Draft: 6/2/22

Attachment One

Adopted by the Executive (EX) Committee and Plenary, ___ __, ___
Adopted by the Market Regulation and Consumer Affairs (D) Committee, July, xx, 2022

2022 Proposed Revised Charges

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

The mission of the Market Regulation and Consumer Affairs (D) Committee is to monitor all aspects of the market regulatory process for continuous improvement. This includes market analysis, regulatory interventions with companies, and multi-jurisdictional collaboration. The Committee will also review and make recommendations regarding the underwriting and market practices of insurers and producers, as those practices affect insurance consumers, including the availability and affordability of insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
   A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
   B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
   C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
   D. Oversee the activities of the Antifraud (D) Task Force.
   E. Oversee the activities of the Market Information Systems (D) Task Force.
   F. Oversee the activities of the Producer Licensing (D) Task Force.
   G. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
   H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
   I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
   J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
   K. Review the "Best Practices and Guidelines for Consumer Information Disclosures" (adopted October 2012) and update, as needed.

2. The **Advisory Organization (D) Working Group** will:
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).

3. The **Market Actions (D) Working Group** will:
   A. Facilitate interstate communication and coordinate collaborative state regulatory actions.

4. The **Market Analysis Procedures (D) Working Group** will:
   A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
   B. Discuss other market data collection issues and make recommendations, as necessary.
   C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).

5. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
   A. Review the MCAS data elements and the "Data Call and Definitions" for those lines of business that have been in effect for longer than three years and update them, as necessary.
   B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

6. The **Market Conduct Examination Guidelines (D) Working Group** will:
   A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
   B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
   C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook.*
   D. Develop uniform market conduct procedural guidance (e.g., a library, depository, or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook.*
   E. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities' use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
   F. Discuss the effectiveness of group supervision of market conduct risks and develop examination procedural guidance, as necessary.
   G. Discuss the role of market conduct examiners in reviewing insurers' corporate governance as outlined in the NAIC's *Corporate Governance Annual Disclosure Model Act* (#305) and *Corporate Governance Annual Disclosure Model Regulation* (#306).

7. The **Market Regulation Certification (D) Working Group** will:
   A. Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states' compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.

8. The **Speed to Market (D) Working Group** will:
   A. Consider proposed System for Electronic Rate and Form Filing (SERFF) features or functionality presented to the Working Group by the SERFF ~~Advisory Board (SAB), likely originating from the SERFF~~ Product Steering Committee (PSC). ~~Upon approval and acquisition of any needed funding, direct the SAB to implement the project.~~ Receive periodic reports from the ~~SAB~~ PSC, as needed.
   B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.

C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
   i. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
   ii. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts, as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
   iii. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with, and report on state implementation of any PCM changes.
   iv. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook.*
D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.
E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):
   i. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states' participation in, and the industry's usage of, the Compact.
   ii. Receive periodic reports from the Compact, as needed.

NAIC Support Staff: Tim Mullen/Randy Helder

Draft: 3/12/22
Adopted by the Executive (EX) Committee and Plenary, XX, 2022
Adopted by the Market Regulation and Consumer Affairs (D) Committee, XX, 2022
Adopted by the Producer Licensing (D) Task Force, May 5, 2022

2022 Proposed Revised Charges

PRODUCER LICENSING (D) TASK FORCE

The mission of the Producer Licensing (D) Task Force is to: 1) develop and implement uniform standards, interpretations, and treatment of producer and adjuster licensees and licensing terminology; 2) monitor and respond to developments related to licensing reciprocity; 3) coordinate with industry and consumer groups regarding priorities for licensing reforms; and 4) provide direction based on NAIC membership initiatives to the National Insurance Producer Registry (NIPR) Board of Directors regarding the development and implementation of uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology.

Ongoing Support of NAIC Programs, Products or Services

1. The **Producer Licensing (D) Task Force** will:
   A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC's Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
   B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions, and ideas on producer licensing activities in the states and at the NAIC.
   C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
   D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
   E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
   F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention, and use of data in the NAIC's Market Information Systems (MIS).
   ~~G. Monitor the state implementation of adjuster licensing reciprocity and uniformity; update, as necessary, NAIC adjuster licensing standards.~~
   ~~H~~G. Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
   ~~I~~H. Discuss how criminal convictions may affect producer licensing applicants and review the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* to create a more simplified and consistent approach in how states review 1033 waiver requests.

2. The **Producer Licensing Uniformity (D) Working Group** will:
   A. Work closely with state producer licensing directors and exam vendors to ensure that: 1) the states achieve full compliance with the standards in order to achieve greater uniformity; and 2) the exams test the qualifications for an entry-level position as a producer.
   B. Provide oversight and ongoing updates, as needed, to the *State Licensing Handbook*.
   C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed.
   D. Review and update, as needed, the NAIC's uniform producer licensing applications and uniform appointment form. Provide any recommended updates to the Producer Licensing (D) Task Force by the NAIC Summer National Meeting.

3. The **Uniform Education (D) Working Group** will:
   A. Update, as needed, the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of instructors and courses. Provide any recommended updates to the Producer Licensing (D) Task Force by the 2022 Fall National Meeting.
   B. Coordinate with NAIC parent committees, task forces, and/or working groups to review and provide recommendations, as necessary, on prelicensing education and CE requirements that are included in NAIC model acts, regulations, and/or standards.

4. The **Adjuster Licensing (D) Working Group** will:
   A. Monitor state implementation of adjuster licensing and reciprocity; update, as necessary, the NAIC adjuster licensing standards.

NAIC Support Staff: Tim Mullen/Greg Welker

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, XX, XX, XXXX
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

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

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

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

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

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.

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:

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

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

Exclude:

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

Clarification:

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

Calculation Clarification:

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

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

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

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

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.

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

Calculation Clarification:

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

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

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

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

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

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

Coverage - Liability – Liability insurance provided under Homeowners Policies.

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

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

Calculation Clarification:

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment date was made during the reporting period regardless of the date of loss or when the claims was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.

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

Example:

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

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

Digital Claim Handling Process Level of Detail Breakdown:

Digital Claim – A claim involving a claim settlement determination which was accepted by the insured/claimant without adjustment whereby the entire claim was handled without human intervention on the part of the insurance company in the loss appraisal process, settlement determination, and/or in the 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 polices covered by the market conduct annual statement (new and renewal) written during the reporting period.

Calculation Clarification:

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

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

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

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

Include:

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

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

Include:

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

Exclude:

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

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

Exclude:
- Stand-alone Inland Marine Policies.

Lawsuit – ~~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.

- 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.

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.

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 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.

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, XX, XX, XXXX

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

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

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, XX, XX, XXXX

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

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
3-47	Number of autos which have policies in-force at the end of the period
3-48	Number of policies in-force at the end of the period
3-49	Number of new business policies written during the period
3-50	Dollar amount of direct premium written during the period
3-51	Number of Company-Initiated non-renewals during the period
3-52	Number of cancellations for non-pay or non-sufficient funds
3-53	Number of cancellations at the insured's request
3-54	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
3-59	Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company

3-60	Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
3-61	Number of complaints received directly from any person or entity other than the DOI

Schedule 4—Lawsuit Activity

Reporting Breakdown

Collision	Claim related lawsuits
Comprehensive	
Bodily Injury	
Property Damage	
UMBI and UIMBI	
UMPD and UIMPD	
Medical Payments	
Combined Single Limits	
Personal Injury Protection	
Non-claim Related Lawsuits	Non-claim related lawsuits

ID	Description
4-62	Number of lawsuits open at beginning of the period
4-63	Number of lawsuits opened during the period
4-64	Number of lawsuits closed during the period
4-65	Number of lawsuits open at end of period
4-66	Number of lawsuits closed with consideration for the consumer

Schedule 5—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
5-67	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
5-68	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
5-69	Overall Comments for the Period

Definitions:

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

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

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

Report cancellations separately for:

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

Exclude:

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

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

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

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

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

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

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

- The notice of cancellation is the date the cancellation notice was mailed to the insured.

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

Include:

- Both first- and third-party claims.

Exclude:

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

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

Exclude:

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

Clarifications:

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

Calculation Clarification:

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

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

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

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

Include:

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

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

Include:

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

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

Clarification:

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

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

Clarification:

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

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

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

Include:

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

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

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

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

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

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

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

Coverage - Medical Payments Coverage – First party coverage for injuries incurred in a motor vehicle accident.
Coverage - Combined Single Limit – Bodily injury liability and property damage liability expressed as a single sum of coverage.

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

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

Calculation Clarification:

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

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
    - 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 dataprovided by in-vehicle or in-property sensors.

Hybrid C**laim** – A claim whereby the initial loss settlement determination beganas 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 HybridClaim.

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

Calculation Clarification:

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

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.

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

Treatment of class action lawsuits:

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

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

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

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

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

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

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

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

Exclude:

- Subrogation payments should not be included.

Calculation Clarification / Example:

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

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

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

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

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3

values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

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

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

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

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

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

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

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

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

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

Exclude:

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

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

Include:

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

Exclude:

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

Calculation Clarification:

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

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

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

Include:

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

Exclude:

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

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

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

	associated with Medical Data	
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)

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

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

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

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

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 Underwriting[1] - 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

- **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

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

face amount would include the basic policy plus any riders or amounts for policies with increasing death benefits if these amounts in addition to the basic policy are reported on the company's financial annual statement.

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

Free Look – A set number of days provided in an insurance or annuity contract that allows time for the purchaser to review the contract provisions with the right to return the contract for a full refund of all monies paid. Report the number of policies or contracts that were returned by the owner under the free look provision during the period, regardless of the original issuance date. Count any policy returned under the Free Look provision even if an alternative policy was ultimately purchased by the insured.

Immediate Annuity – An annuity (either fixed or variable) that begins its payment stream to the policyholder within 12 months after a single premium is paid. Immediate annuities are included within the scope of this statement and should be reported as a new immediate contract issued when issued during the reporting period. In addition, immediate annuities still in force at the end of the period should be included as well.

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

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

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

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

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

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

For purposes of reporting lawsuits for Life & Annuities products:

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

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

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

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

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

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

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

Replacement Policy – A policy and/or annuity contract application received by your company that is intended to replace an existing policy and/or annuity contract according to each states 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.

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.

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

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

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**

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

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

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 situsued.

General Definitions:

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

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 situsted.

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)

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

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

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.

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;

- 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.

Draft: 4/13/22

Market Regulation and Consumer Affairs (D) Committee
Kansas City, Missouri
April 7, 2022

The Market Regulation and Consumer Affairs (D) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Jon Pike, Chair (UT); Trinidad Navarro, Vice Chair (DE); Karima M. Woods (DC); Sharon P. Clark (KY); Chlora Lindley-Myers (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Martin Swanson (NE); Russell Toal (NM); Barbara D. Richardson (NV); Michael Humphreys represented by David Buono (PA); Cassie Brown (TX); and Michael S. Pieciak represented by Karla Nuissl (VT). Also participating were: Michael Conway and Damion Hughes (CO); Doug Ommen (IA); Erica Weyhenmeyer (IL); Larry D. Deiter (SD); Katie Johnson and Rebecca Nichols (VA); and John Haworth (WA).

1. Adopted its 2021 Fall National Meeting Minutes

Superintendent Toal made a motion, seconded by Ms. Biehn, to adopt the Committee's Dec. 15, 2021, minutes (*see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. Adopted its 2022 Revised Charges

Commissioner Pike said when the Committee charges were adopted at the 2021 Fall National Meeting, it was noted that the Privacy Protections (D) Working Group might move under the Innovation, Cybersecurity, and Technology (H) Committee to better align the privacy protection discussions with the NAIC members' discussions regarding the increased use of consumer data and innovations. He said the revised charges reflect this change in the reporting structure for the Working Group.

Commissioner Pike also said the Speed to Market (H) Working Group will move to the Market Regulation and Consumer Affairs (D) Committee because of the more technical efforts of the Working Group, which has been focusing on the updates to the product coding matrix (PCM) and *Product Filing Review Handbook*.

Commissioner Pike said the revised charges also include the Antifraud (D) Task Force's revised charges that disbanded the Antifraud Education Enhancement (D) Working Group and moved the charge of the Working Group to the Task Force. He said the elimination of the Working Group should allow for the continuation of the education initiatives in a more streamlined manner.

Commissioner Ommen said he consulted with the vice chair of the Advisory Organization Examination Oversight (D) Working Group, and they agreed that the name of the Working Group should be shortened to the Advisory Organization (D) Working Group. He asked for a motion to shorten the name of the Working Group. Commissioner Richardson made a motion, seconded by Director Lindley-Myers, to rename the Advisory Organization Examination Oversight (D) Working Group to the Advisory Organization (D) Working Group. The motion passed unanimously.

Superintendent Toal made a motion, seconded by Commissioner Richardson, to adopt the Committee's 2022 revised charges (Attachment One), including renaming the Advisory Organization Examination Oversight (D) Working Group. The motion passed unanimously.

3. Adopted the Reports of its Task Forces and Working Groups

a. Market Regulation Certification (D) Working Group

Superintendent Toal said the Market Regulation Certification (D) Working Group met March 22. He said since this was the first time the Working Group has met since late 2020, the Working Group reviewed the status of the Voluntary Market Regulation Certification Program.

Superintendent Toal noted that the Working Group has three parts of the Voluntary Market Regulation Certification Program to complete this year. First, he said the certification requirements are finished, but the revisions suggested by the certification pilot states need to be adopted for inclusion in the Voluntary Market Regulation Certification Program. Second, the implementation plan for the Voluntary Market Regulation Certification Program needs to be brought up to date. Third, the Working Group needs to complete the scoring guidelines to enable jurisdictions to understand what is needed to be certified and uniformly self-evaluate themselves.

Superintendent Toal said the Working Group heard a report from the small group of state insurance regulators working on the scoring matrix for the Voluntary Market Regulation Certification Program. He said they made progress in 2020 and will have a draft of the scoring matrix to the Working Group prior to the Summer National Meeting.

b. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met March 28. He said the Task Force discussed a letter received concerning racial bias and discrimination potentially taking place. The Task Force heard comments from NAIC Consumer Representative Birny Birnbaum (Center for Economic Justice—CEJ) and will continue to monitor the topic and schedule additional discussions, if warranted.

Commissioner Navarro said the Task Force adopted a recommendation to temporarily disband the Antifraud Education Enhancement (D) Working Group and move its current charge under the Task Force. As the Working Group's last official action, the Task Force received an update from the Working Group. Commissioner Navarro said updated Investigator Safety Training Webinars for the state insurance regulators and private investigators will be held this year, and specific dates will be distributed once confirmed. He said Michelle Brugh Rafeld (OH) will continue her position as the Task Force's education subject matter expert (SME) and work with the NAIC to develop additional advanced training throughout the year.

Commissioner Navarro said the Task Force received an update from the Antifraud Technology (D) Working Group. He said the Working Group requested that state insurance regulator SMEs work with NAIC staff to create a template for industry to use when creating their Antifraud Plans. The Working Group will expose the final draft of the template for comment, and the Working Group will meet to discuss the comments and potentially adopt the template. Commissioner Navarro said once the template is adopted by the Working Group, it will be presented to the Task Force for consideration at the Summer National Meeting. He said the Working Group chair has continued to work with NAIC staff to redesign the Online Fraud Reporting System (OFRS). He said the OFRS industry section is currently in beta testing, and the NAIC is accepting suggestions to finalize the redesign.

Commissioner Navarro said the Task Force received an update from the newly appointed Improper Marketing of Health Insurance (D) Working Group. He said the Working Group continues to meet monthly in regulator-to-regulator session, and it held its second open meeting April 4 at the Spring National Meeting. He said during the meeting, the Working Group discussed current issues being witnessed throughout the states, including enforcement actions taking place due to their continued efforts. He said the Working Group also heard from the

Coalition Against Insurance Fraud (CAIF) regarding the work it has completed specific to the improper marketing of insurance. He said the Working Group discussed the collaborative document on lead generators comprising potential fraudulent entities who are improperly marketing health insurance. The collaborative document was created to assist states and federal agencies to coordinate necessary actions to fight insurance fraud.

Lastly, Commissioner Navarro said the Task Force received a report on matters of national interest to the insurance fraud bureaus from the CAIF.

c. Market Information Systems (D) Task Force

Commissioner Conway said the Market Information Systems (D) Task Force met March 25 and adopted its Dec. 3, 2021, and 2021 Fall National Meeting minutes. The Task Force met Dec. 3, 2021, to extend the Task Force charge to "develop recommendations for the incorporation of artificial intelligence (AI) abilities in the NAIC Market Information Systems."

Commissioner Conway said the Task Force also considered the report of the Market Information Systems Research and Development (D) Working Group regarding the incorporation of artificial intelligence (AI) in the NAIC market information systems (MIS). He said the report lays out five sequential steps needed to incorporate AI into the MIS, beginning with a full analysis of the current state of the data in the MIS and the data's usefulness for AI analysis techniques. He said after hearing comments regarding the time and resources needed to implement all five of the report's recommendations and a proposal to limit adoption to only the first two recommendations to assess the current quality of the market information data, the Task Force decided to continue its discussions and consideration of adoption at its next meeting.

Commissioner Conway said the Task Force also received reports from the Working Group on the status of current MIS projects and its analysis of the completeness, accuracy, and timeliness of the data in the MIS. He said the Task Force adopted both reports.

d. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force has not met since the 2021 Fall National Meeting, but progress has been made on several important initiatives, and a call will be scheduled in late April or early May.

Director Deiter said the Task Force has continued its development of a uniform process for considering updates to the NAIC's Uniform Applications. He said one of the main changes to the document is language that clarifies the coordination between the NAIC, the National Insurance Producer Registry (NIPR), and NAIC member jurisdictions, including any back-office system vendors, in assessing the cost and time needed to implement adopted changes to the Uniform Licensing Applications. He said the Task Force will accept a final round of comments and plans to consider the adoption of the Uniform Application Change Process during its next call. He said the Task Force will then begin the review of suggested changes to the Uniform Producer Licensing Application within the guidelines of the adopted process.

Director Deiter said there has been additional discussions regarding how states review 1033 waiver requests. He said the Federal Violent Crime Control and Law Enforcement Act of 1994 requires producer applicants who have been convicted of crimes involving dishonesty or breach of trust to obtain written consent or approval before engaging int the business of insurance. He noted that NAIC staff have been working with industry to clarify industry's request to simplify the 1033 wavier process and bring a proposal to the Task Force.

Director Deiter said the Task Force has faced delays appointing working group chairs due to the resignation and lack of availability of producer licensing directors to chair the working groups. He said Richard Tozer (VA) has

agreed to chair the Uniform Education (D) Working Group, and he is working with Commissioner Clark, the vice chair of the Task Force, to identify a chair for the Producer Licensing Uniformity (D) Working Group.

Director Deiter said the Task Force will consider the formal appointment of a new Adjuster Licensing (D) Working Group during its next conference call. He said Rachel Chester (RI) agreed to move forward with leading initial discussions falling under the current Task Force charge to "monitor the state implementation of adjuster licensing reciprocity and uniformity and update, as necessary, NAIC adjuster licensing standards."

e. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met March 23 and reviewed its charges for 2022. He said during 2022, the Working Group will focus on the MIS data to ensure it is effectively meeting the needs of market analysts and, if necessary, provide recommendations for enhancements and improvements. He also said in 2022, the Working Group will open discussions on the next line of business for the Market Conduct Annual Statement (MCAS). He encouraged all interested state insurance regulators, interested parties, and industry to provide suggestions for the Working Group to consider.

Mr. Haworth said the Working Group discussed the new standard MCAS ratios for the two newest lines of business in the MCAS; i.e., Short-Term Limited-Duration (STLD) Insurance and Travel Insurance. He said the ratios are exposed on the Working Group web page, and the Working Group will be voting on their adoption on its conference call.

Finally, Mr. Haworth said the Working Group adopted a motion to add the disability and lender-placed insurance MCAS data to the Market Analysis Review System (MARS). The Working Group forwarded the request to the Market Information Systems Research and Development (D) Working Group for its consideration. He said during the Market Information Systems Research and Development (D) Working Group's discussion, it asked the Market Analysis Procedures (D) Working Group for additional details, and that will be on the agenda during its next meeting.

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

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group met March 17 and received an update regarding the Life MCAS draft edits for Accelerated Underwriting. She said the Accelerated Underwriting (A) Working Group adopted its draft paper. She said the MCAS Accelerated Underwriting SMEs has a meeting scheduled on April 13 to discuss a definition for the proposed Life MCAS Accelerated Underwriting proposal.

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group received an update regarding the Other Health MCAS draft. She said the SMEs working on the Other Health draft are finalizing the draft, and it is anticipated that the draft will be exposed in time for the Working Group to consider adoption prior to the June 1 deadline for edits to the 2023 MCAS reporting.

Ms. Weyhenmeyer said the Working Group discussed the proposed lawsuit definitions and placement of lawsuit data elements for the Homeowners MCAS and Private Passenger Auto (PPA) MCAS. The SMEs working on this issue have scheduled a call on April 12 to discuss outstanding questions and concerns prior to providing a draft proposal to the Working Group for public discussion.

Ms. Weyhenmeyer said the Working Group adopted the proposal for digital claims interrogatories for the Homeowners and PPA MCAS lines of business. She said the edits will be provided to the Committee, along with

any other MCAS edits that need to be considered prior to the Committee's Aug.1 deadline for edits to the 2023 MCAS reporting.

Finally, Ms. Weyhenmeyer said the Working Group reviewed guidance regarding the new data element asking for the "Number of Lawsuits Closed with Consideration for the Consumer" on the Homeowners and PPA MCAS Lines of business.

g. Market Conduct Examination Guidelines (D) Working Group

Mr. Hughes said the Market Conduct Examination Guidelines (D) Working Group met March 10 and reviewed its 2022 charges and established priorities for 2022. First, the Working Group will develop a new, updated Chapter 24 of the *Market Regulation Handbook* on conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) examination in the *Market Regulation Handbook*. Mr. Hughes said at the end of 2021, the Working Group was asked to coordinate with the MHPAEA (B) Working Group to develop updates to the mental health parity-related chapter of the *Market Regulation Handbook* to ensure it reflects current MHPAEA parity compliance analysis requirements for non-quantitative treatment limits (NQTLs) and better align the chapter with established federal guidance related to mental health parity. He said the Market Conduct Examination Guidelines (D) Working Group's vice chair, Ms. Weyhenmeyer, is the chair of the MHPAEA (B) Working Group, and the two working groups are already collaborating to address this request. He said as a result of that coordination, an updated MHPAEA chapter is forthcoming and will be distributed after the Spring National Meeting as a new exposure draft for the Market Conduct Examination Guidelines (D) Working Group's consideration. Second, the Working Group will update Chapter 23—Conducting the Life and Annuity Examination of the *Market Regulation Handbook* to include revised guidance pertaining to the revisions to the *Suitability in Annuity Transactions Model Regulation* (#275) that were adopted by the NAIC in February 2020. Third, the Working Group will develop new travel insurance-related Standardized Data Requests (SDRs) to address in-force policies and claims.

Mr. Hughes said the Working Group will also move forward in 2022 with its charges to develop uniform market conduct procedural guidance; coordinate with the Innovation, Cybersecurity, and Technology (H) Committee; discuss the effectiveness of group supervision of market conduct risks; and discuss the role of market conduct examiners in reviewing insurers' corporate governance.

Mr. Hughes said the Working Group also discussed draft revisions to Chapter 21—Conducting the Property and Casualty Examination of the *Market Regulation Handbook* regarding provisions from the *Real Property Lender-Placed Insurance Model Act* (#631) and to Chapter 20—General Examination Standards of the *Market Regulation Handbook* regarding provisions in the *Insurance Holding Company System Regulatory Act* (#440).

h. Speed to Market (H) Working Group

Ms. Nichols said the Speed to Market (H) Working Group leadership and NAIC staff support met March 10 to discuss the Working Group's goals and plans for 2022. She said a Working Group call is scheduled for April 20 to discuss its 2022 goals. Ms. Nichols said the Working Group will: 1) hear an update on the System for Electronic Rates & Forms Filing (SERFF) Modernization Project; 2) hear a status update on edits to the *Product Filing Review Handbook;* and 3) discuss the annual review of the PCM and Uniform Transmittal Document suggestions.

i. Advisory Organization (D) Working Group

Commissioner Ommen said the Advisory Organization (D) Working Group met March 22. He noted that because the Working Group's charge is to oversee the regularly scheduled examinations of advisory organizations, the Working Group always meets in closed regulator-only session.

Commissioner Ommen said in addition to receiving updates on exams currently in progress and the most recent company responses to their annual self-evaluations, the Working Group began consideration of advisory organizations that primarily provide telematics and other services heavily reliant in the use of big data technology to insurers. He said this is beyond the standard loss cost and actuarial type services that most advisory organizations provide for their members. He said this year, the Working Group is considering the examination standards that should be in place to effectively regulate these entities. He noted that there are currently a couple states that participate in the Working Group who are conducting examinations of these organizations, and the Working Group will be reviewing and discussing the results of these examinations as it works on examination standards.

Mr. Birnbaum asked whether the development of the standards would be on open conference calls so interested parties could participate. Commissioner Ommen said the development would initially be closed, but once a framework of standards is developed, it would likely move to the Market Conduct Examination Guidelines (D) Working Group for completion. Mr. Birnbaum also asked whether the results of advisory organization examinations could be made public. Commissioner Ommen said the decision to make examination reports public belongs to the jurisdictions participating in the examination, not the Advisory Organization (D) Working Group.

j. Privacy Protections (D) Working Group

Ms. Johnson said the Privacy Protections (D) Working Group met March 23 and March 9 in regulator-only session. She said state insurance regulator SMEs conducted their initial drafting via email and then met March 29 and April 4 following the Working Group's meeting.

Ms. Johnson said the Working Group adopted its 2021 Fall National Meeting minutes and heard updates by Jennifer McAdam (NAIC) on state privacy legislation and Brooke Stringer (NAIC) on federal privacy legislation.

Ms. Johnson said the Working Group also discussed comments received on the exposure draft of the Working Group's work plan, which was exposed March 23 for a seven-day public comment period that ended on March 30. She said the Working Group adopted the 2022 work plan during its April 4 meeting.

Superintendent Toal made a motion, seconded by Commissioner Clark, to adopt the following reports: 1) Market Regulation Certification (D) Working Group (Attachment Two); 2) Antifraud (D) Task Force; 3) Market Information Systems (D) Task Force; 4) Producer Licensing (D) Task Force; 5) Market Analysis Procedures (D) Working Group (Attachment Three); 6) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Four); 7) Market Conduct Examination Guidelines (D) Working Group (Attachment Five); 8) Speed to Market (H) Working Group; 9) Advisory Organization (D) Working Group; and 10) Privacy Protections (D) Working Group (Attachment Six). The motion passed unanimously.

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

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