

Property & Casualty Market Conduct Annual Statement

Homeowner Data Call & Definitions

Line of Business: Homeowners

Reporting Period: January 1, 2017 through December 31, 2017

Filing Deadline: April 30, 2018

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.

Interrogatories

Were there policies in-force during the reporting period that provided Dwelling coverage? (Y/N)	
Were there policies in-force during the reporting period that provided Personal Property coverage? (Y/N)	
Were there policies in-force during the reporting period that provided Liability coverage? (Y/N)	
Were there policies in-force during the reporting period that provided Medical Payments coverage? (Y/N)	
Were there policies in-force during the reporting period that provided Loss of Use coverage? (Y/N)	
Was the Company still actively writing policies in the state at year end? Yes/No	
Does the Company write in the non-standard market? (Y/N)	
If yes, what percentage of your business is non-standard?	Comment (if necessary)
If yes, how is non-standard defined?	Comment (if necessary)
Has the company had a significant event/business strategy that would affect data for this reporting period? Yes/No (If yes, add additional comments)	Comment (if necessary)
Has this block of business or part of this block of business been sold, closed or moved to another company during the year? Yes/No	Comment (if necessary)
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
Claims Comments	Comment (if necessary)
Underwriting Comments	Comment (if necessary)

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Coverages

Dwelling (includes – Other Structures)
Personal Property
Liability
Medical Payments
Loss of Use

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.

Description
State Indicator (State for which data is being submitted) Automatically loaded
NAIC Company Code Automatically loaded
NAIC Group Code Automatically loaded
Coverage Identifier Automatically loaded
Number of claims open at the beginning of the period
Number of claims opened during the period
Number of claims closed during the period, with payment
Number of claims closed during the period, without payment
Number of claims open at the end of the period
Median days to final payment
Number of claims closed with payment within 0-30 days
Number of claims closed with payment within 31-60 days
Number of claims closed with payment within 61-90 days
Number of claims closed with payment within 91-180 days
Number of claims closed with payment within 181-365 days
Number of claims closed with payment beyond 365 days
Number of claims closed without payment within 0-30 days
Number of claims closed without payment within 31-60 days
Number of claims closed without payment within 61-90 days

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Number of claims closed without payment within 91-180 days
Number of claims closed without payment within 181-365 days
Number of claims closed without payment beyond 365 days
Number of suits open at beginning of the period
Number of suits opened during the period
Number of suits closed during the period
Number of suits open at end of period

Homeowners Underwriting

State Indicator (State for which data is being submitted) Automatically loaded
NAIC Company Code Automatically loaded
NAIC Group Code Automatically loaded
Number of dwellings which have policies in-force at the end of the period
Number of policies in-force at the end of the period
Number of new business policies written during the period
Dollar amount of direct premium written during the period
Number of Company-Initiated non-renewals during the period
Number of cancellations for non-pay or non-sufficient funds
Number of cancellations at the insured's request
Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated company
Number of Company-Initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to an affiliated company
Number of Company-Initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to an affiliated company
Number Of Complaints Received Directly From Any Person or Entity Other than the DOI

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Definitions:

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

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

Report cancellations separately for:

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

Exclude:

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

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

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

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

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

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

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- 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.

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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.

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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.

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- Report a claim as “closed with payment” or “closed without payment” if it is closed in the company’s claims system during the reporting period (even if the final payment was issued in a prior reporting period).
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company’s claims system, would you report the days to final payment.

Example:

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

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

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

Calculation Clarification:

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

Dwelling – A personally occupied residential dwelling.

Calculation Clarification:

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

Dwelling Fire and Dwelling Liability Policies – Coverage for dwellings and their contents. It may also provide liability coverage and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner’s policy, or because of a

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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.
- Renters insurance, policies covering log homes, land homes, and site built homes are included.
- Inland Marine or Personal Articles endorsements.

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.

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.

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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:

	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.

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

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

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

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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.

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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.

Suit – A court proceeding to recover a right to a claim, including suits for arbitration cases.

Exclude:

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

Calculation Clarification:

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