explain the situation and how it may affect the data.	Comment
1-11	Has all or part of the company’s pet insurance block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-12	If yes, describe the nature and extent of the transaction(s).	Comment
1-13	How does the company treat subsequent supplemental or additional payments	Comment

	on previously closed claims?	
1-14	Does the company use pet program administrators, managing general agents (MGA) or insurance producers for purposes of supporting the pet insurance business being reported, other than the sale, solicitation, or negotiation of business?	Yes/No
1-15	If yes, provide the names, NPN (if applicable) and functions for each third party identified in question 13.	Comment
1-16	Does the company have a system of supervision in place to oversee and potentially audit each type of third party identified in question 14?	Yes/No
1-17	If yes, please provide frequency of audits, if any, for each type of third party identified in question 14.	Comment
1-18	Does the company require third parties identified in question 14 to forward insurance-related complaints to the company so the company may report the complaints in its complaint logs?	Yes/No
1-19	Does the company or any of its pet program administrators, managing general agents (MGA) or insurance producers offer a non-insurance wellness program to the consumers of the company's pet insurance products?	Yes/No
1-20	Additional comments if desired:	Comment
1-21	Additional state specific Underwriting Activity comments (optional)	Comment
1-22	Additional state specific Claims Activity comments (optional)	Comment
1-23	Additional state specific Marketing & Sales comments (optional)	Comment
1-24	Additional state specific Lawsuit and Complaint comments (optional)	Comment

Schedule 2 – Underwriting Activity

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

ID	Description
2-25	Number of policies in force at the beginning of the period
2-26	Number of certificates in force at the beginning of the period (Group only)
2-27	Number of covered pets on policies/certificates in force at the beginning of the period
2-28	Number of policies in force during the period that included accident-only coverage
2-29	Number of certificates in force during the period that included accident-only coverage (Group only)
2-30	Number of policies in force during the period that included illness-only coverage
2-31	Number of certificates in force during the period that included illness-only coverage (Group only)
2-32	Number of policies in force during the period that included accident and illness coverage
2-33	Number of certificates in force during the period that included accident and illness coverage (Group only)

2-34	Number of policies in force during the period that included wellness coverages (other than a wellness only policy)
2-35	Number of certificates in force during the period that included wellness coverages (other than a wellness only policy) (Group only)
2-36	Number of policies in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness)
2-37	Number of certificates in force during the period that covered wellness as an insurance benefit (and did not cover accident and/or illness) (Group only)
2-38	Number of policies returned during the period under the consumer's "Right to Examine and Return the Policy"
2-39	Number of certificates returned during the period under the consumer's "Right to Examine and Return the Policy" (Group only)
2-40	Number of policies cancelled/terminated during the period at the policyholder's request
2-41	Number of certificates cancelled/terminated during the period at the certificate holders request (Group only)
2-42	Number of policies cancelled/terminated during the period by the insurer
2-43	Number of certificates cancelled/terminated during the period by the insurer (Group only)
2-44	Number of policies cancelled/terminated during the period for non-pay or non-sufficient funds
2-45	Number of certificates cancelled/terminated during the period for non-pay or non-sufficient funds (Group only)
2-46	Number of company-initiated policy non-renewals during the period
2-47	Number of company-initiated certificate non-renewals during the period (Group only)
2-48	Number of certificates expired during the period (Group only)
2-49	Number of new policies issued during the period
2-50	Number of new certificates issued during the period (Group only)
2-51	Number of covered pets on new policies/certificates issued during the period
2-52	Number of policies in force at end of the period
2-53	Number of certificates in force at the end of the period (Group only)
2-54	Number of covered pets on policies/certificates in force at the end of the period
2-55	Number of renewal policies issued during the period
2-56	Number of renewal certificates issued during the period (Group only)
2-57	Dollar amount of direct premium written during the period
2-58	Dollar amount of direct premium earned during the period
2-59	Number of applications pending at beginning of the period
2-60	Number of new applications received during the period (Individual Only)
2-61	Number of new applications denied for health status or condition during the period (Individual Only)
2-62	Number of new applications denied for any other reason during the period (Individual Only)

2-63	Number of applications pending at the end of the period (Individual Only)
2-64	Number of policies issued during the period that included a preexisting condition exclusion
2-65	Number of certificates issued during the period that included a preexisting condition exclusion (Group only)

Schedule 3 – Claims Activity

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

ID	Description
3-66	Number of claims open at the beginning of the period
3-67	Number of claims opened during the period
3-68	Number of claims closed during the period
3-69	Number of claims closed during the period with full payment
3-70	Dollar amount of claims closed with full payment during the period
3-71	Median days to claim closure for claims closed with full payment (Aggregate only)
3-72	Number of claims closed during the period with partial payment
3-73	Dollar amount requested for claims closed with partial payment during the period
3-74	Dollar amount of claims closed with partial payment during the period
3-75	Median days to claim closure for claims closed with partial payment (Aggregate only)
3-76	Median days to final payment for all claims paid in full and closed with partial payment (Aggregate only)
3-77	Number of claims closed during the period, without payment
3-78	Dollar amount requested for claims closed without payment during the period
3-79	Median days to claim closure for claims closed without payment during the period (Aggregate only)
3-80	Number of claims open at the end of the period
3-81	Number of claims closed during the period with full payment 0-30 days
3-82	Number of claims closed during the period with full payment 31-60 days
3-83	Number of claims closed during the period with full payment 61-90 days
3-84	Number of claims closed during the period with full payment 91-180 days
3-85	Number of claims closed during the period with full payment 181-365 days
3-86	Number of claims closed during the period with full payment beyond 365 days
3-87	Number of claims closed during the period with partial payment 0-30 days
3-88	Number of claims closed during the period with partial payment 31-60 days
3-89	Number of claims closed during the period with partial payment 61-90 days
3-90	Number of claims closed during the period with partial payment 91-180 days

3-91	Number of claims closed during the period with partial payment 181-365 days
3-92	Number of claims closed during the period with partial payment beyond 365 days
3-93	Number of claims closed during the period without payment within 0-30 days
3-94	Number of claims closed during the period without payment within 31-60 days
3-95	Number of claims closed during the period without payment within 61-90 days
3-96	Number of claims closed during the period without payment within 91-180 days
3-97	Number of claims closed during the period without payment within 181-365 days
3-98	Number of claims closed during the period without payment beyond 365 days
3-99	Number of claims closed during the period without payment – ineligibility
3-100	Number of claims closed during the period without payment – preexisting condition exclusion
3-101	Number of claims closed during the period without payment – waiting period
3-102	Number of claims closed during the period without payment – maximum benefit limit
3-103	Number of claims closed during the period without payment – claim amount less than deductible
3-104	Number of claims closed during the period without payment – inadequate documentation
3-105	Number of claims closed during the period without payment – hereditary disorder exclusion
3-106	Number of claims closed during the period without payment – congenital anomaly or disorder exclusion
3-107	Number of claims closed during the period without payment – chronic condition exclusion
3-108	Number of claims closed during the period without payment for reasons other than questions 99-107
3-109	Number of claims closed during the period with partial payment – maximum benefit limit
3-110	Number of claims closed during the period with partial payment – inadequate documentation
3-111	Number of claims closed during the period with partial payment for reasons other than questions 109-110
3-112	Number of claimant requests/benefit requests subject to a preexisting condition exclusion

Schedule 4 – Marketing and Sales

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

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

Schedule 5 – Lawsuit and Complaint Activity

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

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

Schedule 6 – Pet Attestation

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

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

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

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

In determining what business to report for a particular jurisdiction, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the

Financial Annual Statement (FAS) and its corresponding state pages. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

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

Definitions for the purposes of MCAS reporting:

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

Cancellations – Includes all cancellations of the policies where the cancellation effective date is during the reporting year.

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

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

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

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

Exclude:

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

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

Exclude:

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

Clarifications:

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

Calculation Clarification:

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

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

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

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

Include:

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

Calculation Clarification:

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

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

Complaints Received Directly from any Person or Entity Other than the Department of

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

Include:

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

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

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

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

Insurer Non-Renewals – Non-renewals initiated by the reporting entity. A non-renewal is the termination of coverage at the end of the policy contract period.

Exclude:

- Non-renewals occurring as a result of nonpayment of premium (these data are reported separately, as policyholder cancellations).

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

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

Example:

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

in the "01" MCAS submission.

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

For purposes of reporting lawsuits in the Travel MCAS blank:

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

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

Managing General Agent (MGA) – An insurance producer authorized by an insurance company to manage all or part of the insurer's business. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs.

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

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

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

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

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

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

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

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

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

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

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

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

Group Policy Clarifications:

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

Individual Policy Clarifications:

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

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

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

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

Policyholder/Certificate holder – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside. Policyholder is the individual when purchased in the individual market. Certificate holder is the individual when purchased through a group, which is the policyholder.

Policyholder cancellations – Policies cancelled at any point during the reporting period at the request of or in response to the policyholder. Exclude policies terminated for nonpayment of premium.

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

- A veterinarian provided medical advice;
- The pet received previous treatment; or
- Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

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

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

Right to Examine and Return the Policy (Free Look) – Report the number of that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.

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

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

Wellness Program – a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. 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.