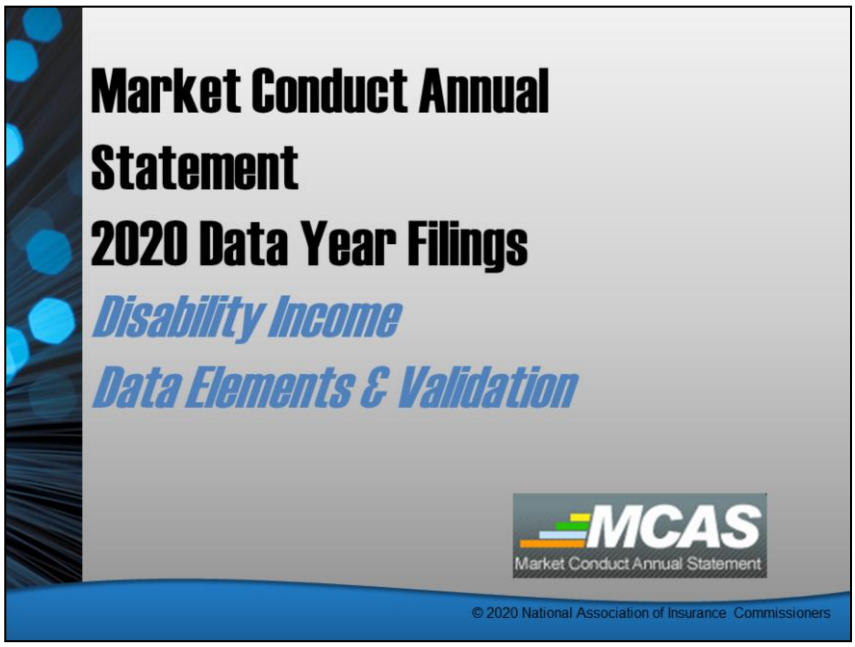
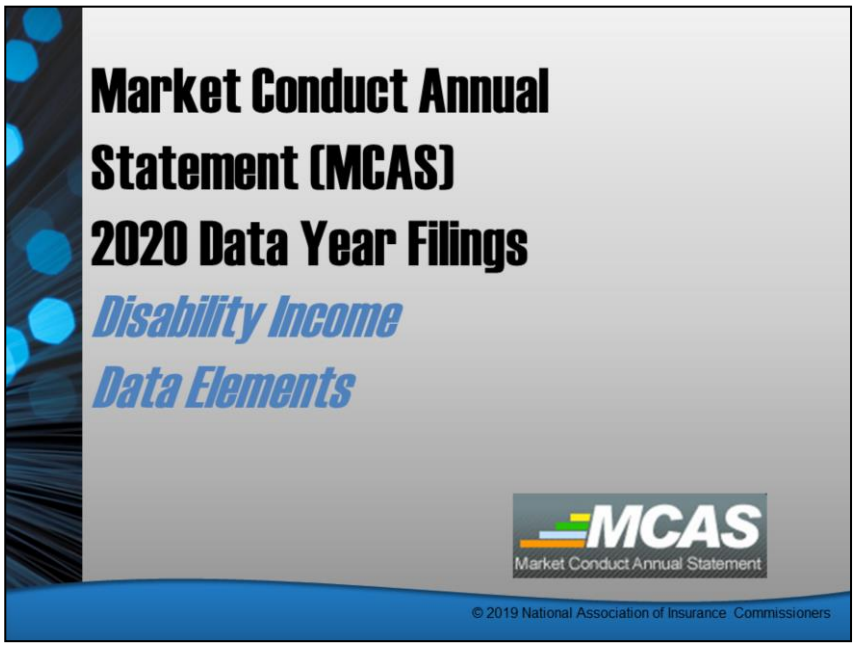
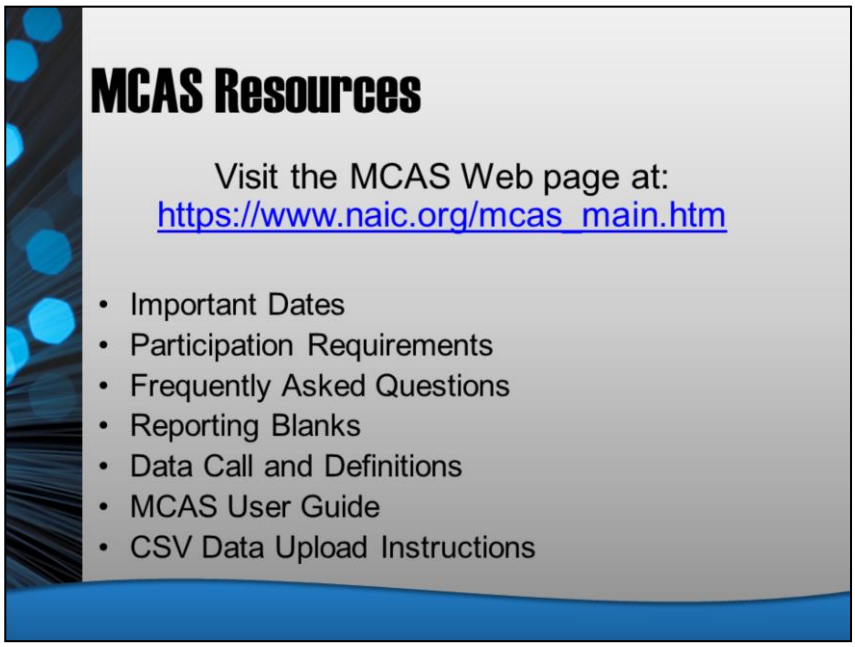

Market Conduct Annual Statement
2020 Data Year Filings
Disability Income
Data Elements & Validation
MCAS
Market Conduct Annual Statement
© 2020 National Association of Insurance Commissioners



Hello. I'm Leana Massey.

In this section of the Market Conduct Annual Statement training we will be reviewing the data elements that must be provided for the Disability Income MCAS.



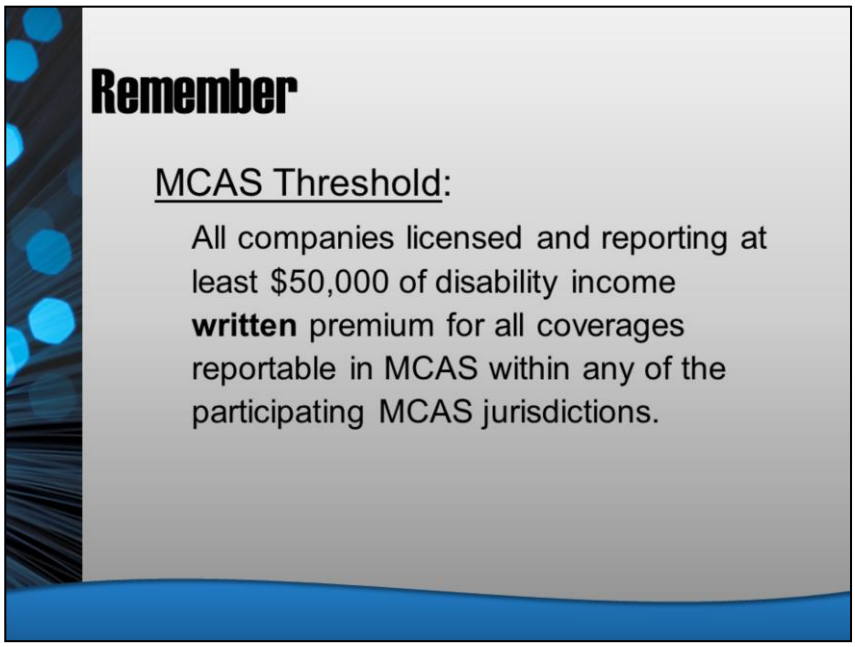
Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

The available resources include:

- A Listing of Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- Copy of the Call Letter
- MCAS User Guide
- And CSV Data Upload Instructions

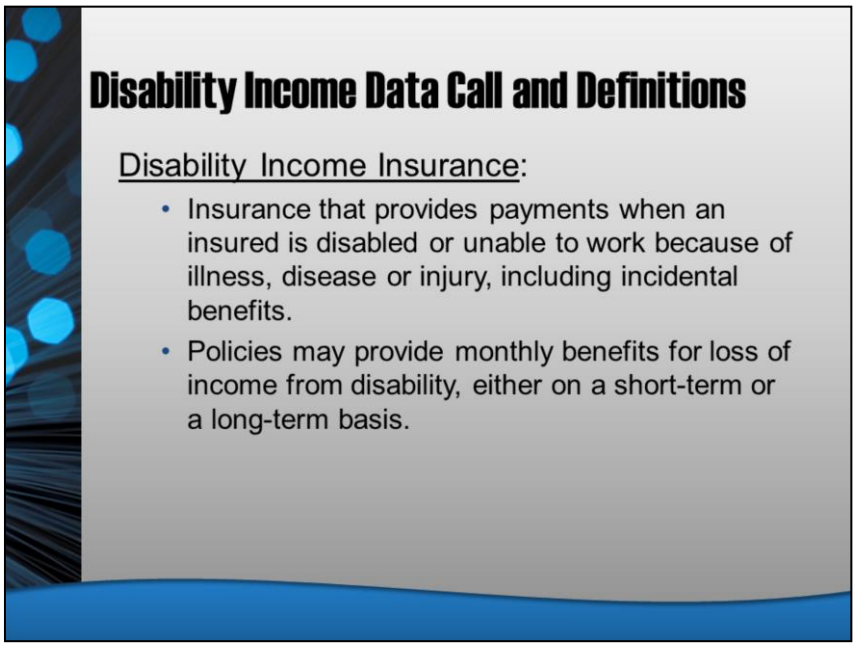
You may find it helpful to pull up the Disability Income Insurance Data call and Definitions and Data Collection Worksheets or blanks documents on the MCAS web page to refer to as we go through this tutorial.

Before we begin, please be sure to remember that the current data year filing is April 30th.



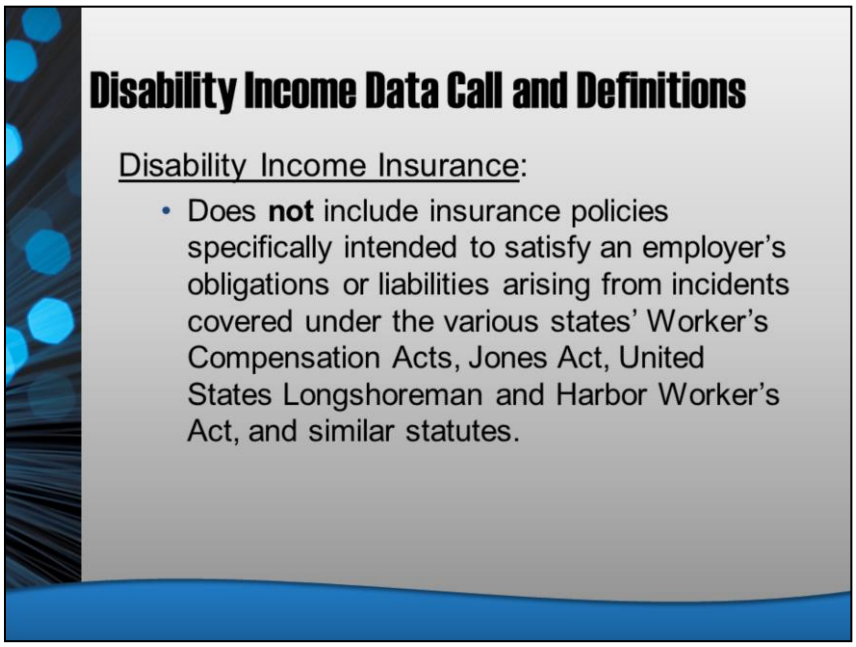
Disability Income MCAS reporting began with the 2019 data year. All companies licensed and reporting at least $50,000 of disability income **written** premium, for all coverages reportable in MCAS within any of the participating MCAS jurisdictions, are required to report.

It should be noted that this is a change from the first reporting year where it was asked that earned premium be reported. The data reference for determining if a company is required to submit Disability Income data for a state, is taken from Schedule T, Part 2 of the annual statement, so written premium is being requested to match that reporting.

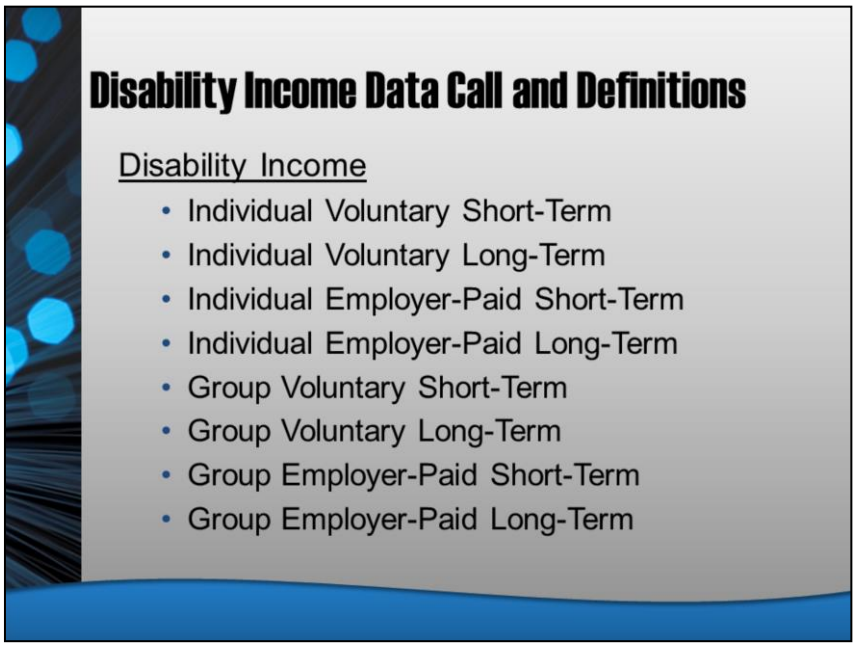


The definition of Disability Income insurance or Disability Income Protection can be found in the MCAS Data Call and Definitions. Per the Data Call and Definitions, Disability Income or D.I. insurance, is insurance that provides payments when an insured is disabled or unable to work because of illness, disease or injury, including incidental benefits.

Policies may provide monthly benefits for loss of income from disability, either on a short-term or a long-term basis.



Disability Income insurance does **not** include insurance policies specifically intended to satisfy an employer's obligations or liabilities arising from incidents covered under the various states' Worker's Compensation Acts, Jones Act, United States Longshoreman and Harbor Worker's Act, and similar statutes.

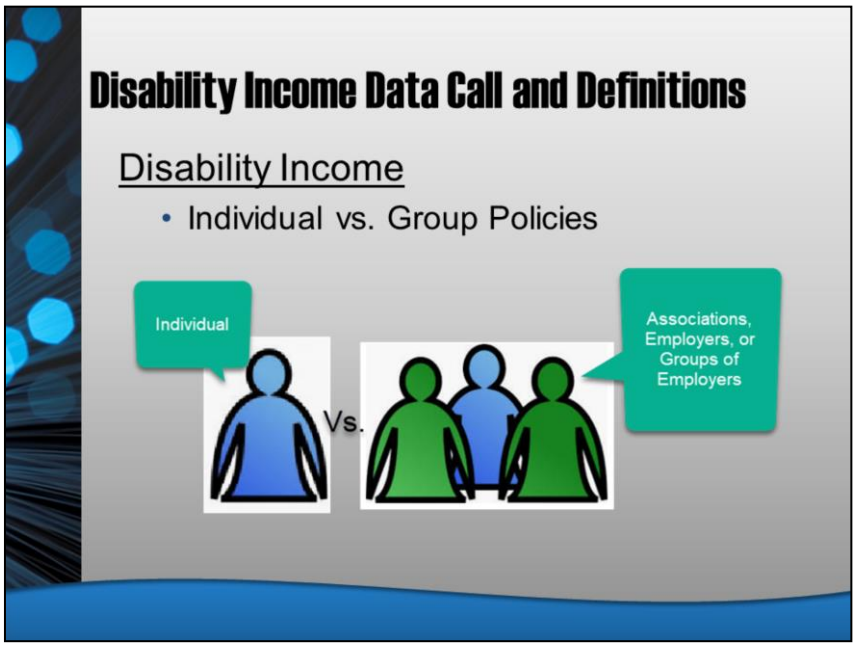


Each Disability Income product represents a unique mix of three characteristics related to:

method of payment, which is voluntary vs. employer paid; duration of the benefit period which is short-term vs. long-term; and method of product marketing and sales, which is group vs. individual.

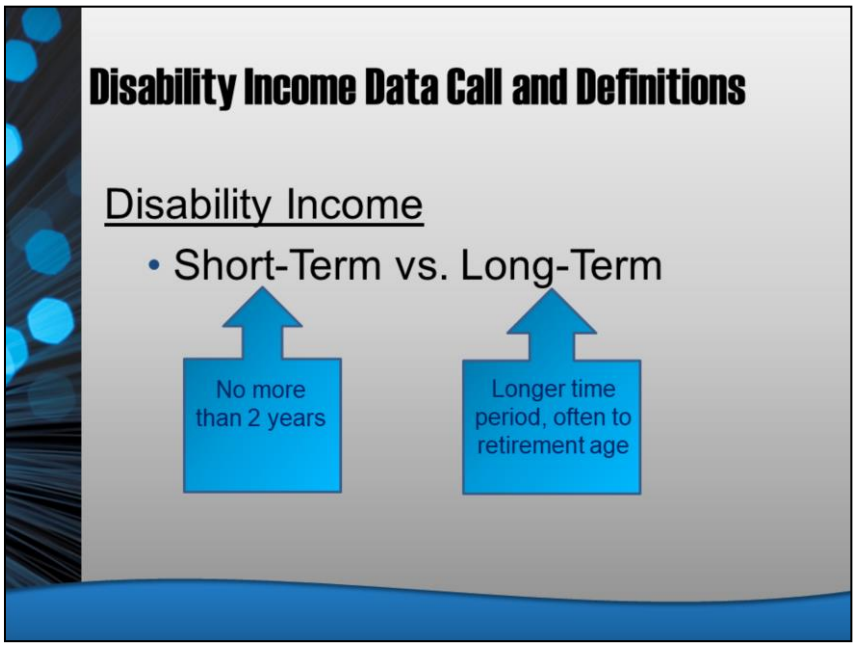
The Disability Income MCAS requests market conduct data on eight different types of products:

- Individual Voluntary Short-Term
- Individual Voluntary Long-Term
- Individual Employer-Paid Short-Term
- Individual Employer-Paid Long-Term
- Group Voluntary Short-Term
- Group Voluntary Long-Term
- Group Employer-Paid Short-Term
- Group Employer-Paid Long-Term

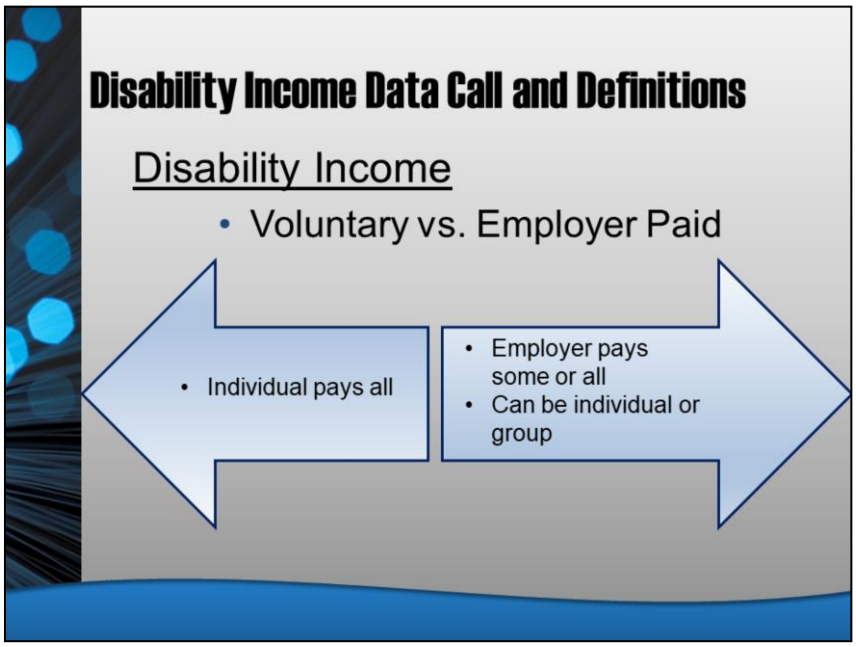


The difference between Individual and Group Policies, is that individual policies are marketed to, or purchased directly by individuals, and Group policies are sold and purchased by or through group sponsors such as associations, employers, or groups of employers.

Policies that originated as group coverage but covering individuals who are no longer members or eligible participants of the group sponsor and are not linked to some other group or trust, are to be reported as individual coverage.



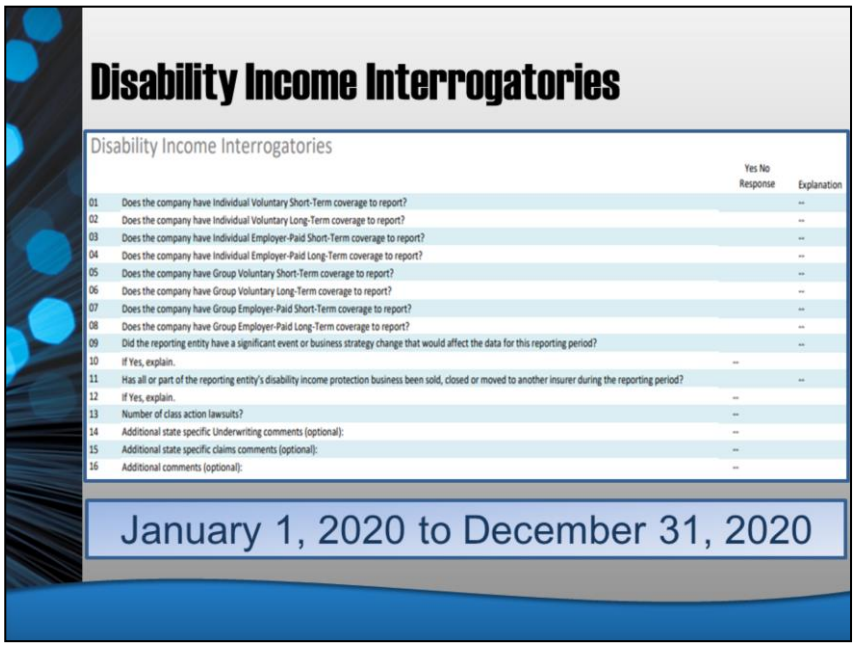
Short term Disability Income policies offer benefit payments during a disability for no more than two years, and long-term policies cover disability for a significantly longer period, often to the age of retirement.



Voluntary coverage is coverage for which an individual pays ALL of the premium, irrespective of whether the policy is a group or individual policy.

Employer-paid policies are coverage for which an employer pays ANY portion of the premium and may also be individual or group coverage.

If you ever have any questions regarding how to categorize any such products or policies for any particular jurisdiction, please contact the Department of Insurance for the relevant jurisdiction.

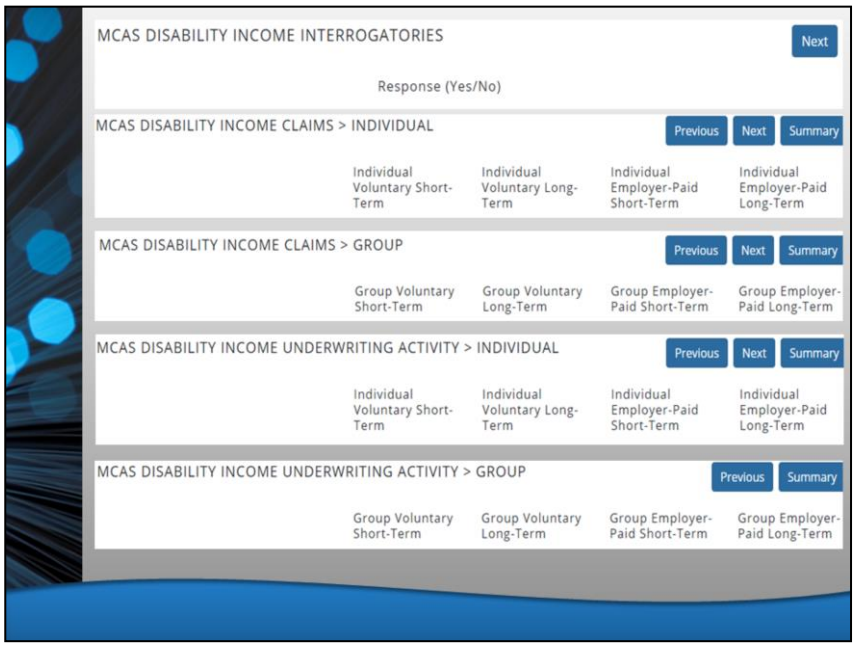


The first section of questions that you will see in the data entry screen is the interrogatories, which is schedule 1 of the disability income MCAS.

The interrogatories provide one location for all comments and questions that require a text response.

This allows reporting entities the opportunity to provide regulators with relevant information that helps them interpret the data,

and gives a general overview of the nature of a company's book of business.

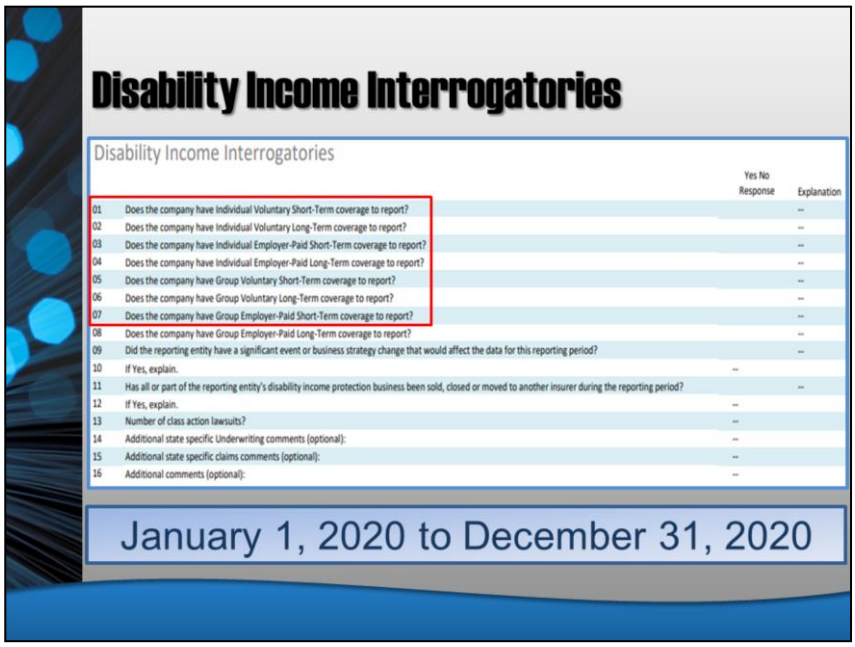


You will notice on your data entry screen within the MCAS submission tool that there are five separate pages for the Interrogatory questions and data questions.

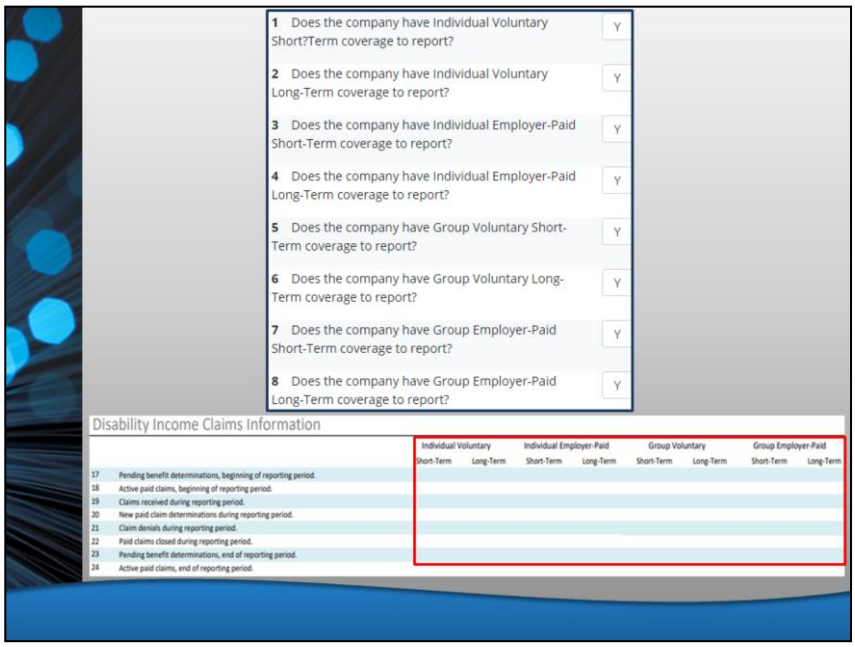
There are a total of 9 sections or schedules for the Disability Income MCAS, with the Interrogatories being the first. However, within the MCAS submission tool the data questions are separated into five pages for a better user experience within the tool itself.

The five pages of data entry in the Disability MCAS are Interrogatories, Claims Individual, Claims Group, Underwriting Individual and Underwriting Group.

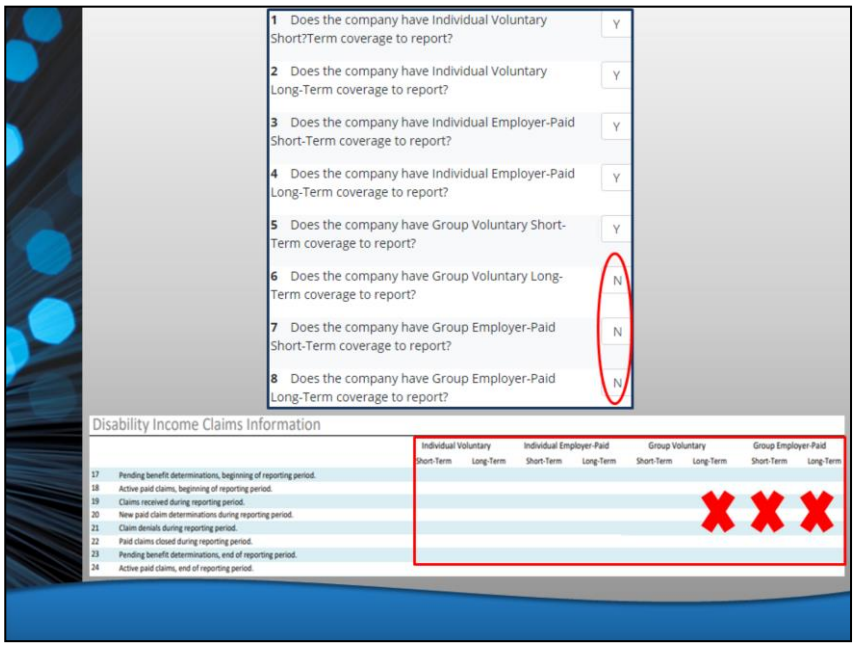
We will discuss the details of each section throughout this tutorial, but the way each page of information begins for the Disability Income MCAS appear here.



The first eight questions in the interrogatories ask insurers to indicate if they will be reporting data for each of the Disability Income coverage types.

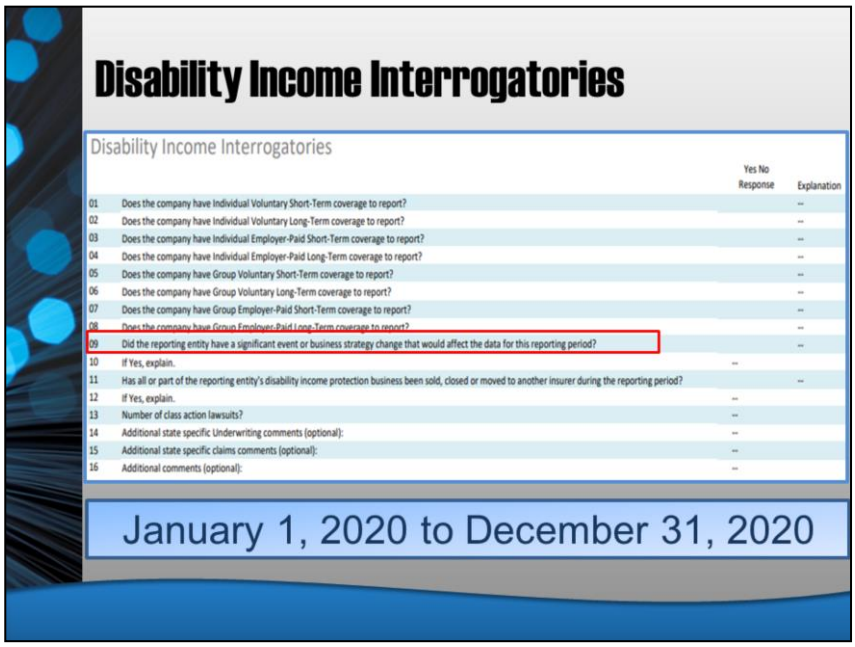


If you answer “YES” you must provide data to each of the data questions in the schedule for the corresponding coverage type.



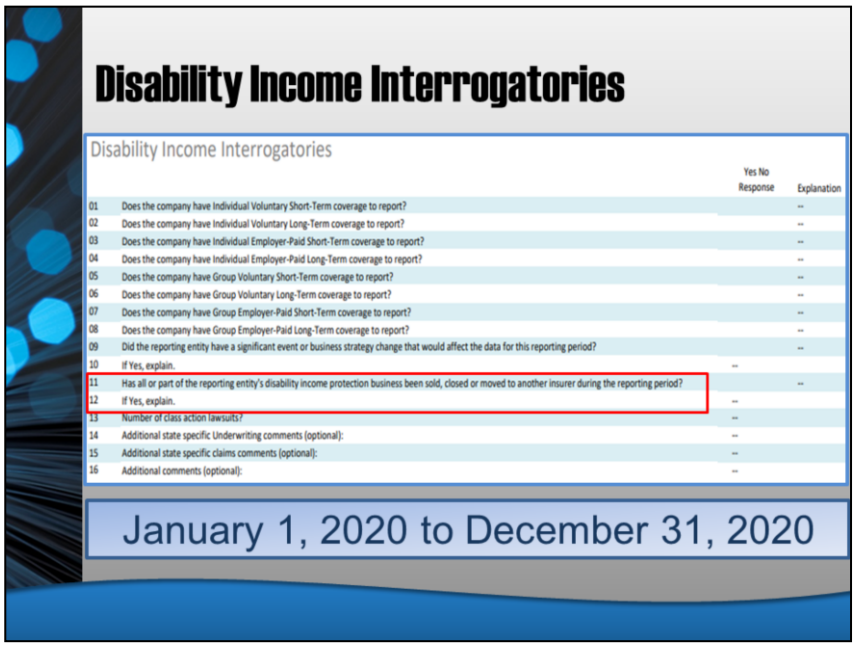
If you respond “NO”, you must leave all the response boxes blank for the corresponding coverage types.

You should only provide data for coverage types where you have indicated that “YES”, the company has coverage to report.



If you indicate that you will be reporting data for any Disability Income coverage, you are asked in the Interrogatories if there has been a significant event or business strategy change that would affect the data for this reporting period.

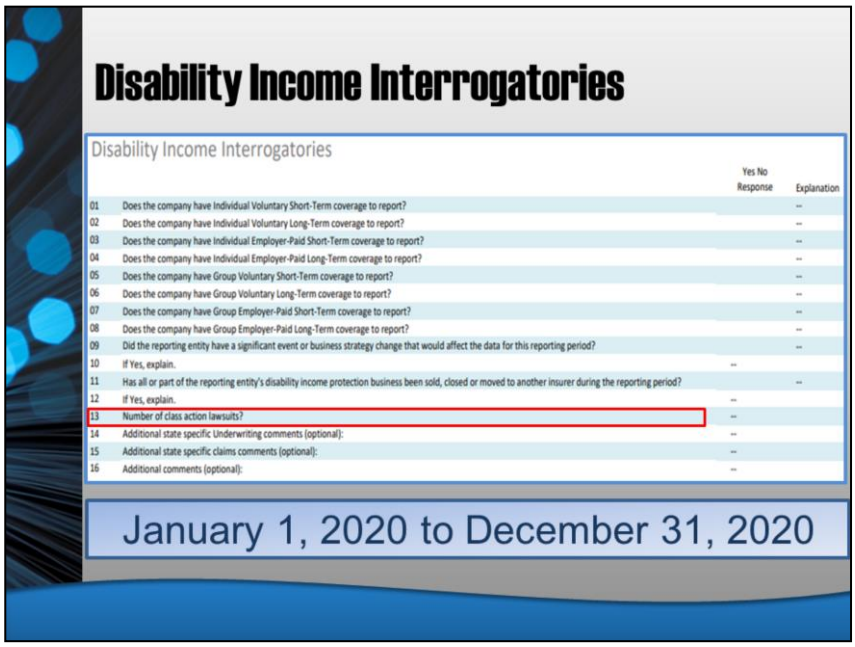
These could include assuming blocks of business, shifting market strategies, or underwriting changes. The explanation should describe the experience and explain the significance with respect to the data filed in this report.



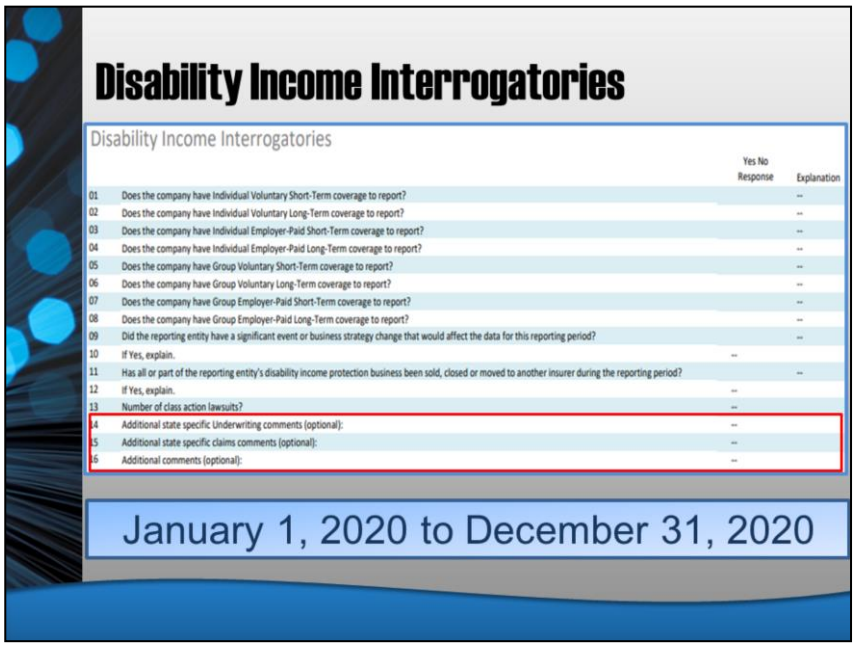
You are also asked if any part of the block of business has been sold, closed or moved to another company during the reporting period.

These questions are your opportunity to explain any of your data that you anticipate may generate an inquiry from the state regulators.

It is important that these questions be answered fully to allow regulators to understand your company's MCAS filing results.



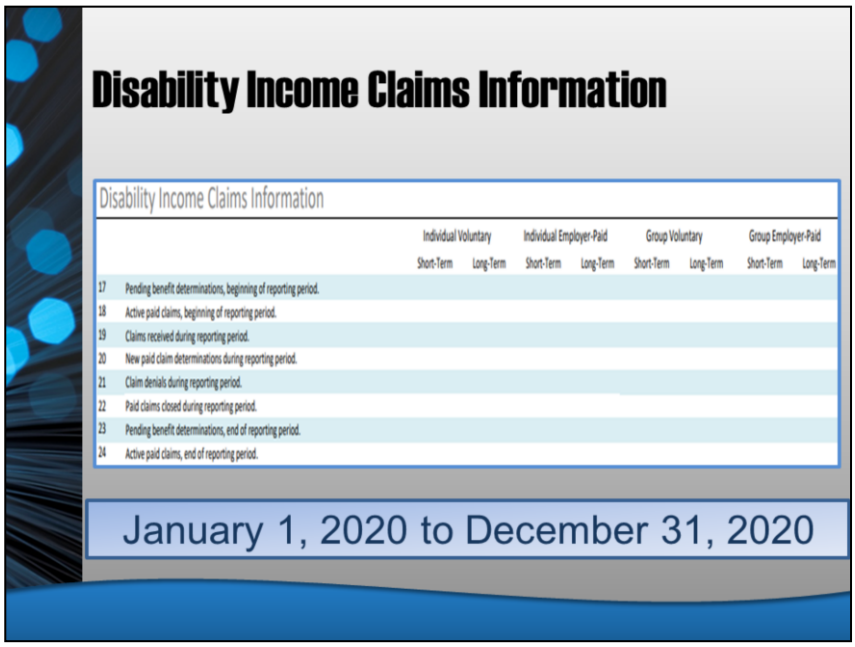
Question 13 of the interrogatories is for the number of class action lawsuits. This is where reporting entities should note the total number of class action lawsuits for Disability Income business.



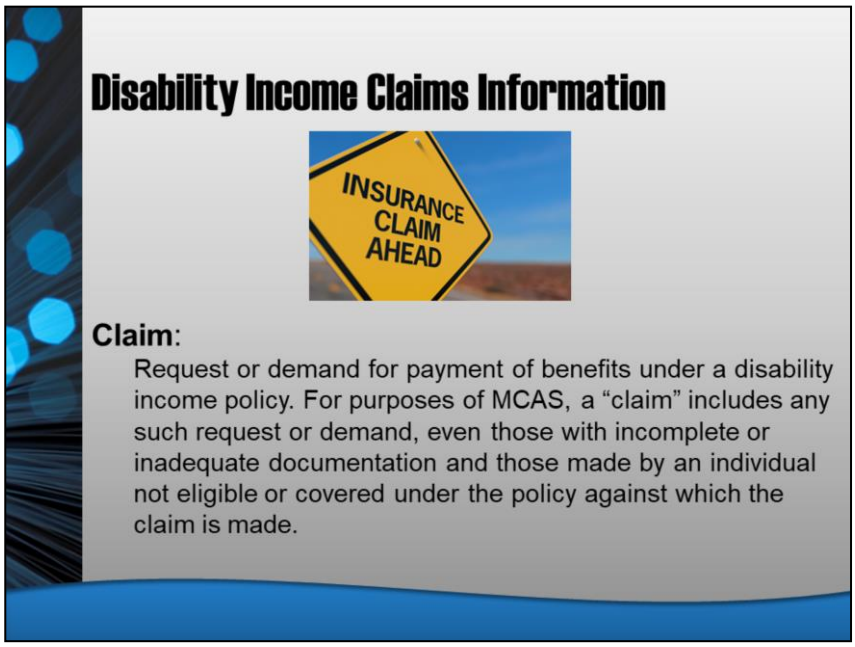
The interrogatories also provide space where you may enter any state specific comments for the coverage types.

Any areas of your data that may raise questions or generated a warning when your data was validated should be explained fully in these comment areas.

At the end of this tutorial we will discuss the MCAS validations in more detail along with the importance of using the comments sections.

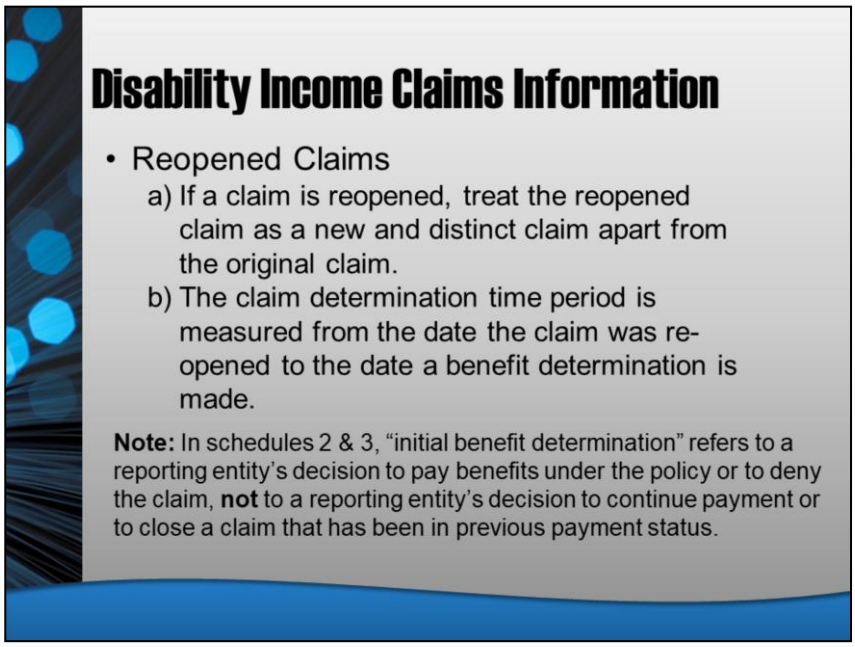


The next five sections in the Disability Income MCAS are related to claims activity. Schedule 2 collects general claims information.



A claim is a request or demand for payment of benefits under a disability income policy. For purposes of this MCAS, 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 this described definition, should not be reported in 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.

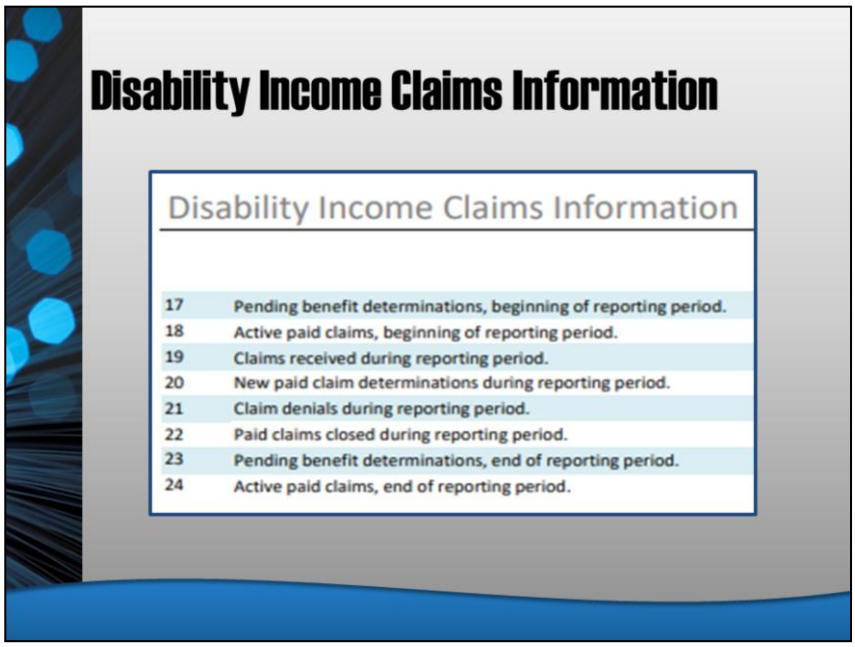


If a claim is reopened, treat the reopened claim as a new and distinct claim apart from the original claim.

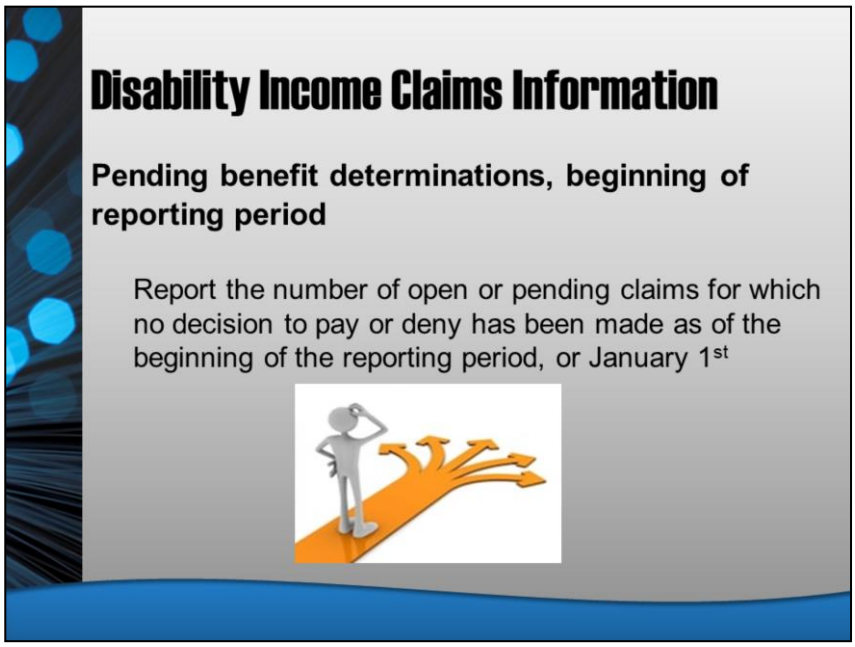
The claim determination time period for reopened claims is measured from the date the claim was re-opened, to the date a benefit determination is made.

Please note, that in schedules 2 & 3, "initial benefit determination" refers to a reporting entity's decision to pay benefits under the policy or to deny the claim. It does **not** refer to a reporting entity's decision to continue payment or to close a claim that has been in previous payment status.

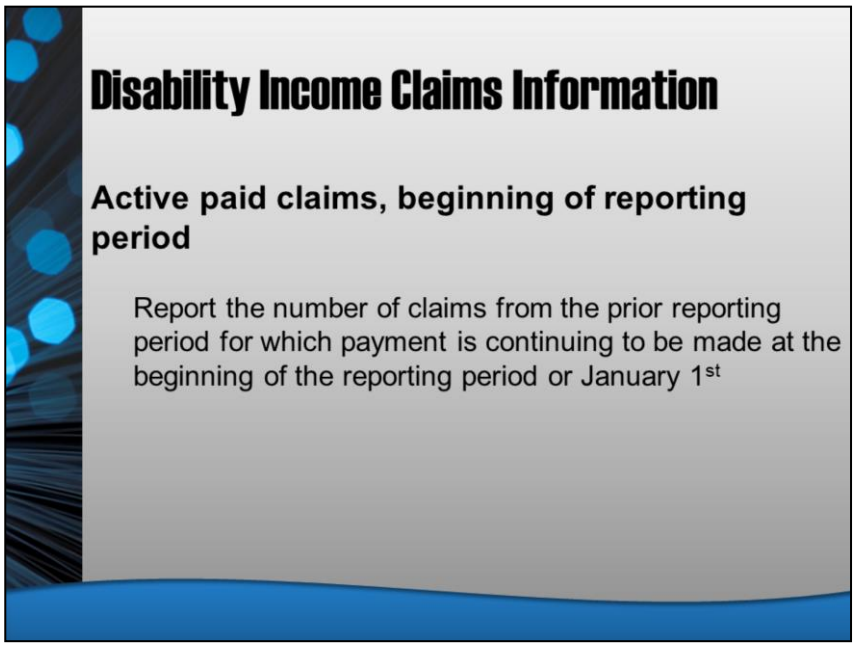
These latter decisions are to be reported in schedule 6.



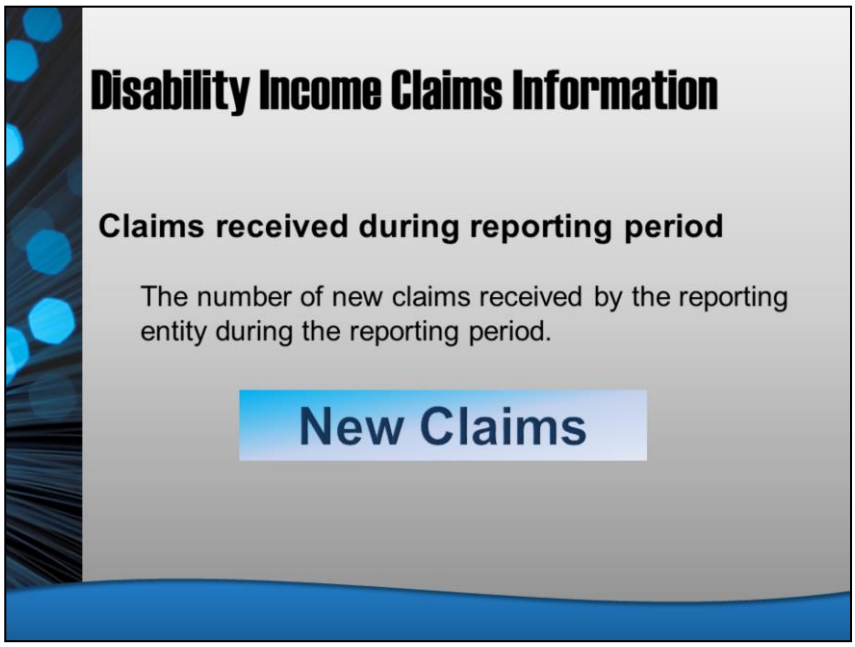
Let's take a closer look at the eight data questions you will see in the disability claims information section of the MCAS.



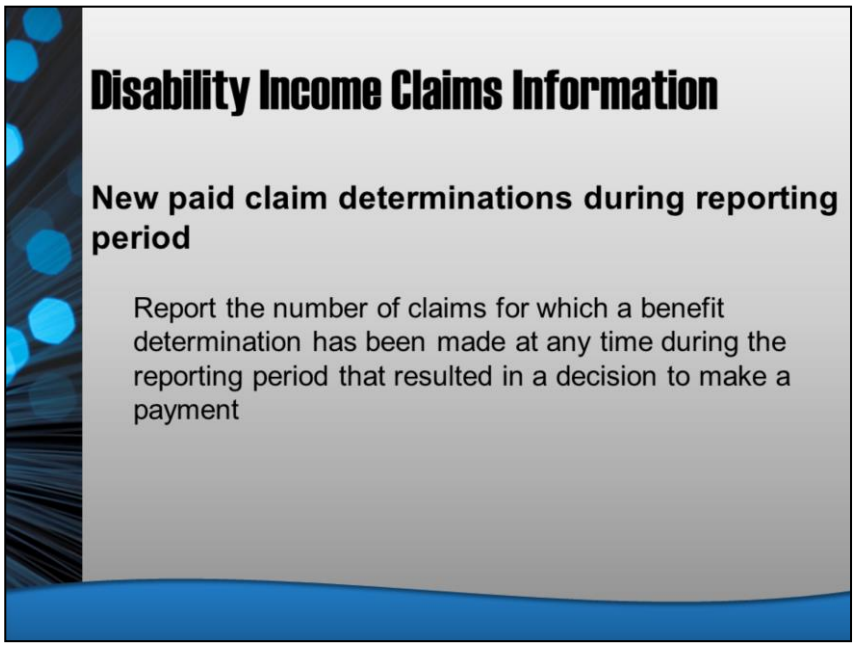
The first line you will see in this section is Pending benefit determinations, beginning of period. This is for the number of open or pending claims for which no decision to pay or deny has been made as of the beginning of the reporting period, or January 1st.



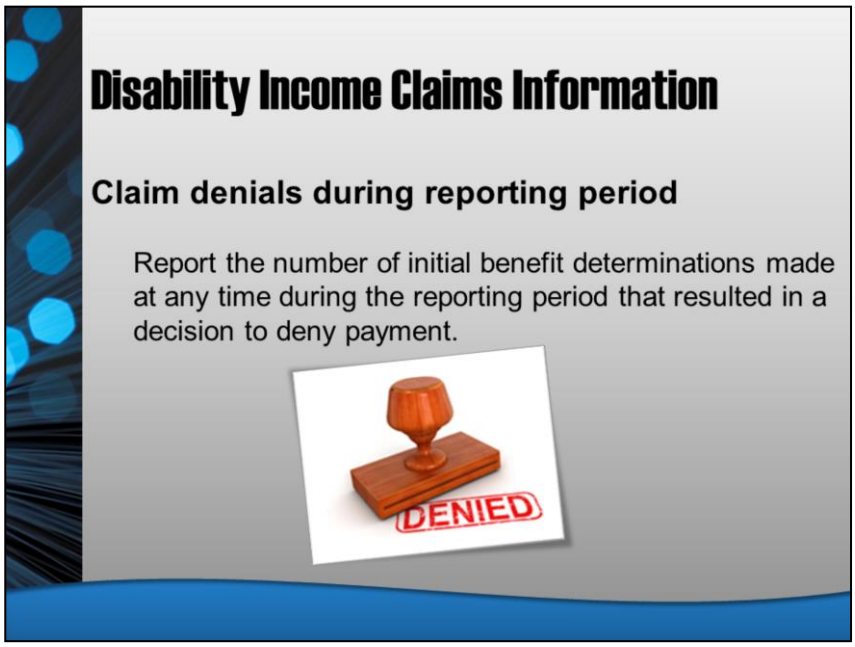
The second line is Active paid claims, beginning of reporting period. This is for the number of claims from the prior reporting period for which payment is continuing to be made at the beginning of the reporting period or January 1st.



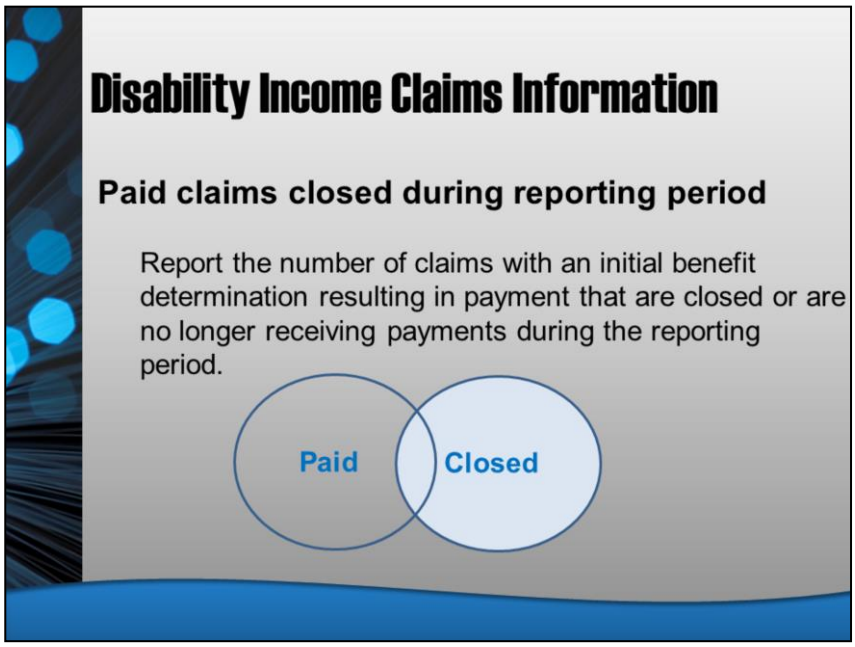
Next is Claims received during reporting period which are the number of new claims received by the reporting entity during the reporting period.



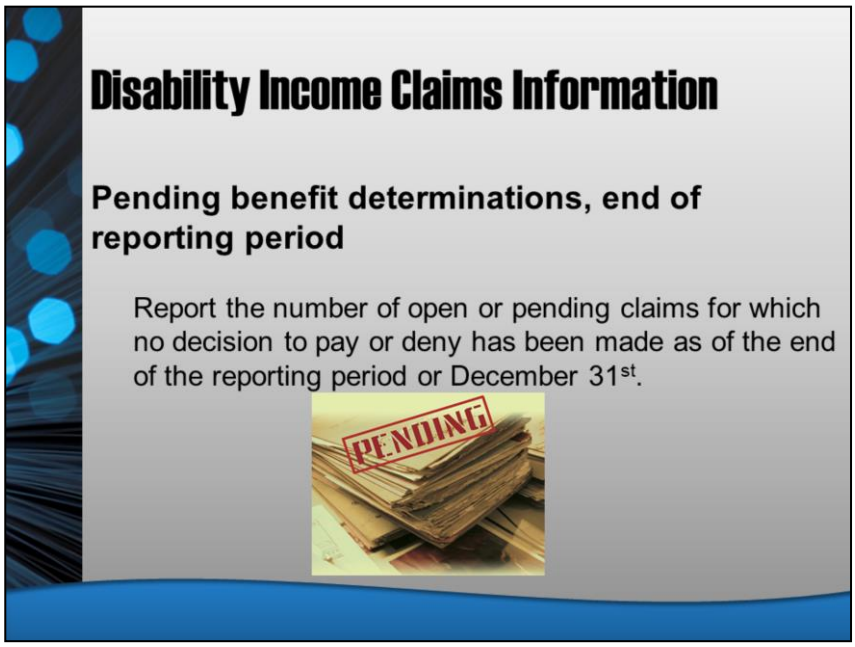
The fourth line in this section is New paid claim determinations during reporting period. This is for the number of claims for which a benefit determination has been made at any time during the reporting period that resulted in a decision to make a payment



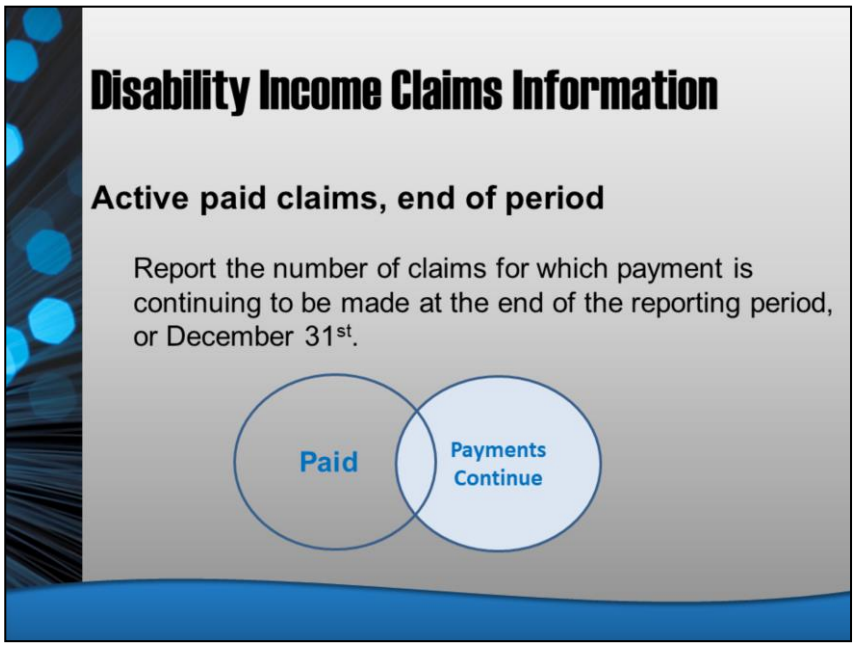
Next you will see the line for Claim denials during reporting period. This is for the number of initial benefit determinations made at any time during the reporting period that resulted in a decision to deny payment.



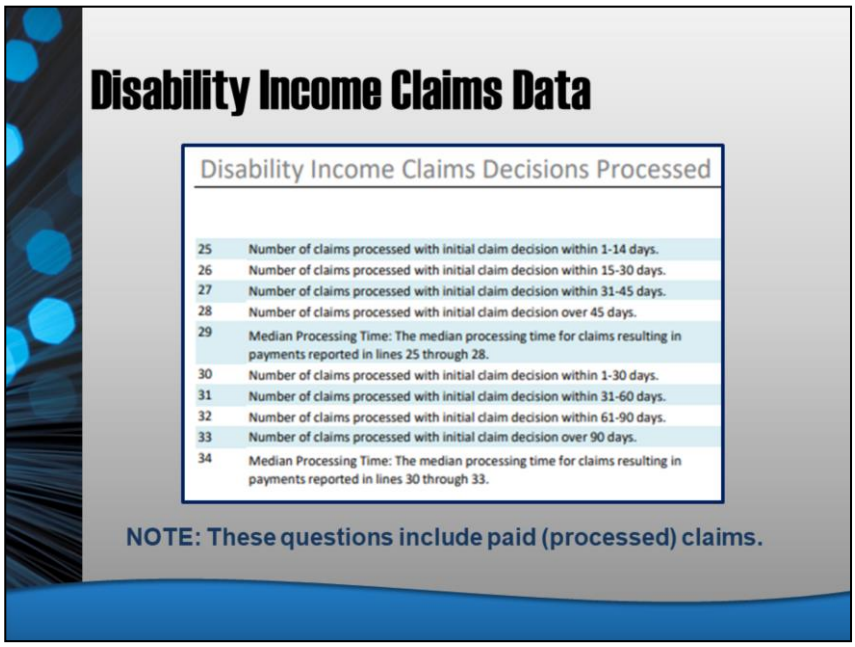
The sixth line is Paid claims closed during reporting period, which are the number of claims with an initial benefit determination resulting in payment that are closed or are no longer receiving payments during the reporting period.



The seventh line is Pending benefit determinations, end of reporting period, which are the number of open or pending claims for which no decision to pay or deny has been made as of the end of the reporting period or December 31st.

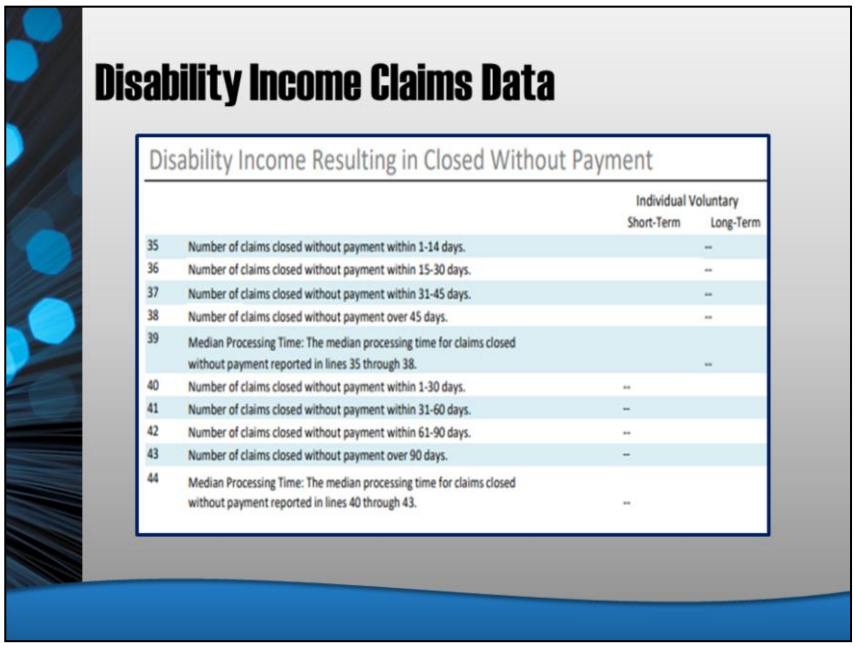


And finally, Active paid claims, end of period, are the number of claims for which payment is continuing to be made at the end of the reporting period, or December 31st.

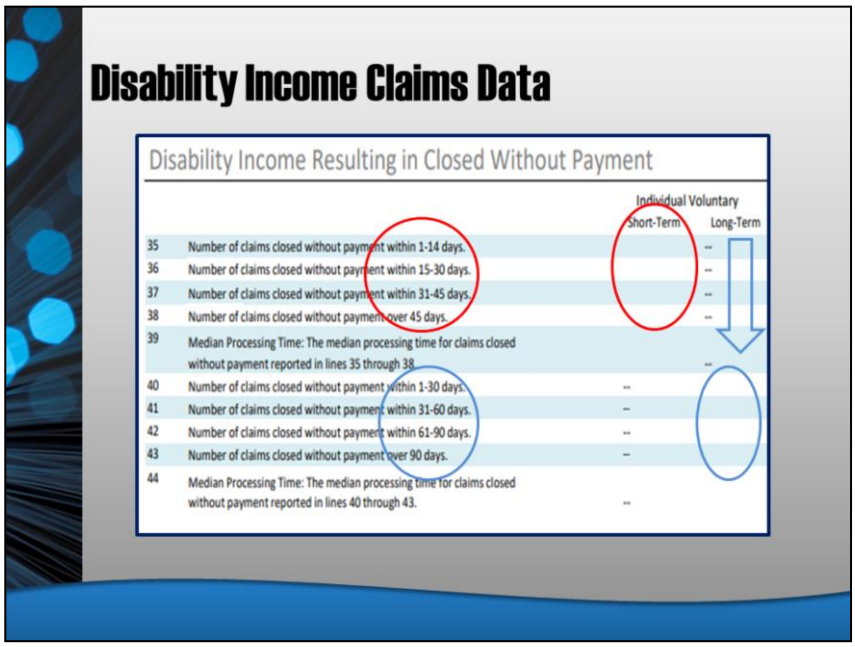


The next set of questions, or schedule 3 in the Disability Income MCAS, asks for information related to the Disability Income Claims Decisions Processed.

For the purposes of the Disability Income MCAS, the term processed means paid.



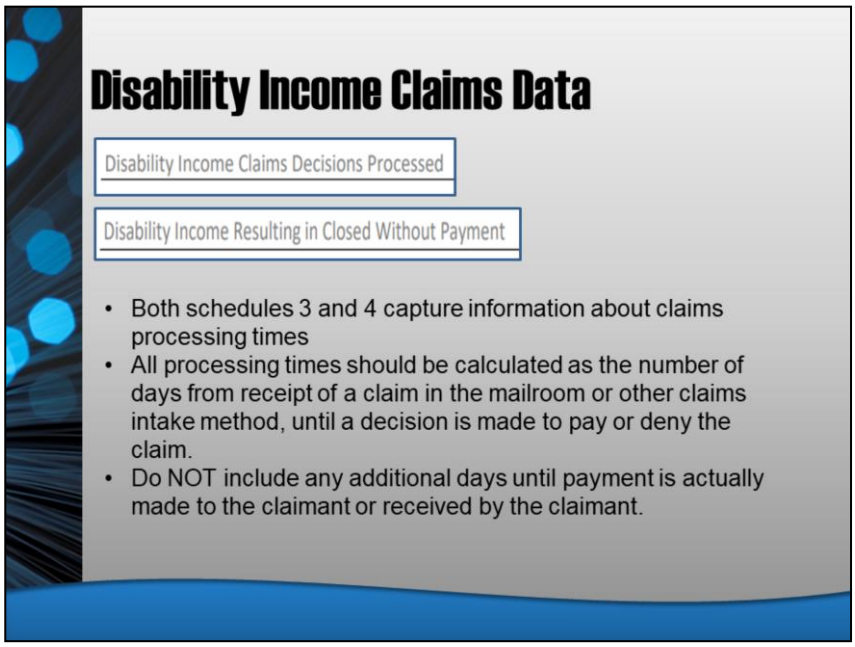
Schedule 4 in the Disability Income MCAS, asks for details for claims resulting in closed without payment.



Please note the different time frames for short-term vs. long-term policies.

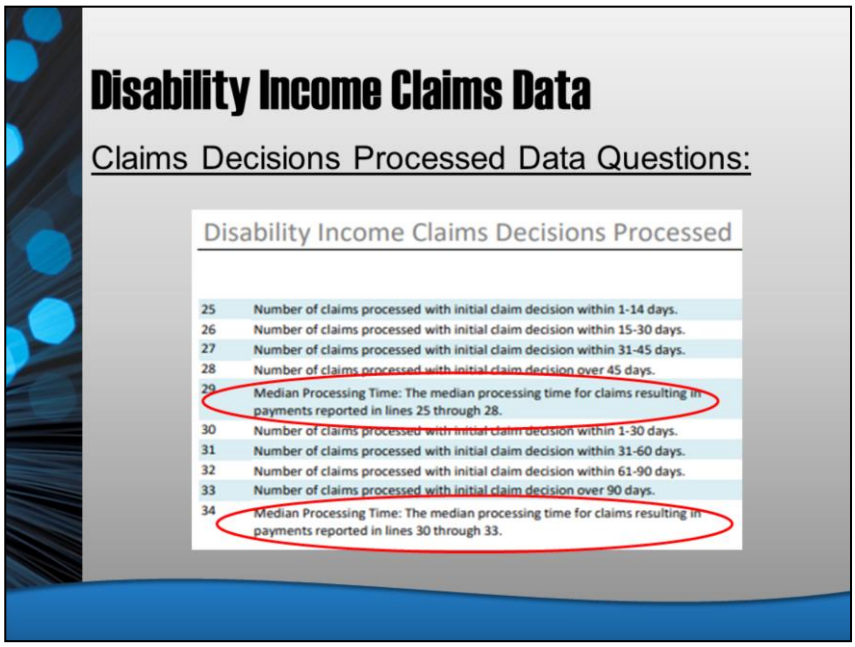
For short-term policies, claims closed without payment are reported within 1-14 days, 15-30 days, 31-45 days and over 45 days.

For long-term policies, claims closed without payment are reported within 1-30 days, 31-60 days, 61-90 days and over 90 days.



The questions for schedules 3 and 4 capture information about claims processing times. All processing times should be calculated as the number of days from the receipt of a claim in the mailroom or other claims intake method, until the decision is made to either pay or deny the claim.

You should not include any additional days until payment is actually made to the claimant or received by the claimant.



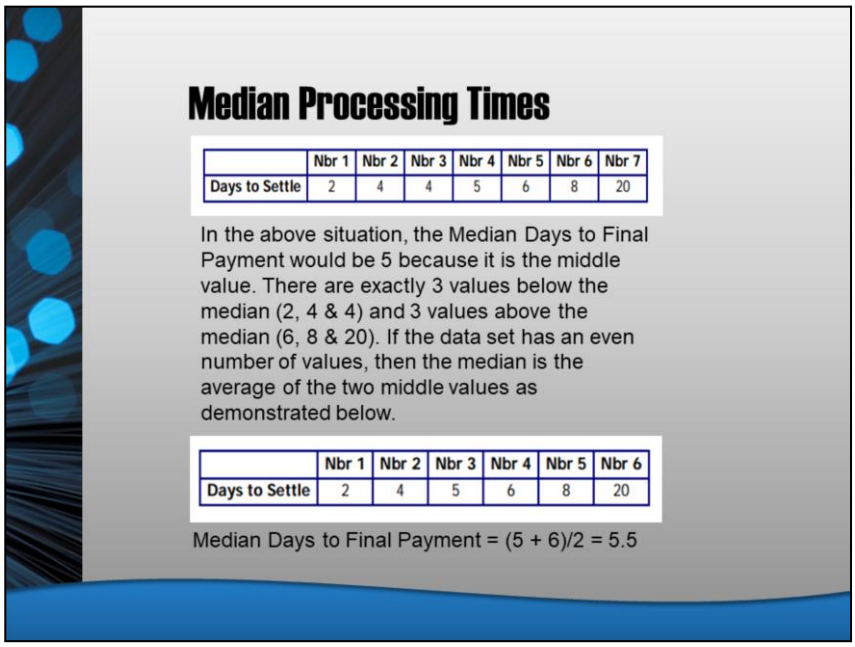
There are two questions in schedules 3 and 4 that are related to the median processing times.

The median reported in line 29 must be derived from the data reported in lines 25-28. This is the same for line 34, which should reflect data in lines 30-33.

The Data Call and Definitions provides a good discussion on what a median is and how to calculate the median number of days. If you are unfamiliar with what a median is, you should review this part of the definitions. Let's take a look at some examples on the next few slides.

Briefly, the median is the value above which, and below which there are an equal number of values. For example, if you have “days to settlement” of 30, 45 and 60, the median is 45 days.

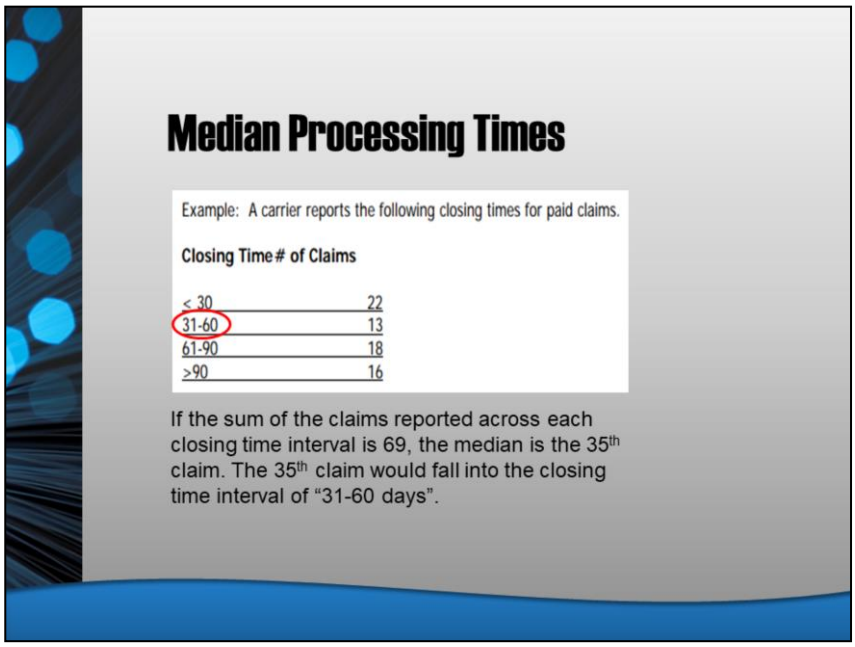
So, to find your median days to settlement, you will need to know the number of days to settlement for each claim closed. Organize them from the most days to the fewest days and find the “days to settlement” value that falls right in the middle of all those values, then enter that amount.



For further illustration, see the 1st data set shown here. 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 has an even number of values, then the median is the average of the two middle values as demonstrated in the 2nd data set.

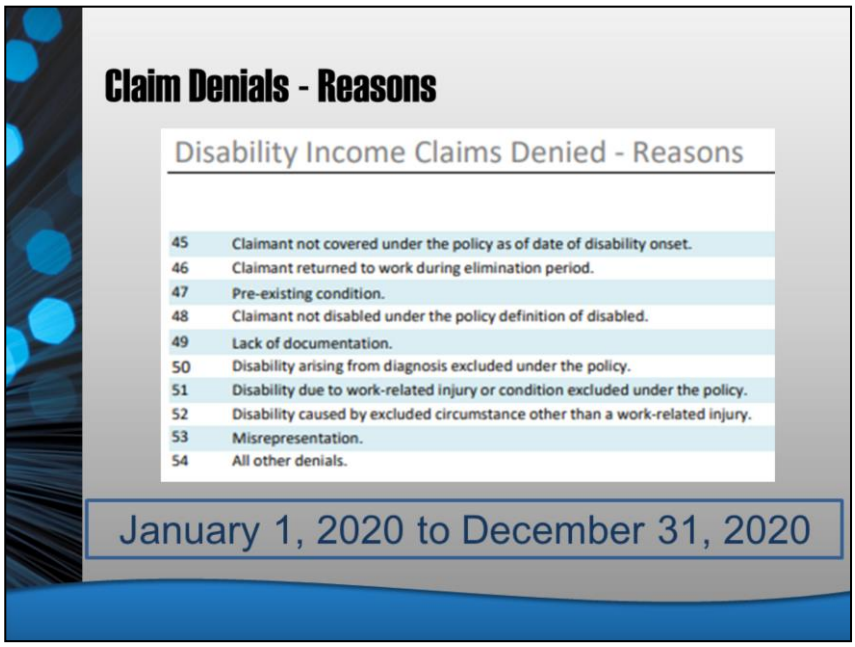


The median should be consistent with the processed claim counts reported in the closing time intervals.

Here's another example: a carrier reports the following closing times for paid claims.

The sum of the claims reported across each closing interval is 69, so that the median is the 35th claim. The claim falls into the closing time interval "31-60 days".

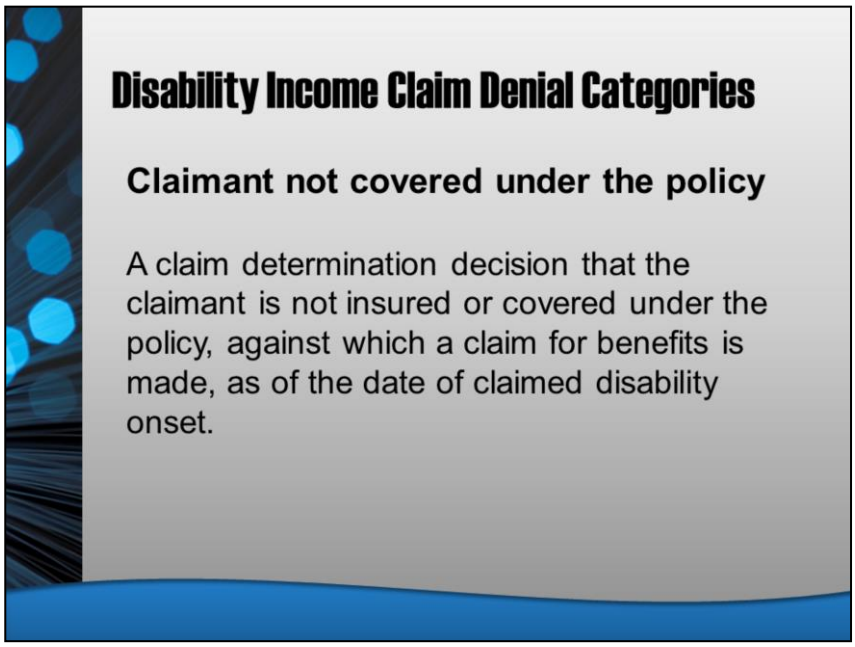
Any reported median that falls outside of this range (i.e. less than 31 or greater than 60) will indicate a data validation failure.



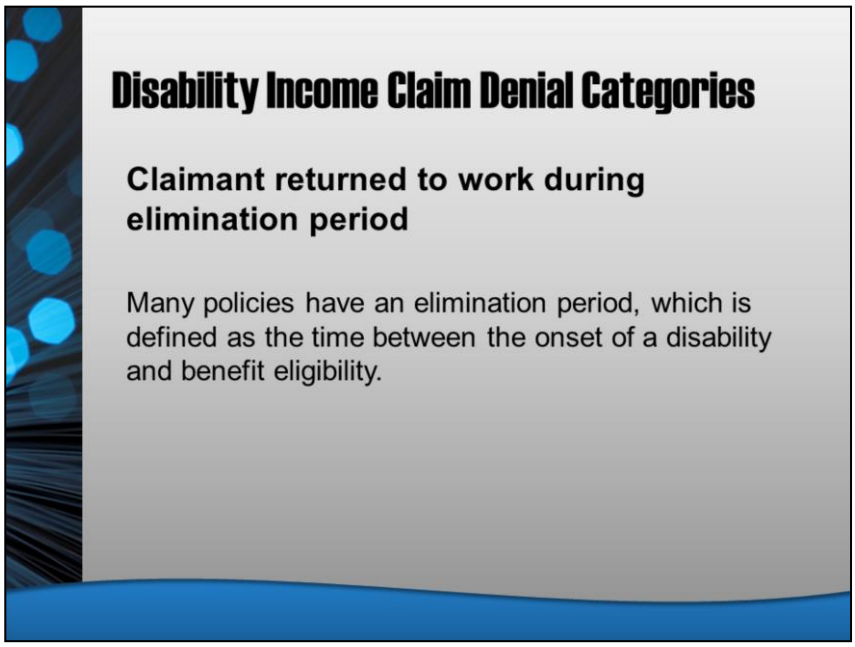
The next set of data questions seeks information on the reasons for claim denials. This is schedule 5 of the Disability Income MCAS.

The ten categories provided here are mutually exclusive and can only be reported in one and only one category.

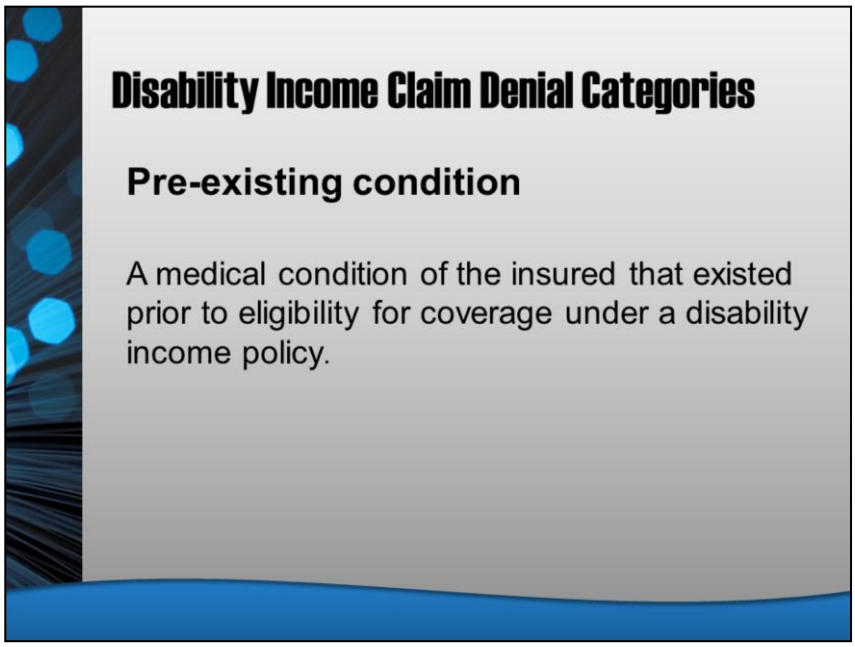
Let's take a closer look at these categories on the following slides.



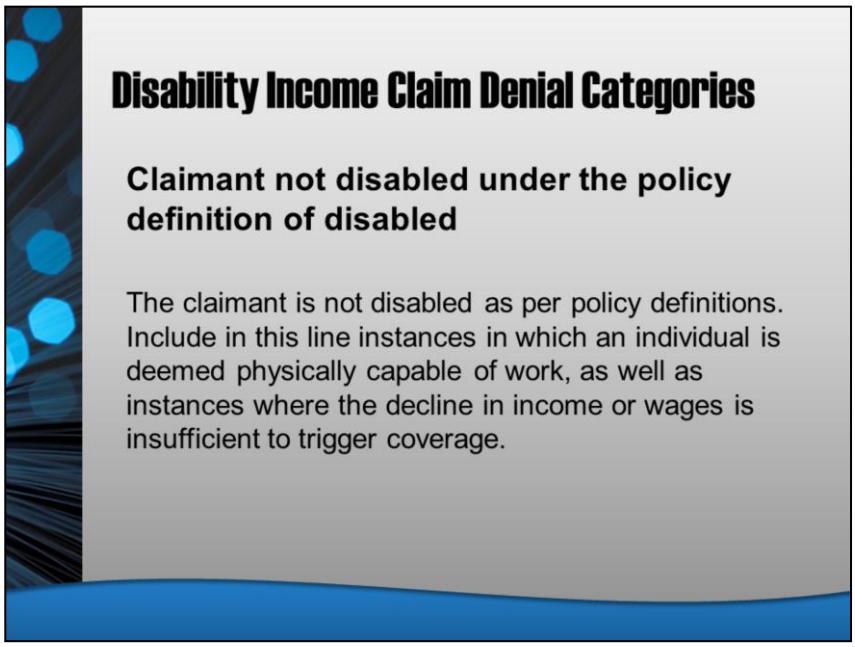
The first category for claim denial reasons is Claimant not covered under the policy. This is a claim determination decision that the claimant is not insured or covered under the policy, against which a claim for benefits is made, as of the date of claimed disability onset.



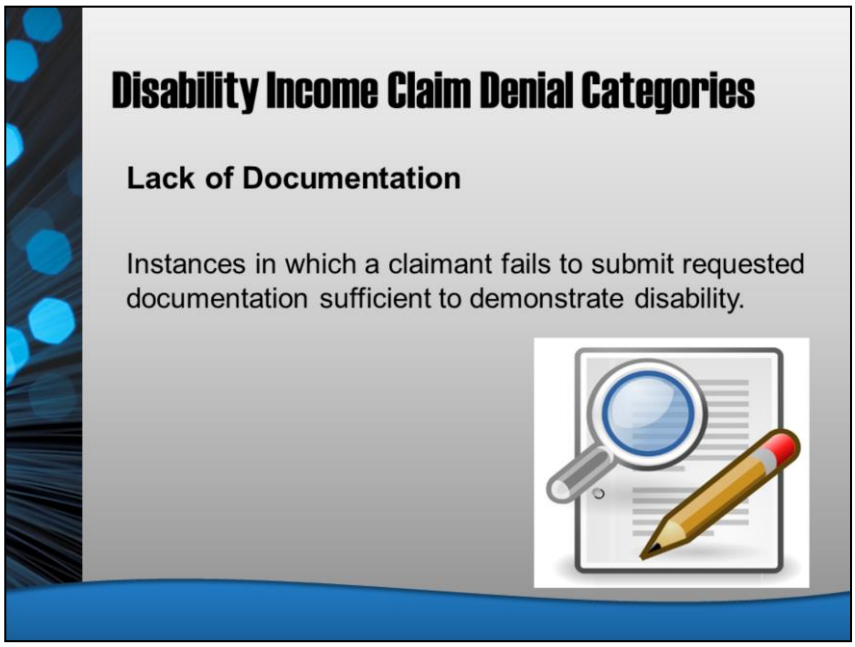
The next category is claimant returned to work during elimination period. Many policies have an elimination period, which is defined as the time between the onset of a disability and benefit eligibility.



The third category is Pre-existing condition, which is a medical condition of the insured that existed prior to eligibility for coverage under a disability income policy.

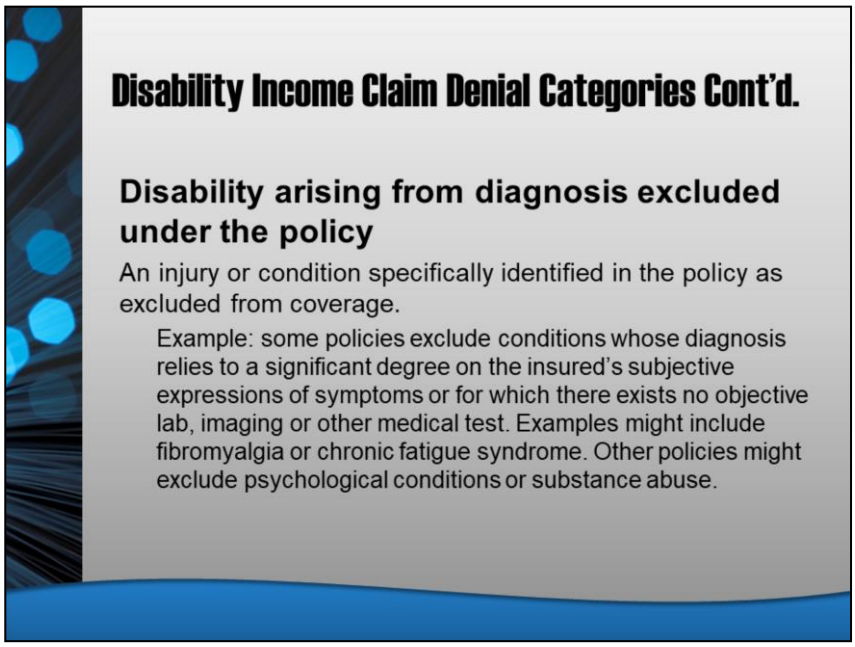


The next one you will see is Claimant not disabled under the policy definition of disabled. This line includes instances in which an individual is deemed physically capable of work, as well as instances where the decline in income or wages is insufficient to trigger coverage.

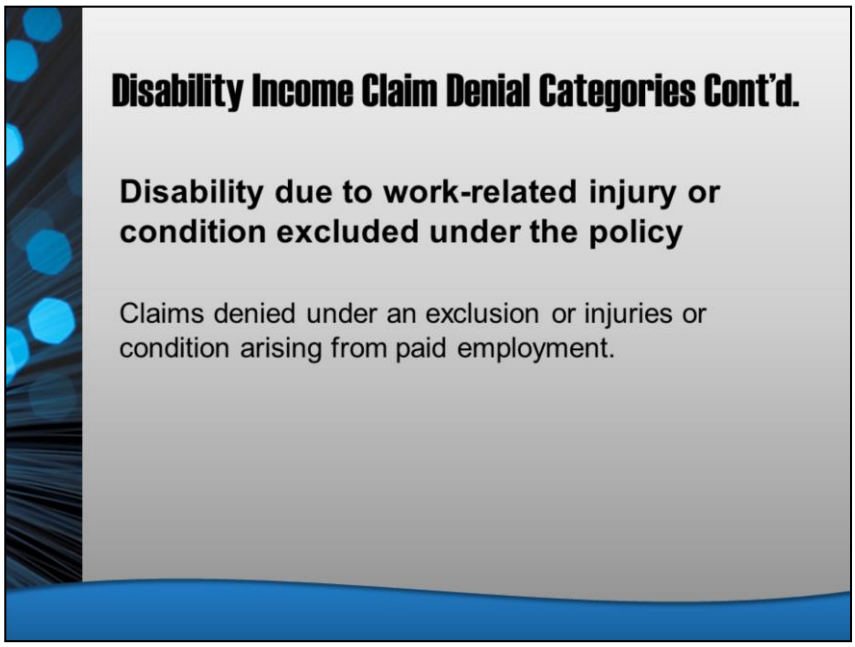


The fifth category is lack of documentation, which is when a claimant fails to submit requested documentation to sufficiently demonstrate disability.

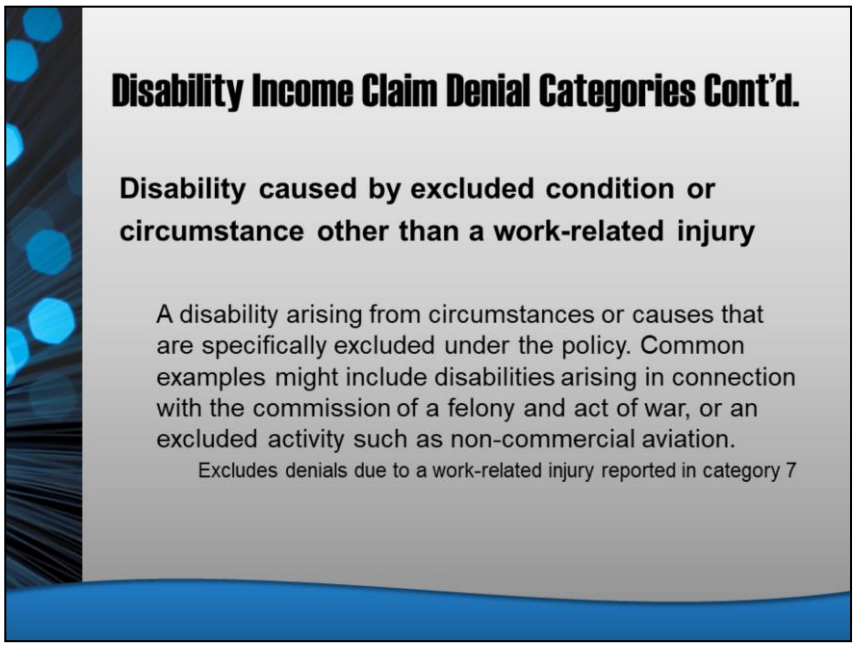
This category excludes cases where requested documentation has been submitted but still fails to establish sufficient evidence of a disability.



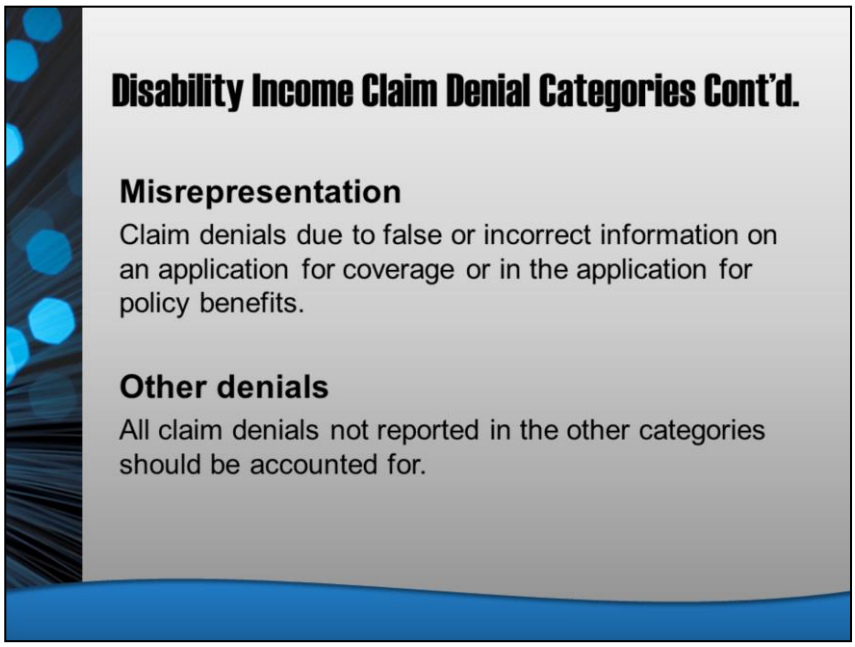
Next is disability arising from diagnosis excluded under the policy, which is for an injury or condition specifically identified in the policy as excluded from coverage. For example, some policies exclude conditions whose diagnosis relies to a significant degree on the insured's subjective expressions of symptoms or for which there exists no objective lab, imaging or other medical test. Examples might include fibromyalgia or chronic fatigue syndrome. Other policies might exclude psychological conditions or substance abuse.



The 7th category is Disability due to work-related injury or condition excluded under the policy. This includes claims denied under an exclusion or injuries or condition arising from paid employment.

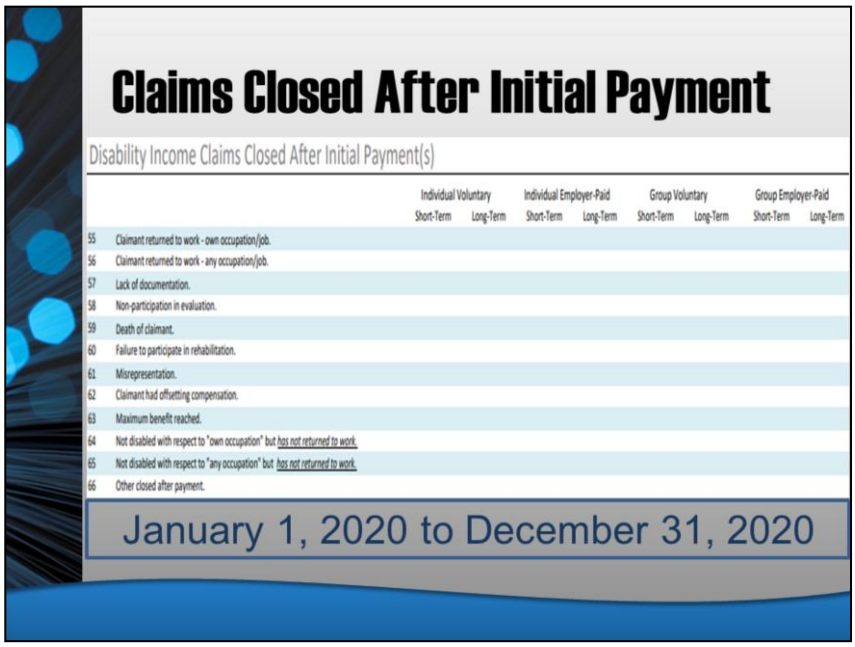


The 8th category is Disability caused by excluded condition or circumstance other than a work-related injury. This is for disability arising from circumstances or causes that are specifically excluded under the policy. Common examples might include disabilities arising in connection with the commission of a felony and act of war, or an excluded activity such as non-commercial aviation. This category excludes denials due to a work-related injury reported in category 7.



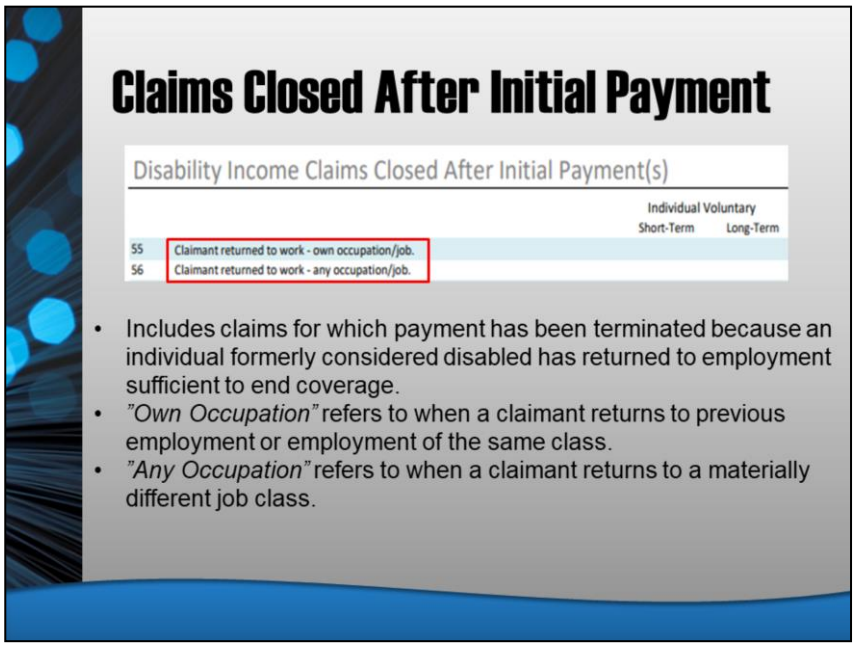
The 9th category is misrepresentation which is for claim denials due to false or incorrect information on an application for coverage or in the application for policy benefits.

And finally, the 10th category is for other denials. This is where claim denials not reported in the other categories should be accounted for.



The next schedule collects information on claims closed, after initial payment at any time during the reporting period, regardless of the reporting year in which they were received.

As with the previous section of data questions, these categories are intended to be mutually exclusive, such that a claim should be reported in one and only one category.



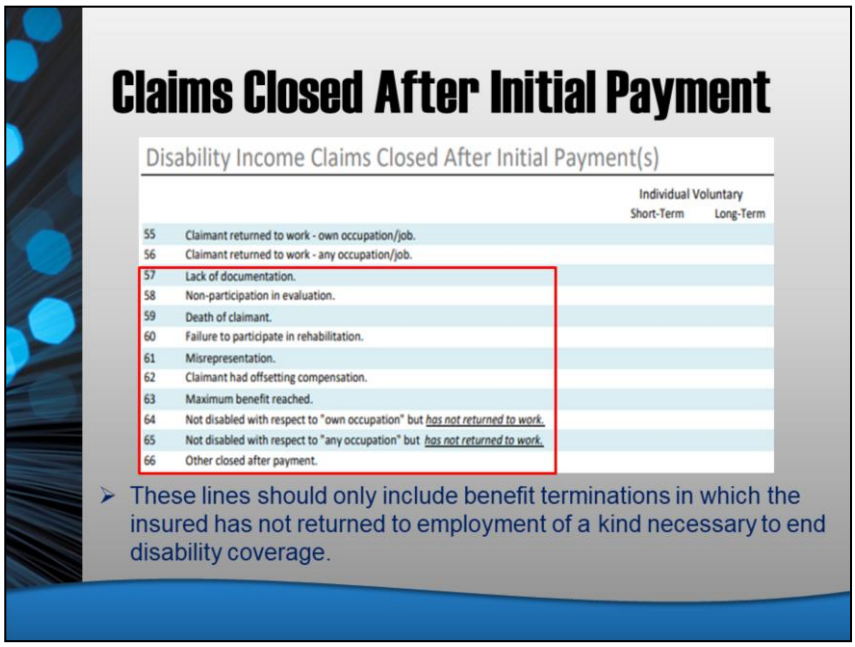
The first two lines in this section are claimant returned to work – own occupation or job, and claimant returned to work any occupation or job.

These lines should include claims for which payment has been terminated because an individual formerly considered disabled has returned to employment sufficient

to end coverage.

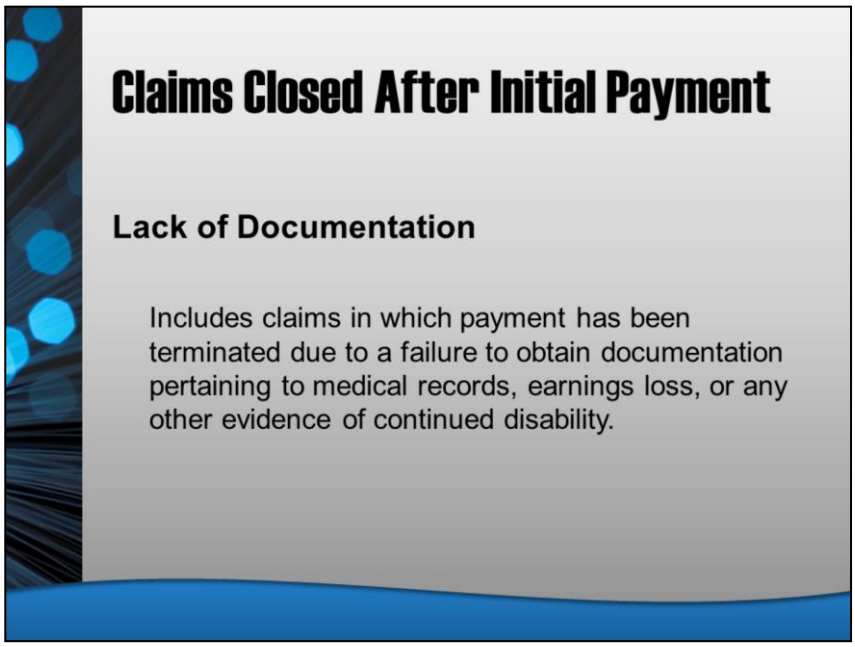
Own occupation or job refers to those instances where a claimant returns to previous employment or employment of the same class as is defined in the policy, which is usually under an “own occupation” definition of disability.

The any occupation or job line should include those instances in which a claimant returns to work, but a materially different job class, which is usually defined in “any occupation” definition of disability.

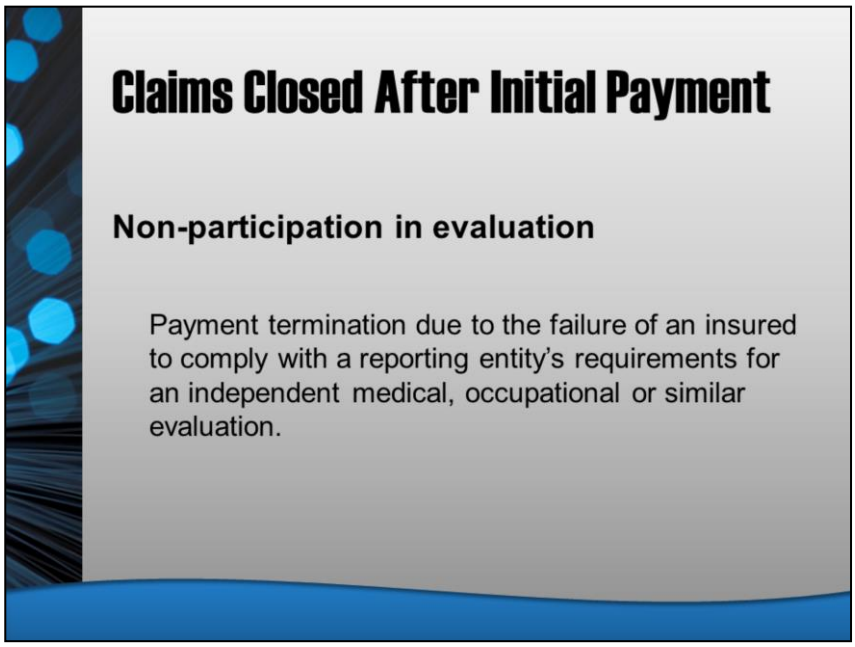


The remaining lines in this section should only include benefit terminations under conditions in which the insured has not returned to employment of a kind necessary to end disability coverage.

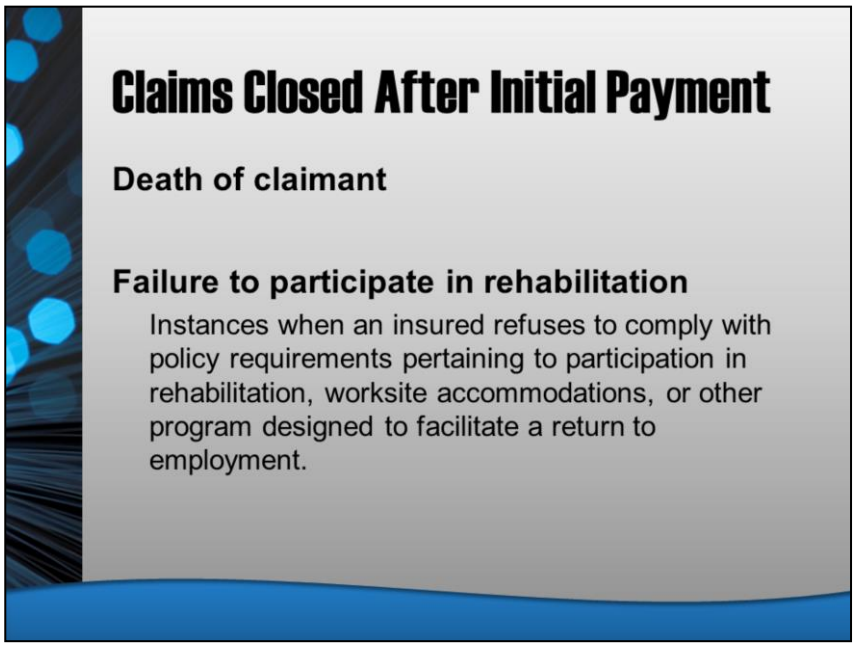
We will review these lines in more detail on the following slides.



Lack of documentation includes claims in which payment has been terminated due to a failure to obtain documentation pertaining to medical records, earnings loss, or any other evidence of continued disability.

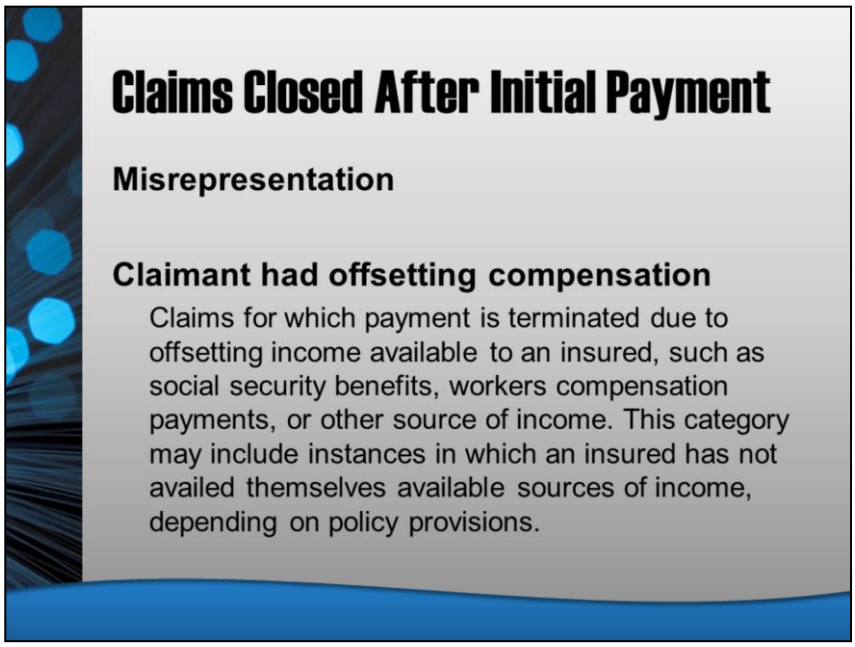


Non-participation in evaluation is when there is payment termination due to the failure of an insured to comply with a reporting entity's requirements for an independent medical, occupational or similar evaluation.



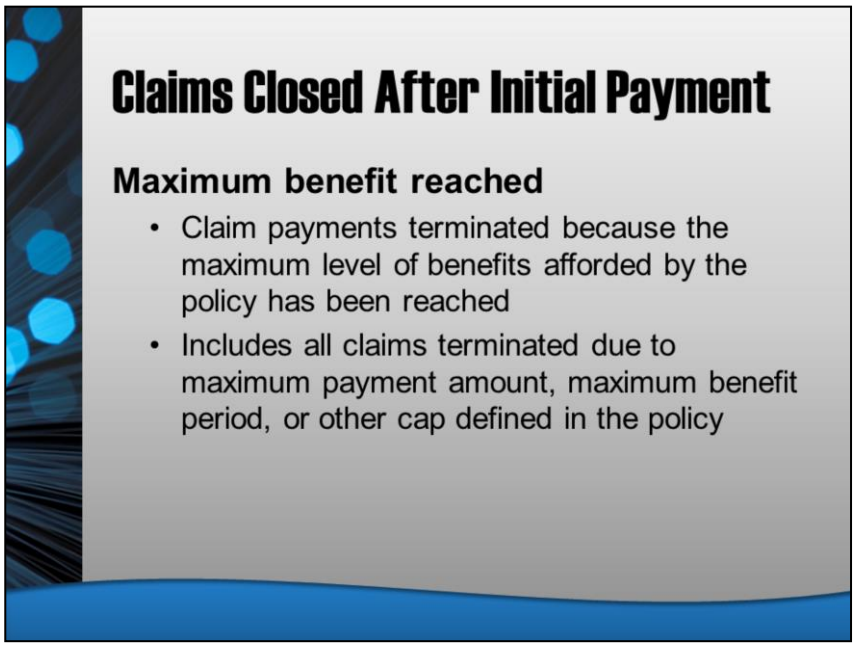
The next line is for payment termination due to the death of a claimant.

Failure to participate in rehabilitation is for those instances when an insured refuses to comply with policy requirements pertaining to participation in rehabilitation, worksite accommodations, or other program designed to facilitate a return to employment.

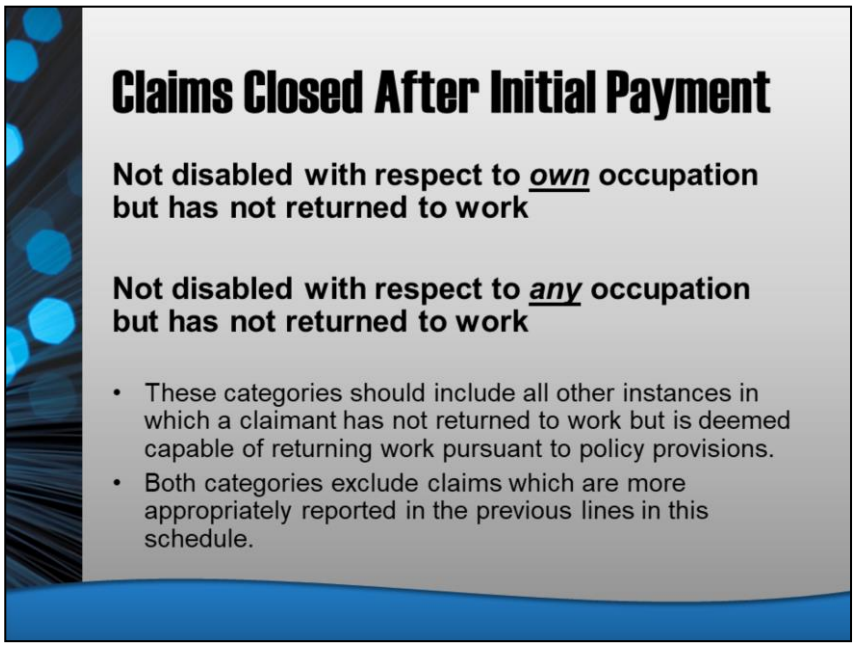


As in schedule 5, there is also a line here for Misrepresentation.

The next line in this section accounts for claims in which payment is terminated due to offsetting income available to an insured, such as social security benefits, workers compensation payments, or other source of income. This category may include instances in which an insured has not availed themselves available sources of income, depending on policy provisions.



Maximum benefit reached is for claim payments terminated because the maximum level of benefits afforded by the policy has been reached. This includes all claims terminated due to maximum payment amount, maximum benefit period, or other cap defined in the policy.

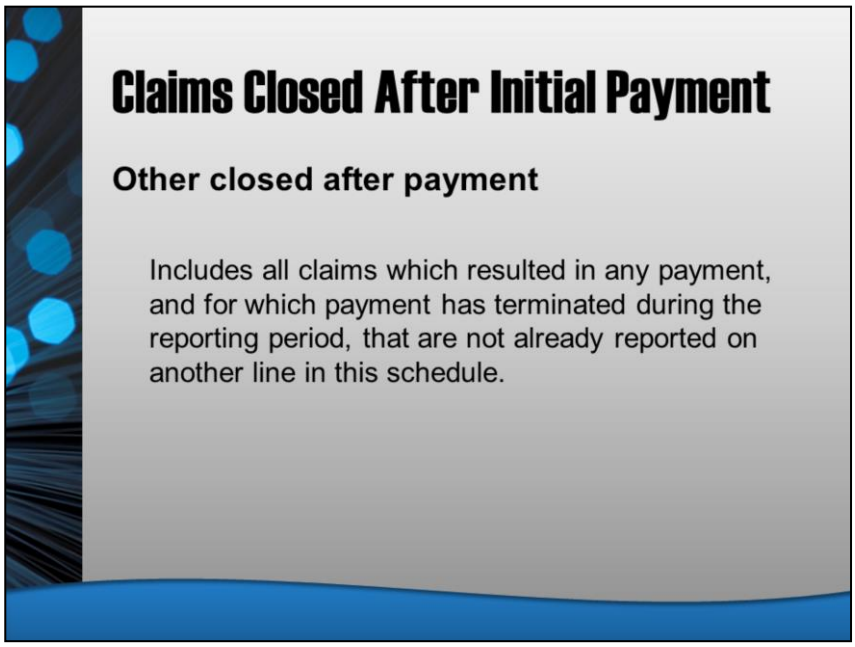


The next two lines are for Not disabled with respect to own occupation but has not returned to work, and;

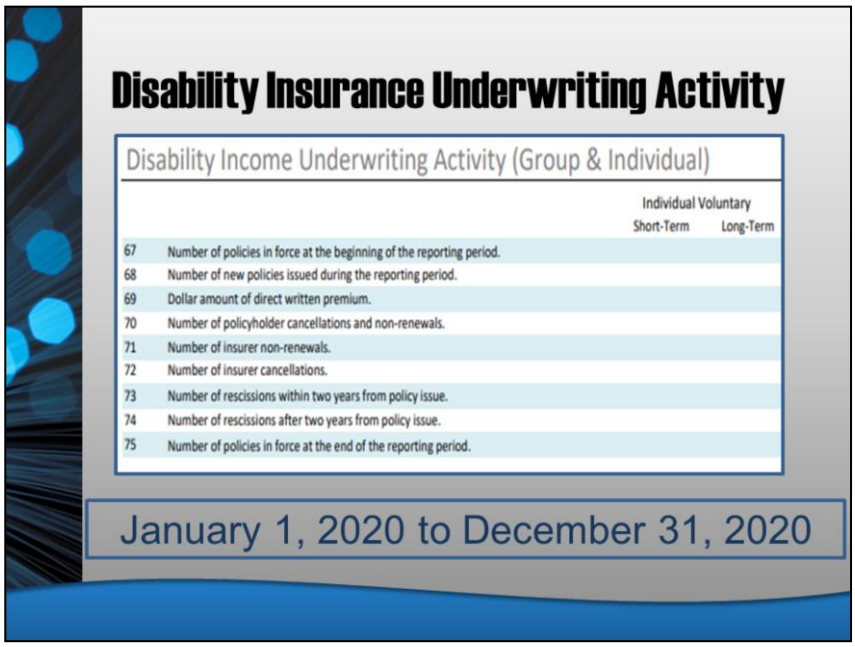
Not disabled with respect to any occupation but has not returned to work.

These two categories should include all other instances in which a claimant has not returned to work but is deemed capable of returning work pursuant to policy provisions. These categories also exclude claims which are more appropriately reported in the previous lines in this schedule.

The definitions for own occupation and any occupation are the same as previously discussed.

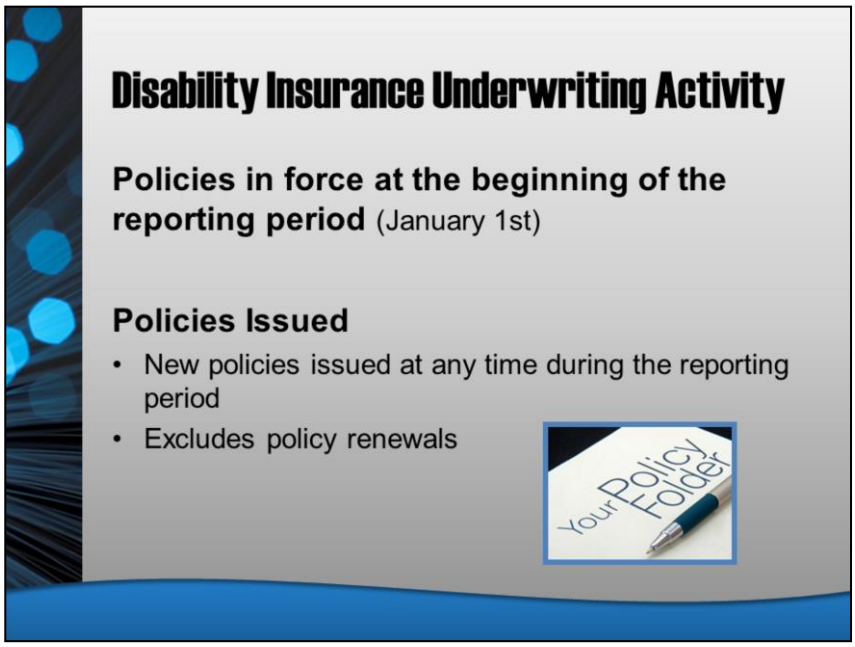


The final category in this section is Other closed after payment. This includes all claims which resulted in any payment, and for which payment has terminated during the reporting period, that are not already reported on another line in this schedule.

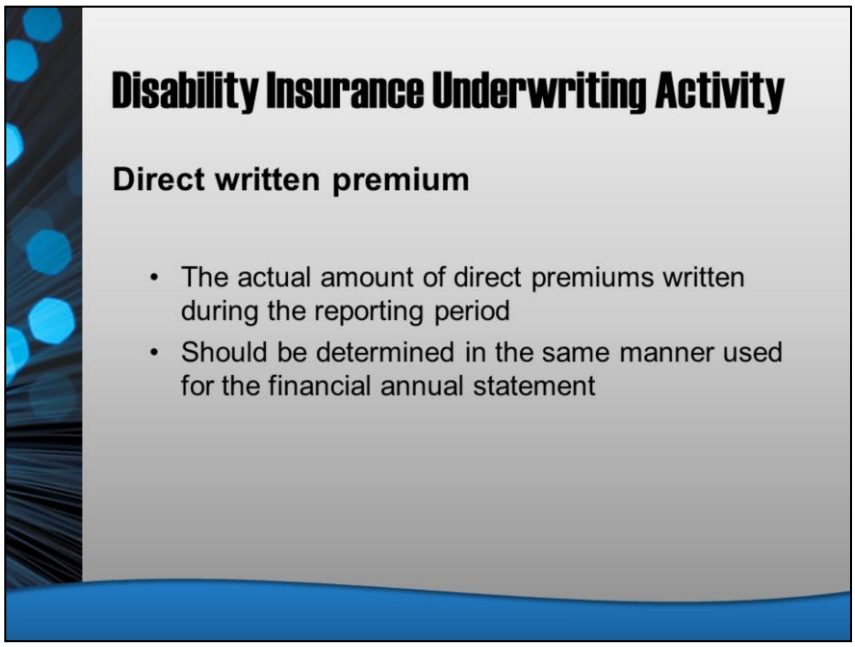


The next schedule we will review is Underwriting Activity, for both Group and Individual Disability Income. There are a total of nine lines in this section, and each definition for these lines refers to the number of policies in force.

We will review the details of these lines on the following slides.



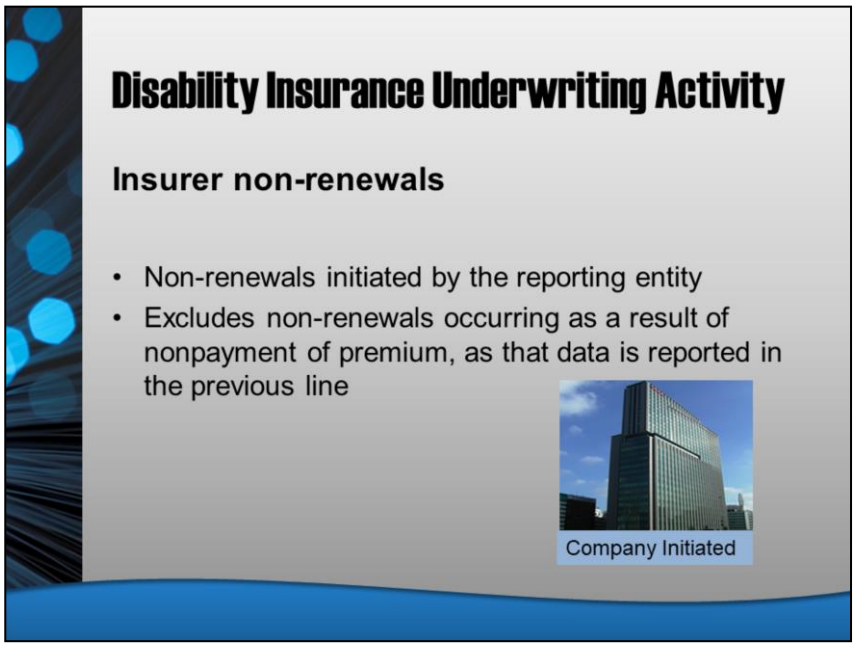
The first two lines in the underwriting section are for the number of policies in force at the beginning of the reporting period, or January 1st, and the number of Policies Issued. The number of policies issued are new policies issued at any time during the reporting period and excludes policy renewals.



The third line is where the dollar amount of Direct written premium is reported.

This is 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.

The next line is Policyholder cancellations and non-renewals, which are policies cancelled or non-renewed at any point during the reporting at the request of, or in response to the policyholder. This includes policies terminated for nonpayment of premium.

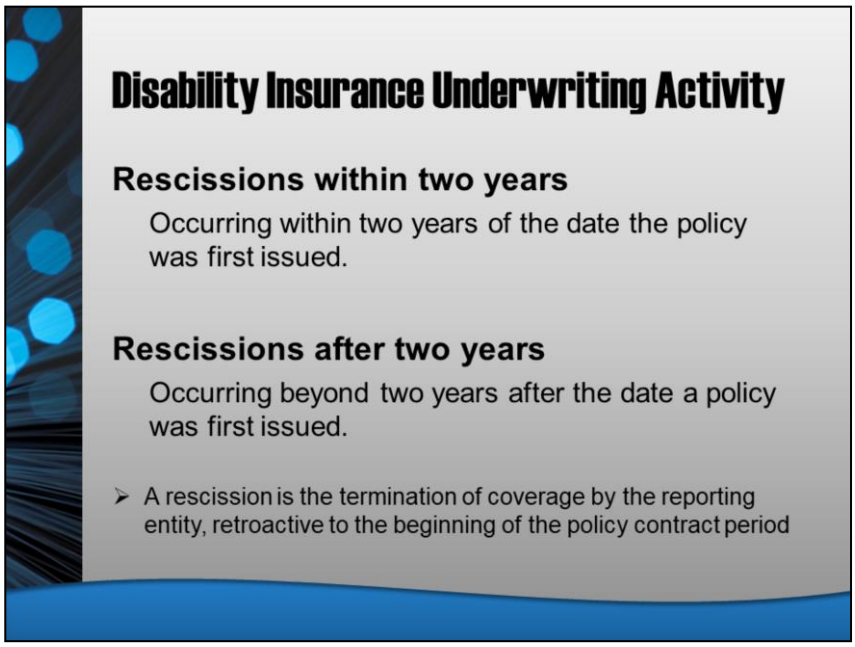


The 5th line is for Insurer non-renewals, which are non-renewals initiated by the reporting entity.

A non-renewal is the termination of coverage at the end of the policy contract period.

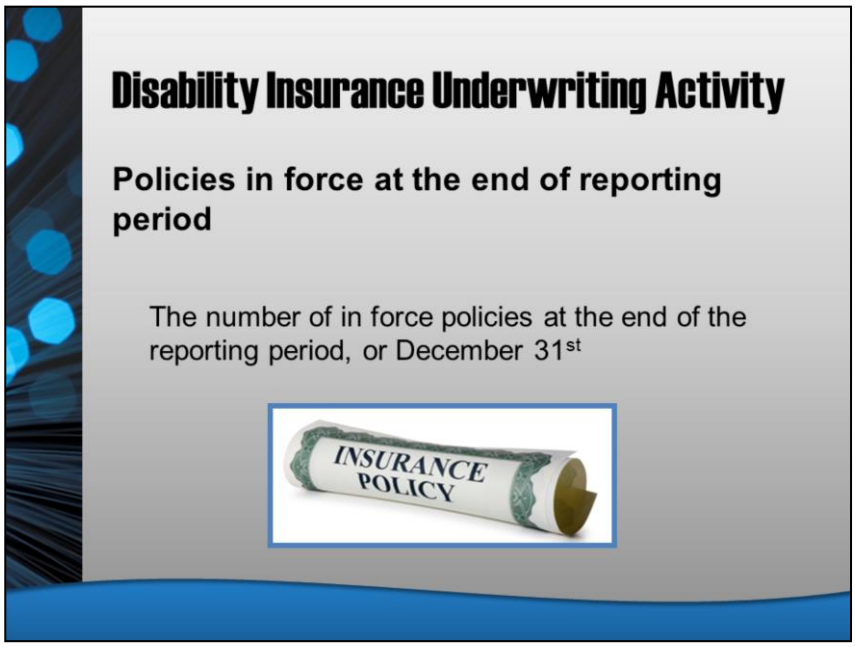
This excludes non-renewals occurring as a result of nonpayment of premium, as that data is reported in the previous line for policyholder cancellations and non-renewals.

The next line is for Insurer cancellations. A cancellation is the termination of an in-force policy during the policy contract period. This line excludes cancellations resulting from nonpayment of premium, as again, that data is reported under policyholder cancellations and non-renewals.



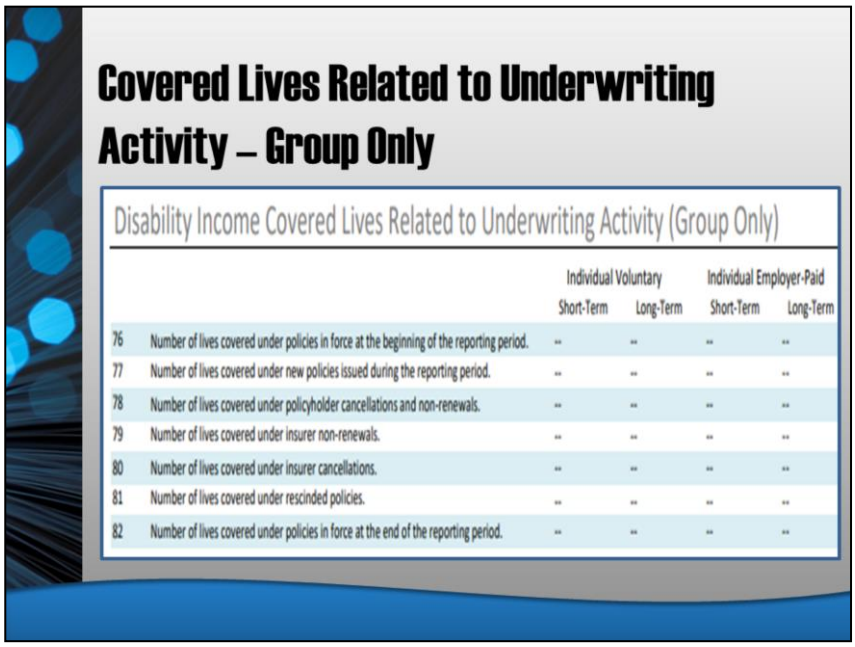
The next two lines are for Rescissions within two years and Rescissions after two years.

A rescission is the termination of coverage by the reporting entity, retroactive to the beginning of the policy contract period.



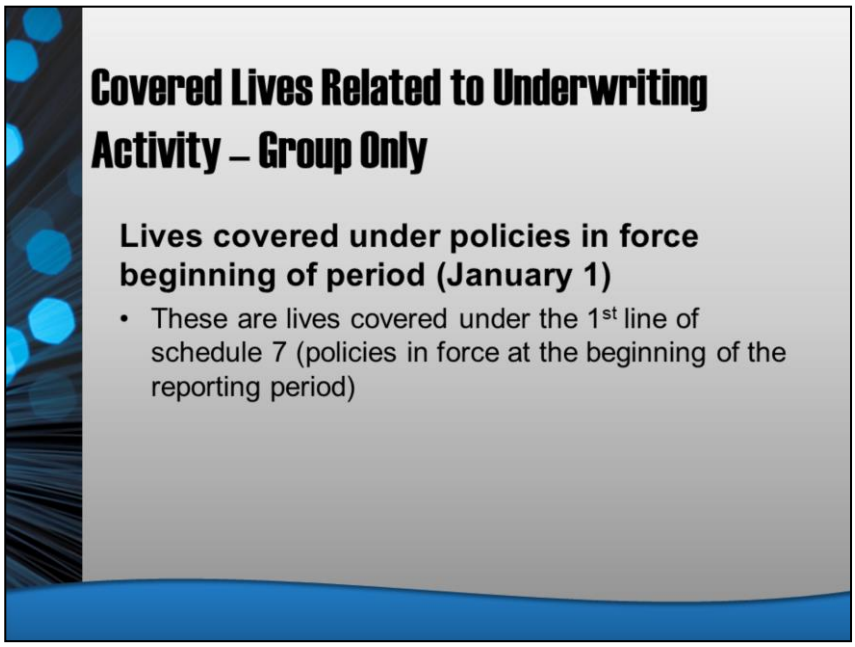
And lastly, the final line for this schedule is Policies in force at the end of reporting period.

This line is for the number of in force policies at the end of the reporting period, or December 31st.



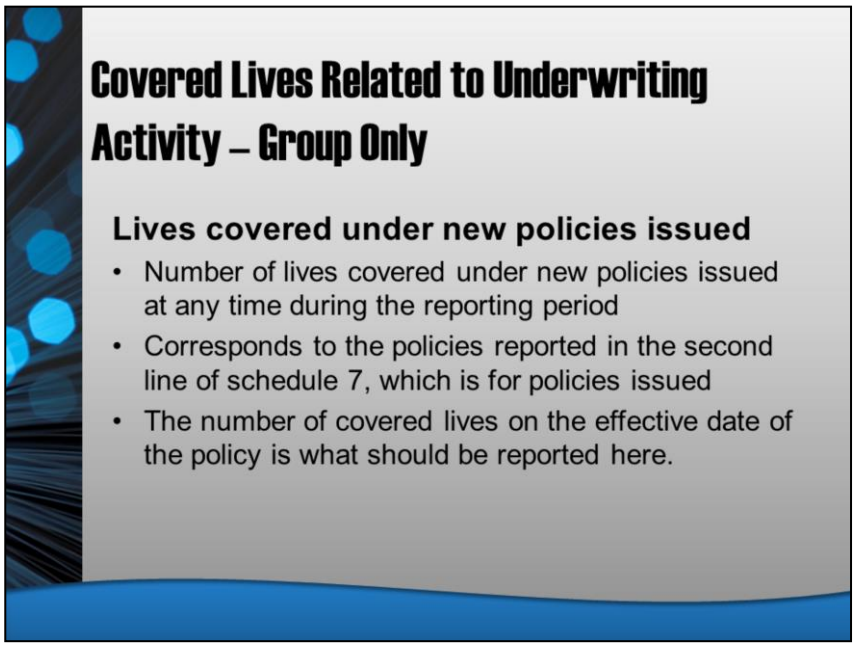
The next section of the Disability Income MCAS is Schedule 8, which captures information on covered lives related to underwriting activity for group disability income only.

There are seven lines in this section, and we will discuss them on the following slides.

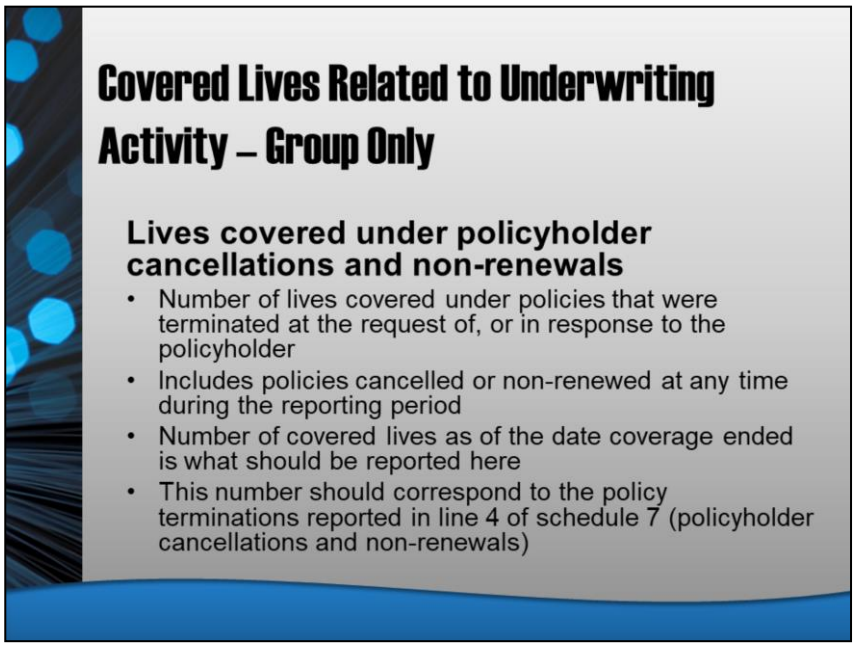


The first line in this section is for the number of lives covered under polices in force at the beginning of the reporting period, or January 1st.

These are lives covered under the policies reported in the first line of schedule 7, which is policies in force at the beginning of reporting period.

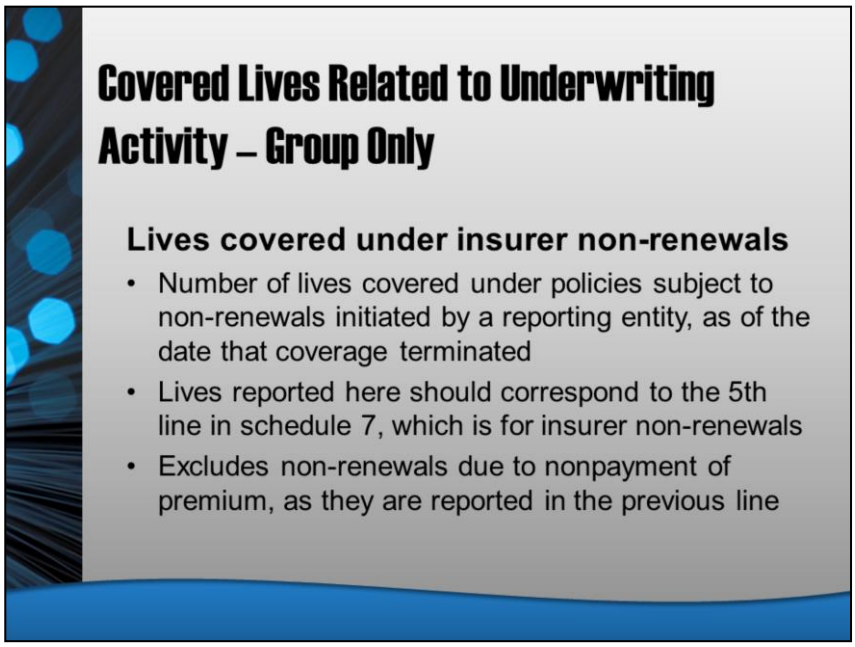


The second line is for the number of lives covered under new policies issued at any time during the reporting period, corresponding to the policies reported in the second line of schedule 7, which is for policies issued. The number of covered lives on the effective date of the policy is what should be reported here.



The third line is for the number of lives covered under policies that were terminated at the request of, or in response to the policyholder. This includes policies cancelled or non-renewed at any time during the reporting period.

The number of covered lives as of the date coverage ended is what should be reported here, and this number should correspond to the policy terminations reported in line 4 of schedule 7, which is for policyholder cancellations and non-renewals.

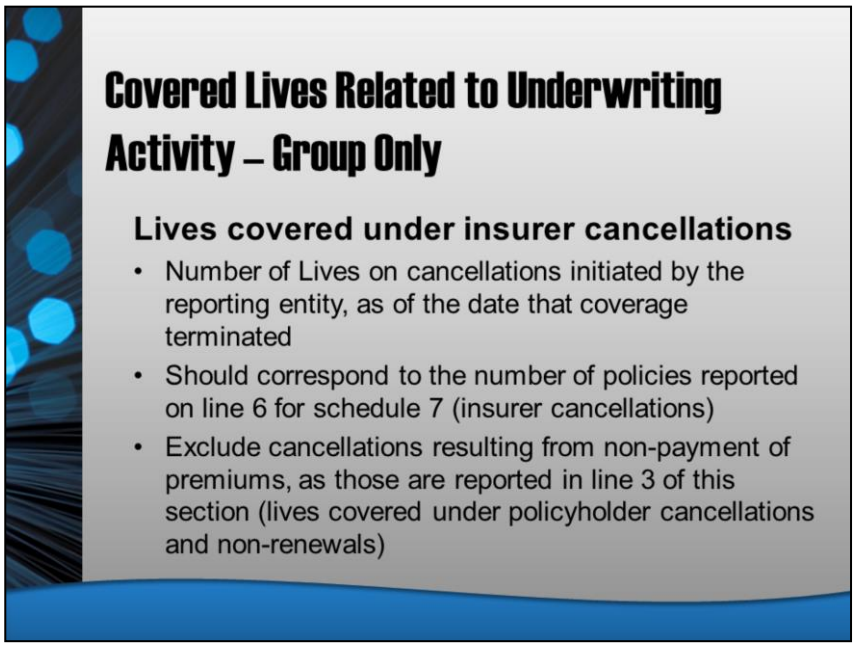


The fourth line is for the number of lives covered under policies subject to non-renewals initiated by a reporting entity, as of the date that coverage terminated.

A non-renewal is the termination of coverage at the end of the policy contract period.

The lives reported here should correspond to the fifth line in schedule 7, which is for insurer non-renewals.

Non-renewals resulting from a nonpayment of premium are excluded from this line, as they are reported in line 3 of this section, which was discussed on the last slide.

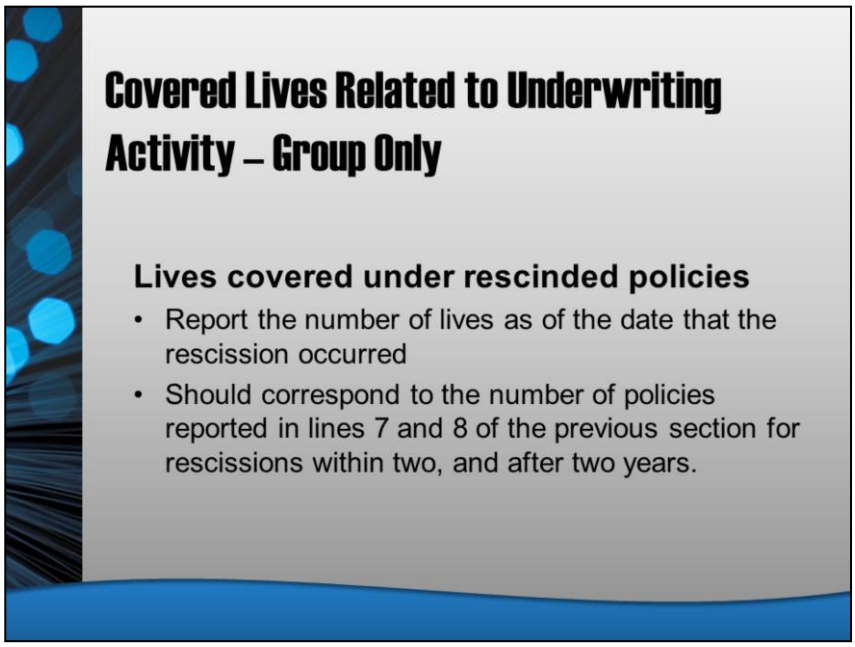


The fifth line in this section is for the number of Lives covered on cancellations initiated by the reporting entity, as of the date that coverage terminated.

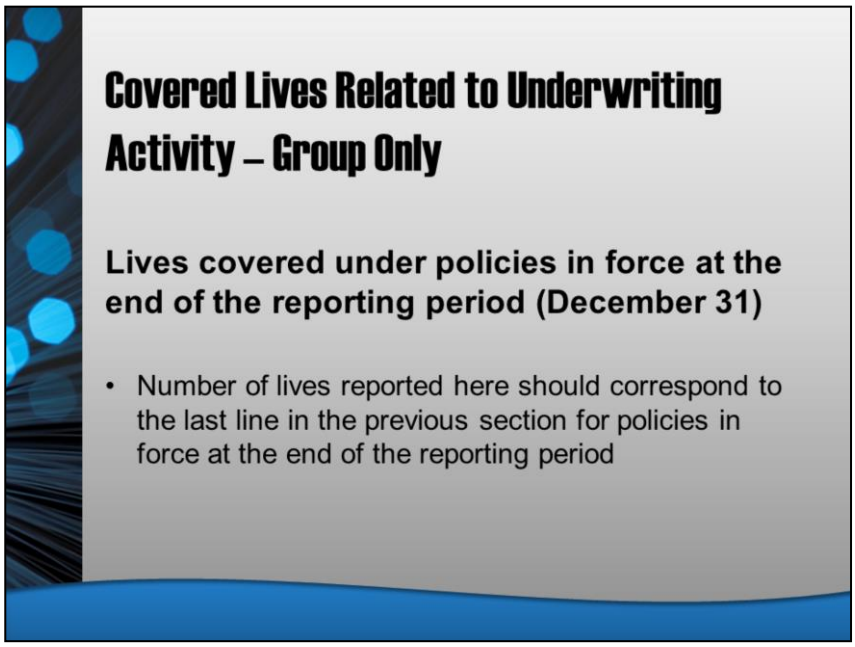
A cancellation is the termination of an in-force policy during the policy contract period.

The number of lives reported here should correspond to the number of policies reported on line 6 for schedule 7, which is insurer cancellations.

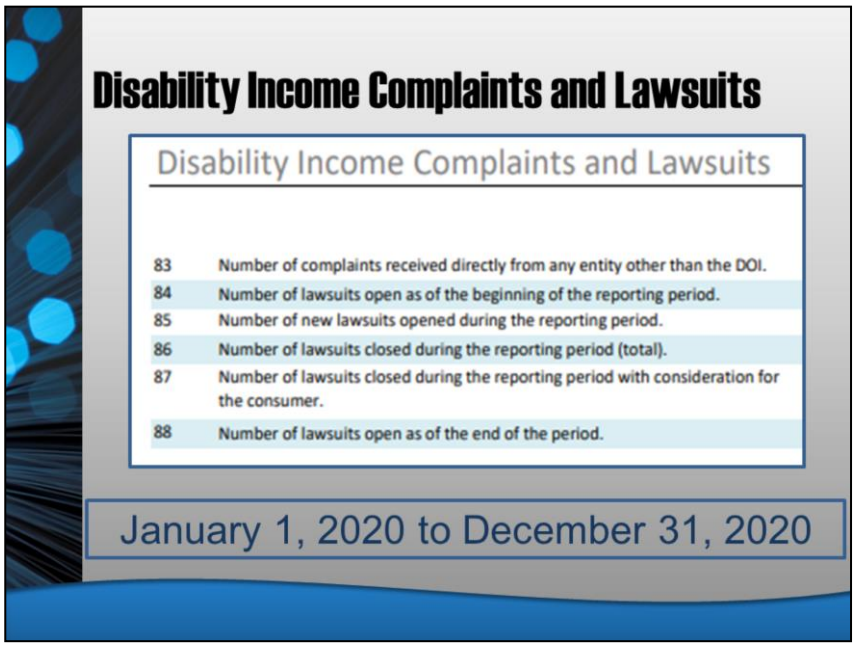
Cancellations resulting from non-payment of premiums should be excluded, as those are reported in line 3 of this section, lives covered under policyholder cancellations and non-renewals.



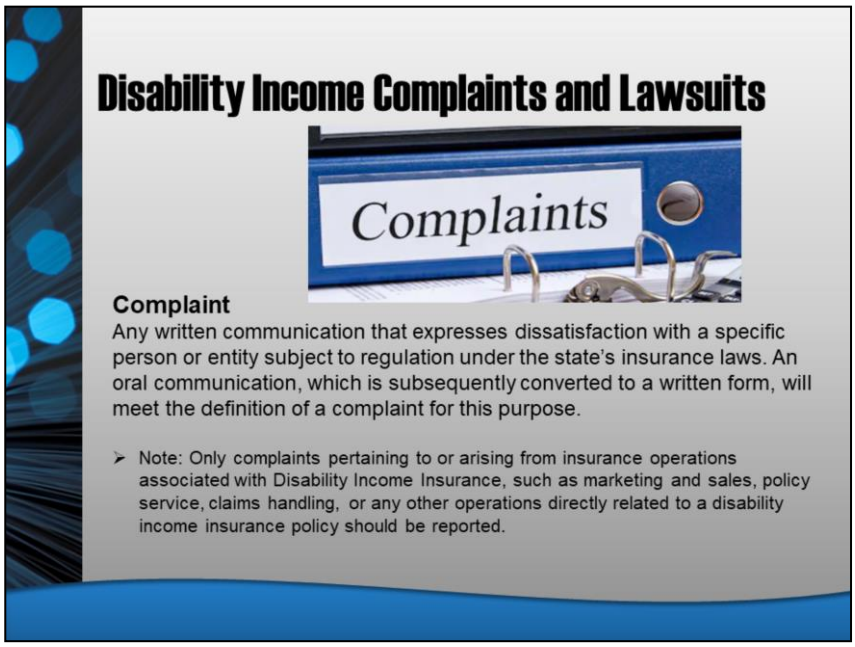
The 6th line for this section is for lives covered under rescinded policies. The number of lives reported here should be as of the date that the rescission occurred and should also correspond to the number of policies reported in lines 7 and 8 of the previous section for rescissions within two, and after two years.



The last line of this section is for the number of lives covered by policies in force at the end of the reporting period, or December 31st. The number of lives reported here should correspond to the last line in the previous section for policies in force at the end of the reporting period.

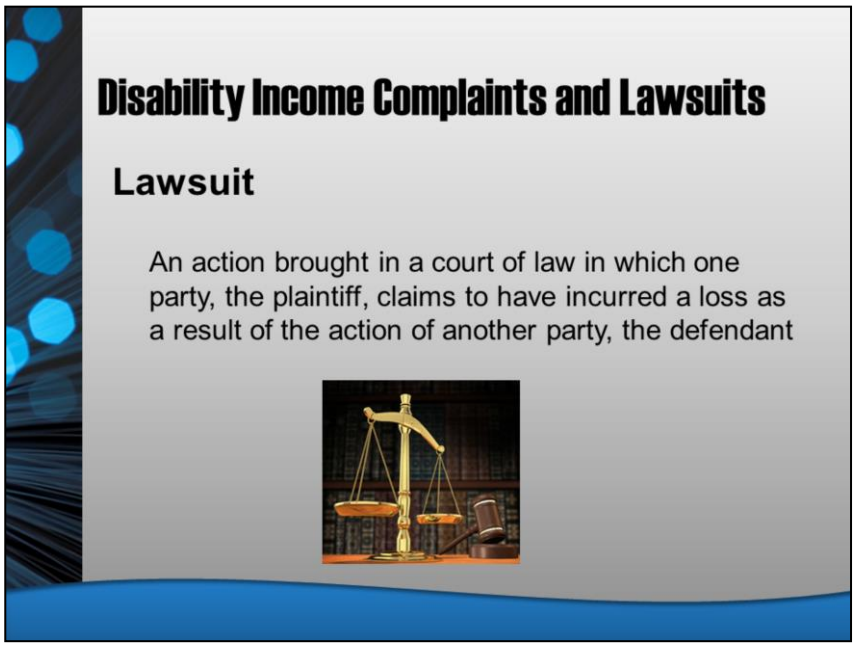


The last section of the Disability Income MCAS is where data is reported for Complaints and Lawsuits.

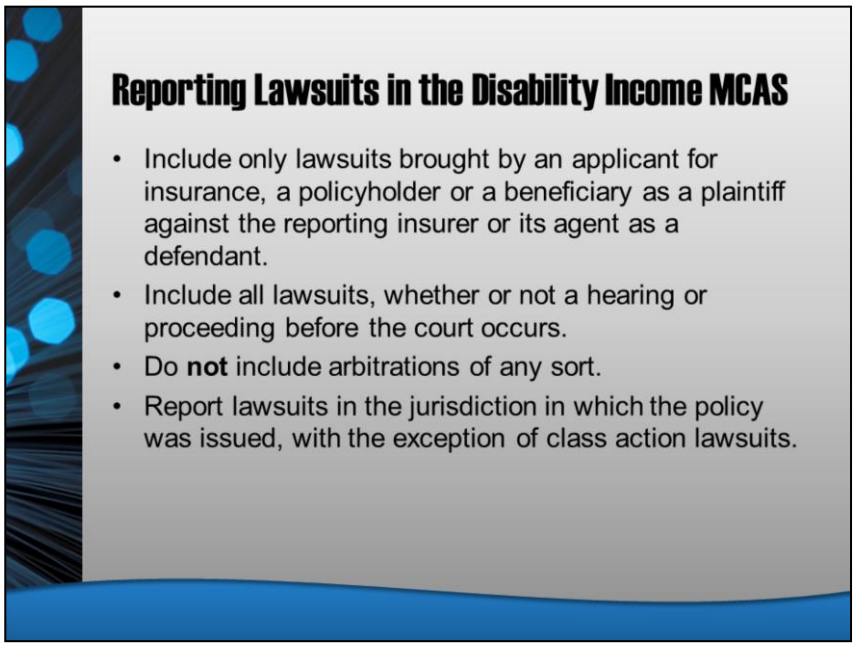


A complaint is defined as “Any written communication from a consumer that expresses dissatisfaction with a specific person, or entity, or product subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form, will meet the definition of a complaint for this purpose.“

Complaints should only be reported that are pertaining to or arising from insurance operations associated with Disability Income Insurance, such as marketing and sales, policy service, claims handling or any other operations directly related to a disability income insurance policy.



A lawsuit is 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.



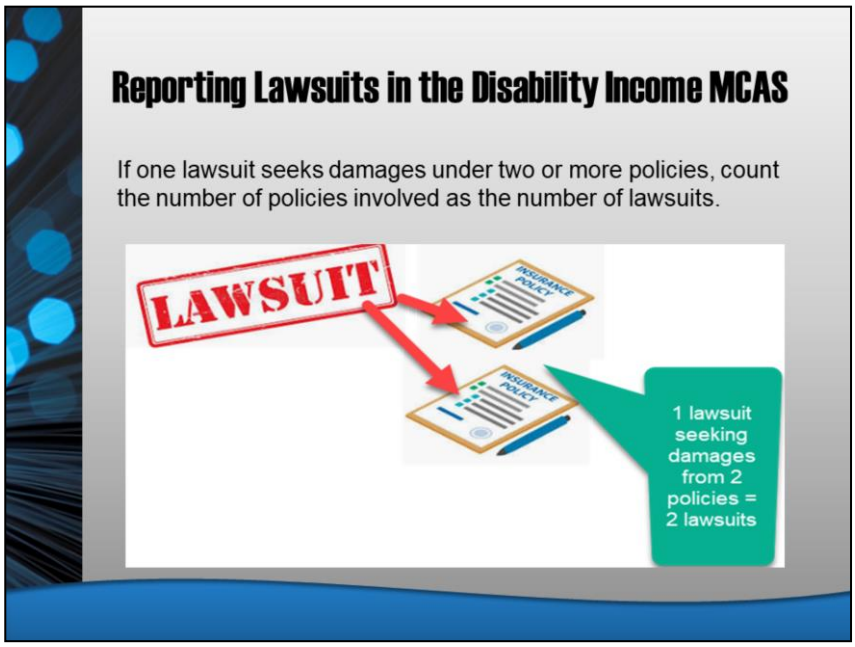
There are several things to consider for the purposes of reporting lawsuits in the Disability Income MCAS:

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.

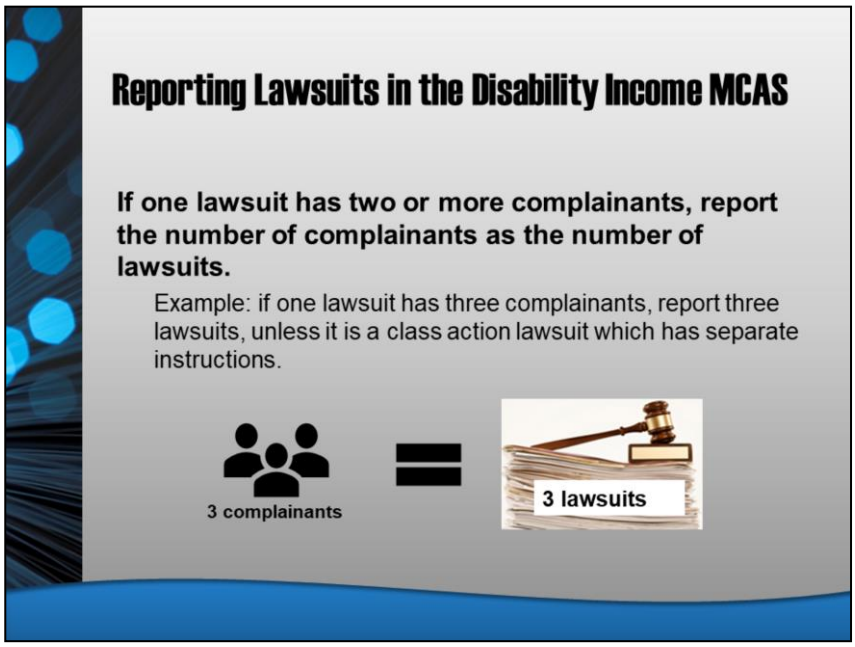
Include all lawsuits, whether or not a hearing or proceeding before the court occurred.

Do not include arbitrations of any sort

Lawsuits must be reported in the jurisdiction in which the policy was issued, with the exception of class action lawsuits.

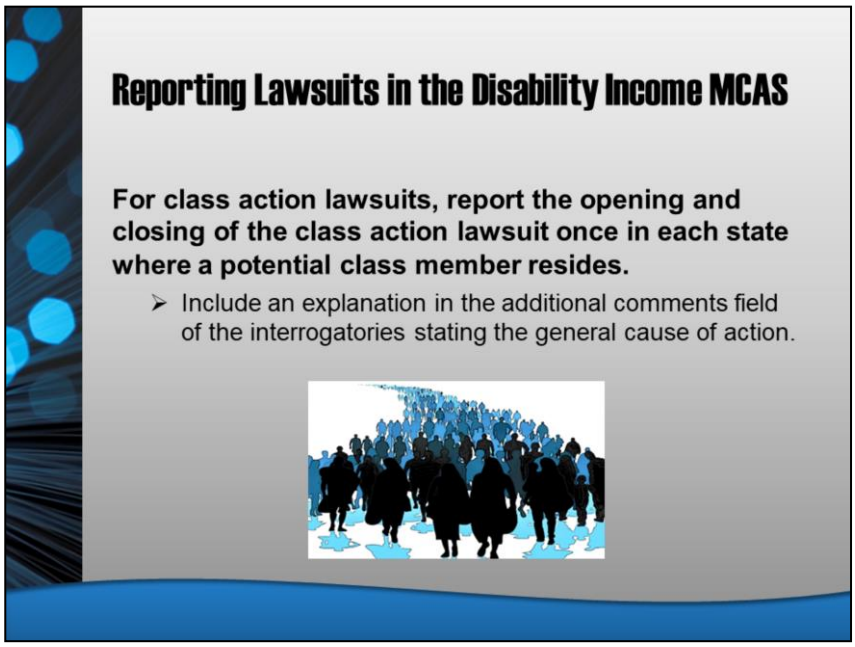


If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example: if one lawsuit seeks damages from two policies, count the action as two lawsuits.

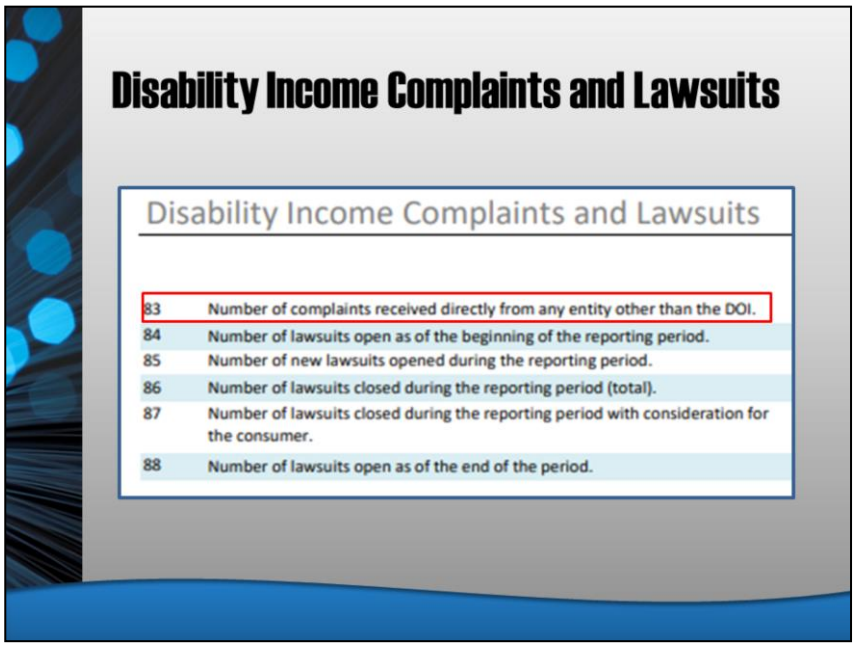


Similar to the previous slide, if one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits.

For example: if one lawsuit has three complainants, report three lawsuits. This does not include class action lawsuits.

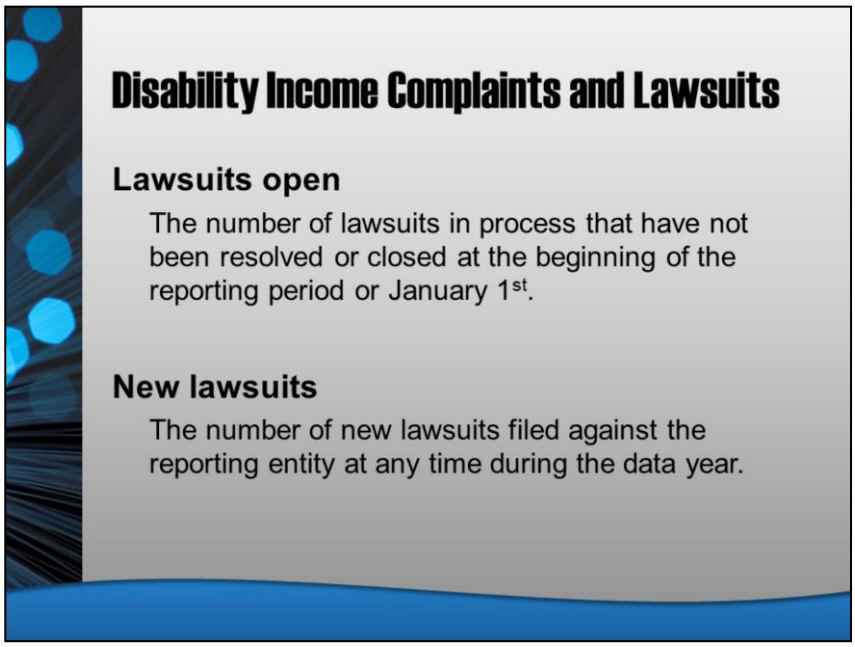


For class action lawsuits, report the opening and closing of the class action lawsuit once in each state where a potential class member resides. Include an explanation in the additional comments field which is line 16 of the Interrogatories stating the general cause of action.



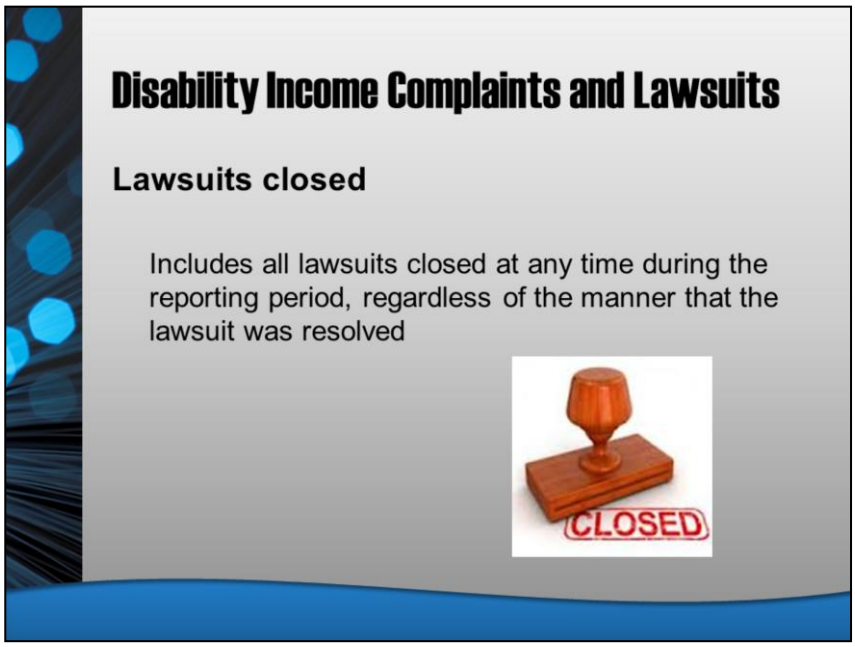
Now that we've reviewed the complaint and lawsuit definitions and details, let's review the six lines for the last section of the Disability Income MCAS.

The first line in this section is for the number of complaints received directly by a reporting entity from any person or entity other than a department of insurance.

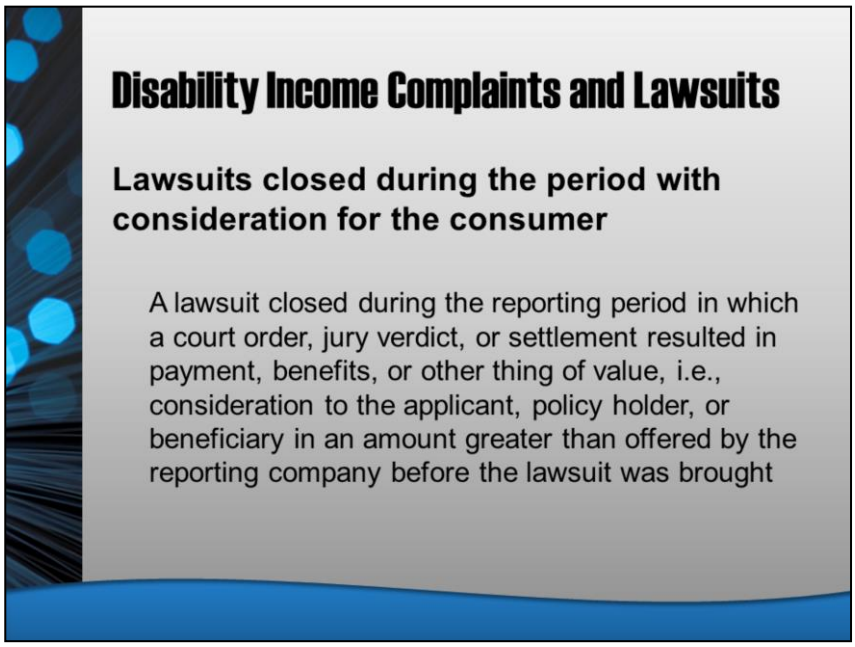


The second line in this section is Lawsuits Open, which is for the number of lawsuits in process that have not been resolved or closed at the beginning of the reporting period or January 1st.

The third line is for the number of new lawsuits filed against the reporting entity at any time during the data year.

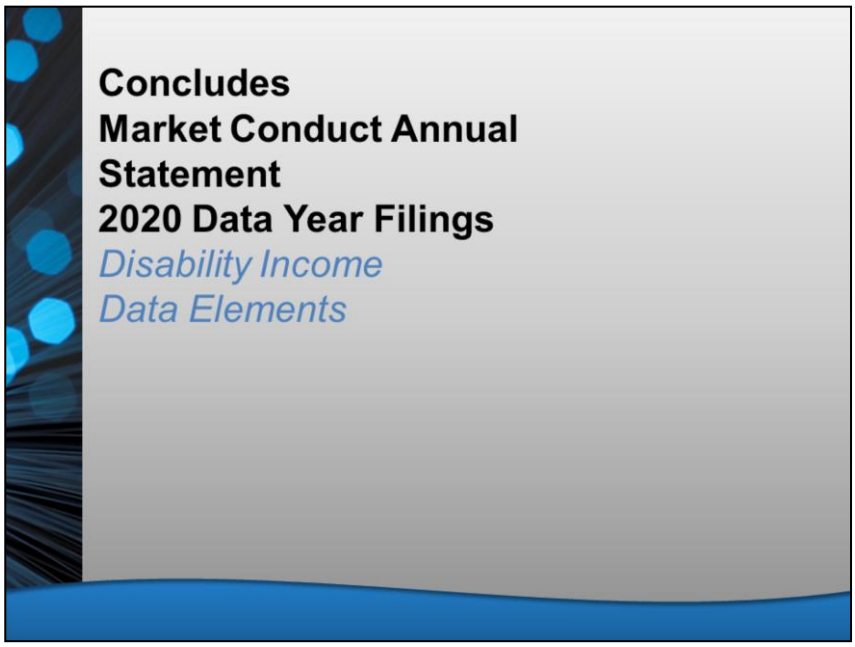


The fourth line is lawsuits closed, which includes all lawsuits closed at any time during the reporting period, regardless of the manner that the lawsuit was resolved.

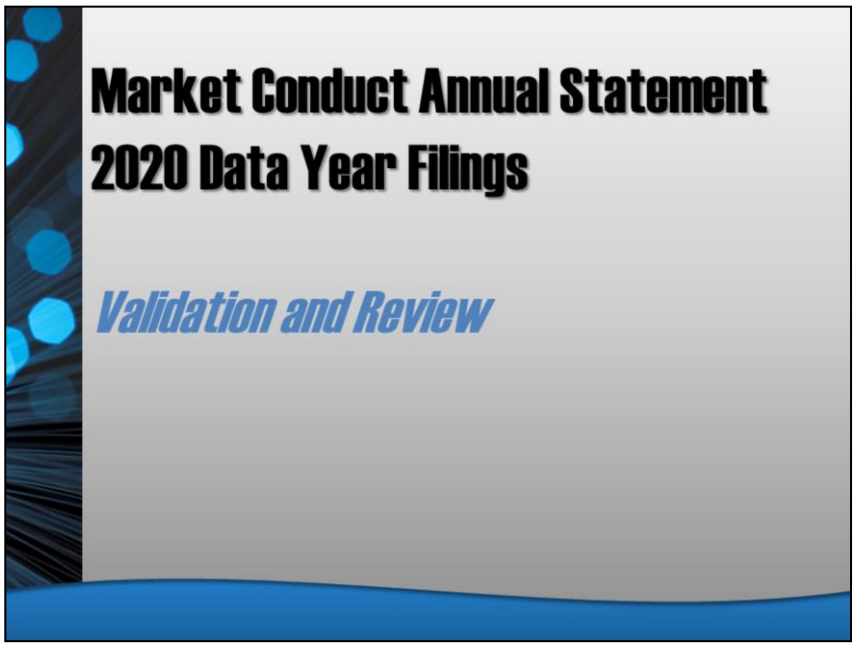


The fifth line is for lawsuits closed during the period with consideration for the consumer. This line includes lawsuits closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, such as consideration to the applicant, policy holder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.

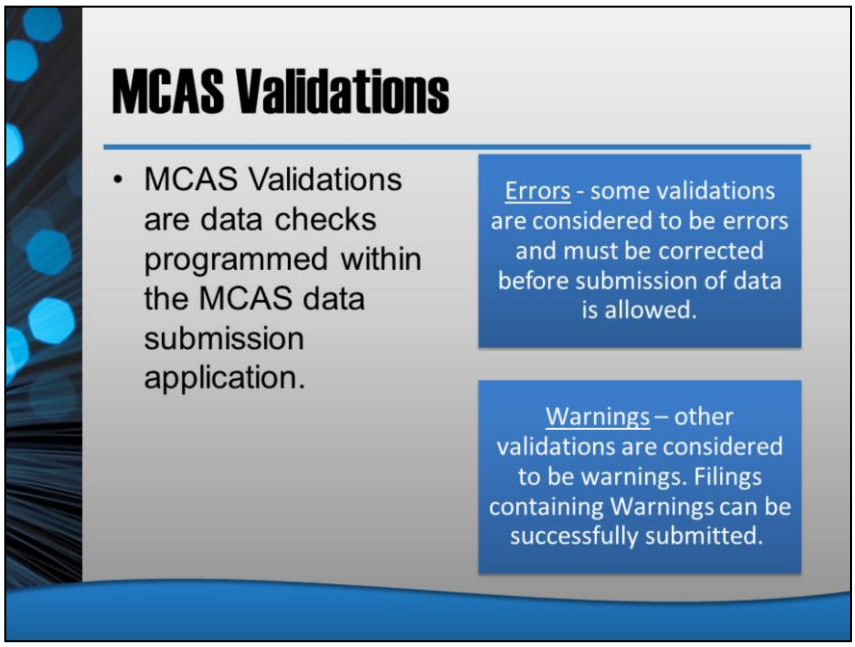
And finally, the last line in the Disability Income MCAS, is for lawsuits open at the end of the period. This line includes the total number of lawsuits that remain open or active at the end of the reporting period, or December 31st.



This concludes the data elements review portion of the tutorial. Now we'll discuss the MCAS data validations.

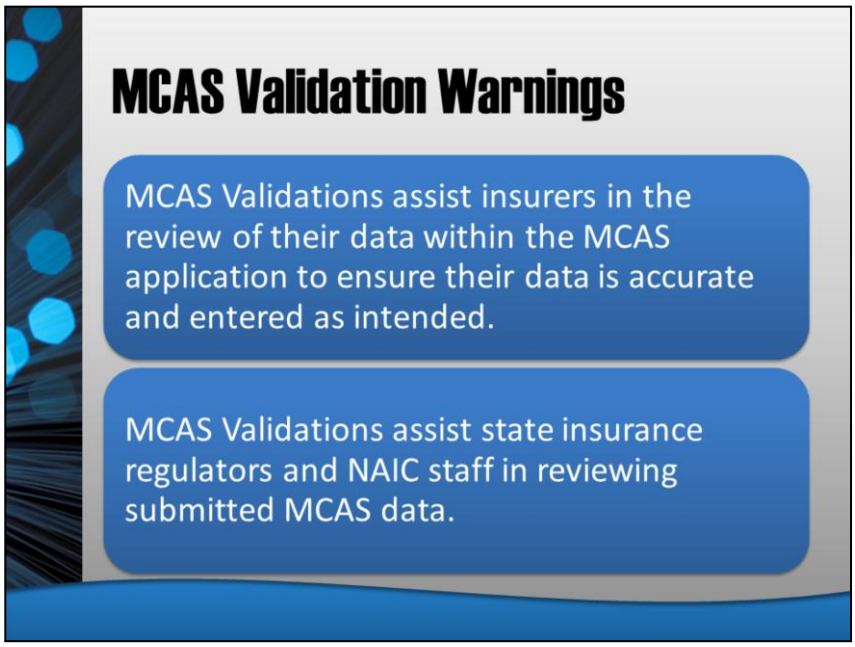


MCAS Validation and Review



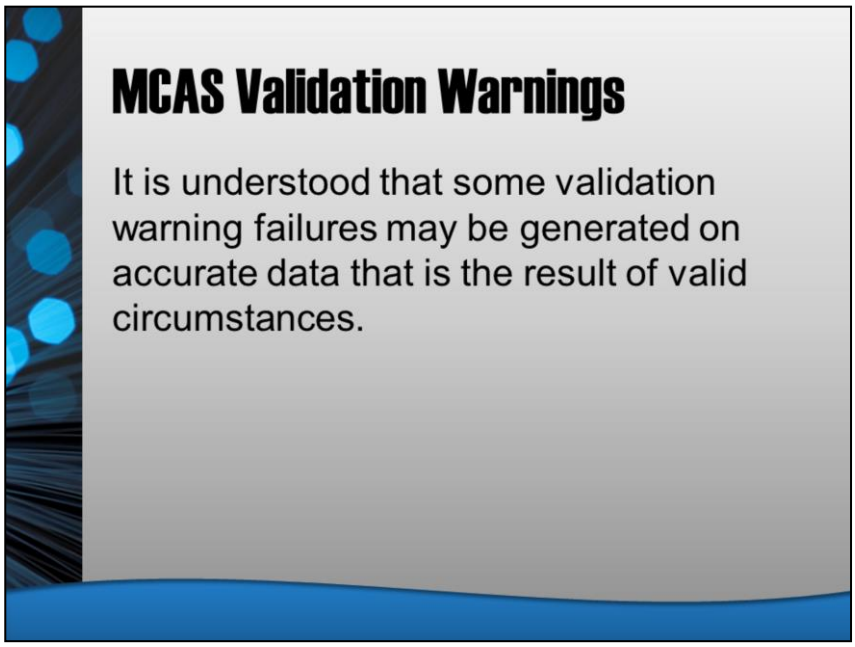
MCAS Validations are data checks programmed within the MCAS data submission application.

- Some validations are considered to be Errors and must be corrected before submission of data is allowed.
- Other validations are considered to be Warnings. Filings containing Warnings can be successfully submitted.

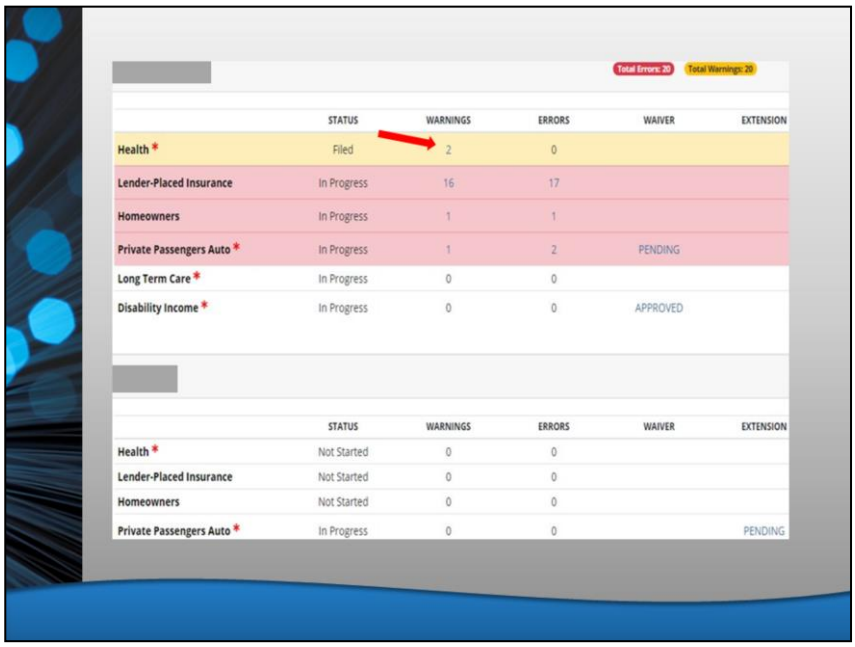


MCAS Validations have multiple purposes.

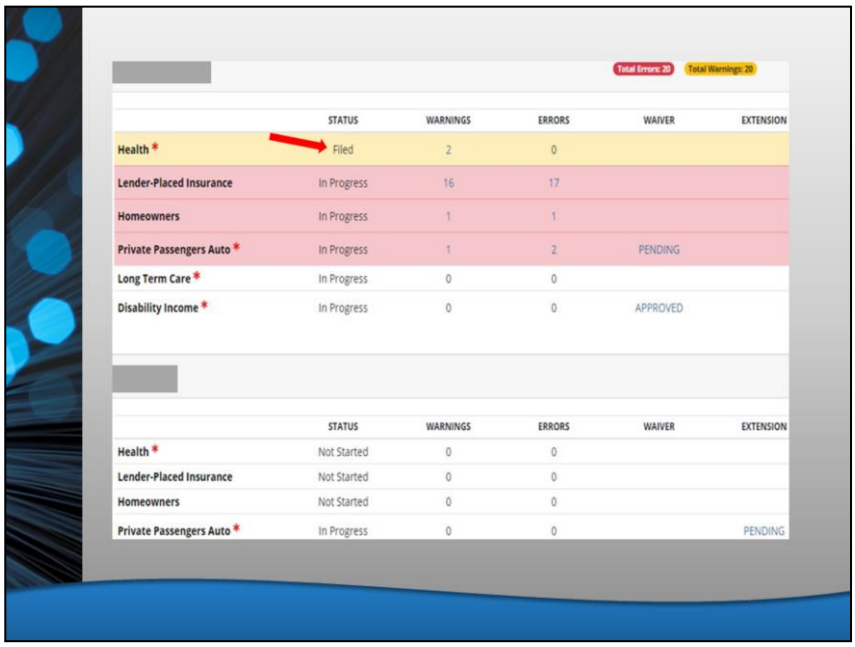
- They assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended. For example: the validations can point out data issues that are a result of data entry errors or coding errors,
- And they assist state insurance regulators and NAIC staff in reviewing submitted MCAS data.



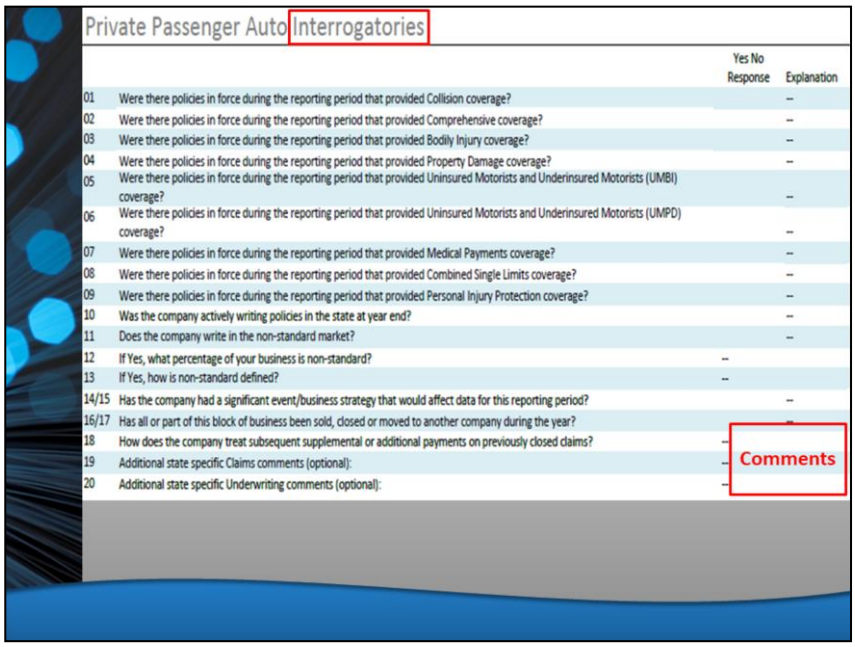
It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances; for example, companies with small amounts of business to report, or runoff business to report may trigger validation warning failures that are not concerning.



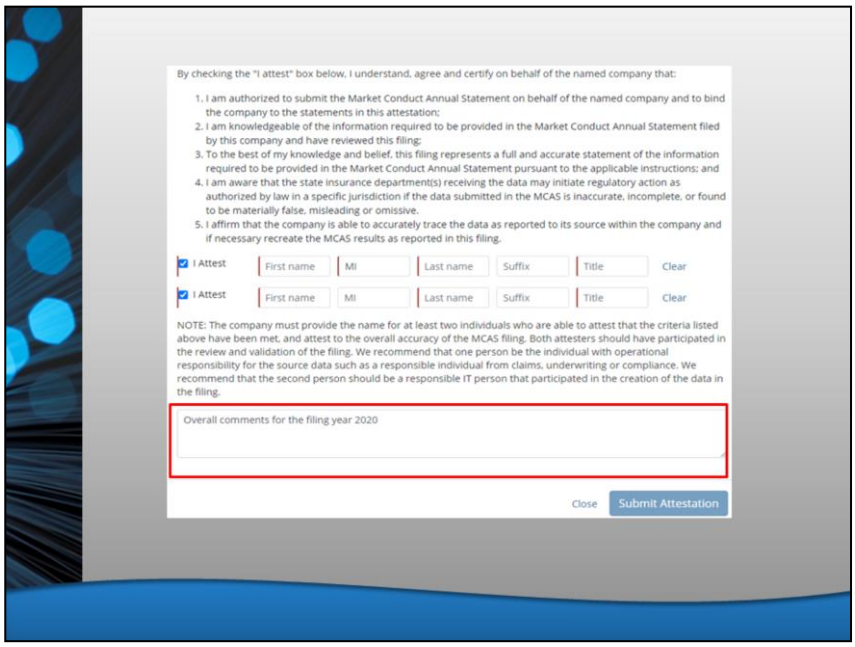
The MCAS system filing matrix provides the MCAS user with information regarding their filings. The filing matrix displays the number of warnings found in submitted or started filings. Before a company submits each filing containing warnings, they are prompted to add comments regarding any outstanding warnings in the submission.



Once a company has filed the MCAS data, the filing matrix will display a status of “filed” for each state and line of business submitted. At this point in the process, NAIC staff will begin a review of the data, checking for data inconsistencies and anomalies.

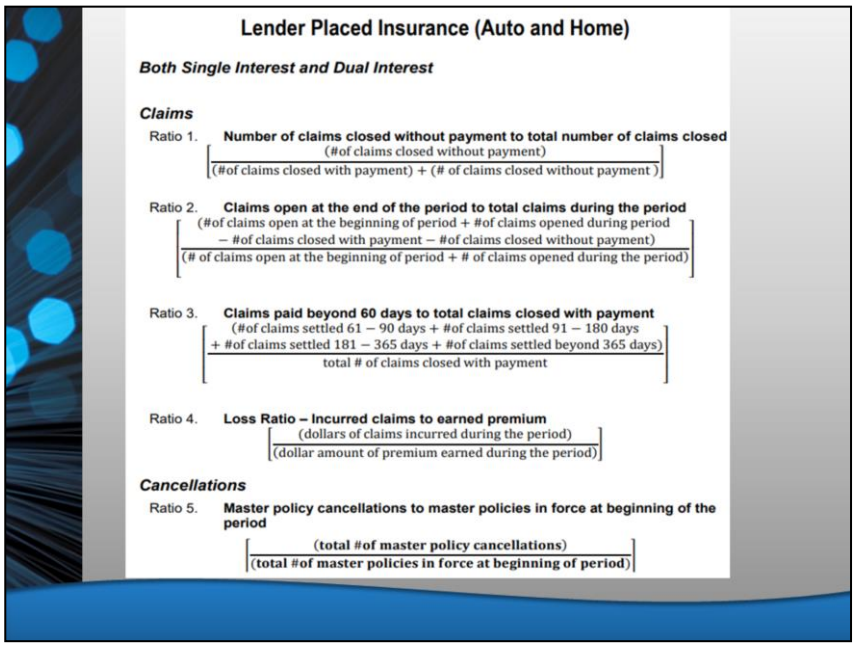


As NAIC analysts review company filings, they view comments found in the interrogatories,



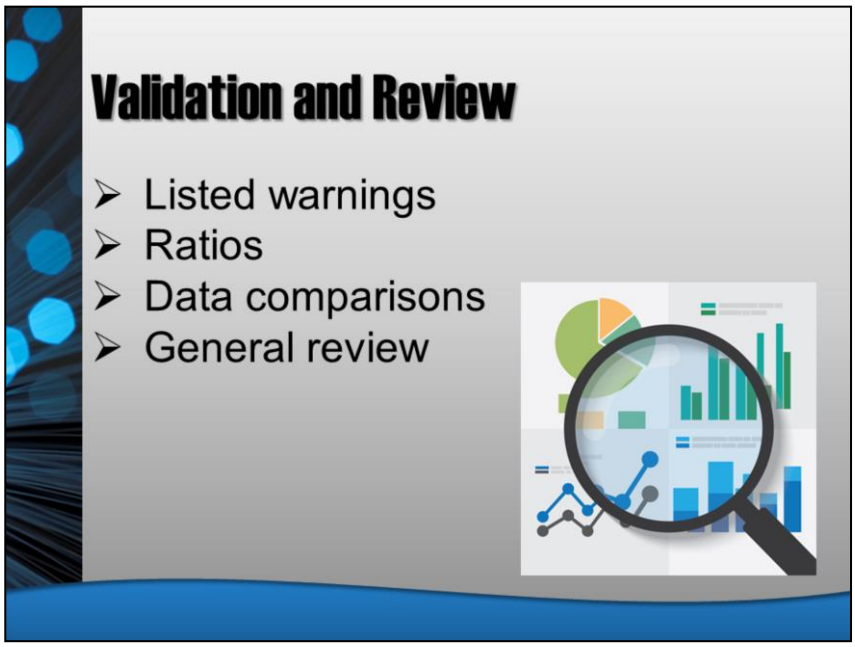
and in the attestation to determine if the warnings have been sufficiently addressed.

If a filing contains “warning messages,” and there are no comments entered by the company, it is more likely that the company will be contacted for an explanation by NAIC staff.



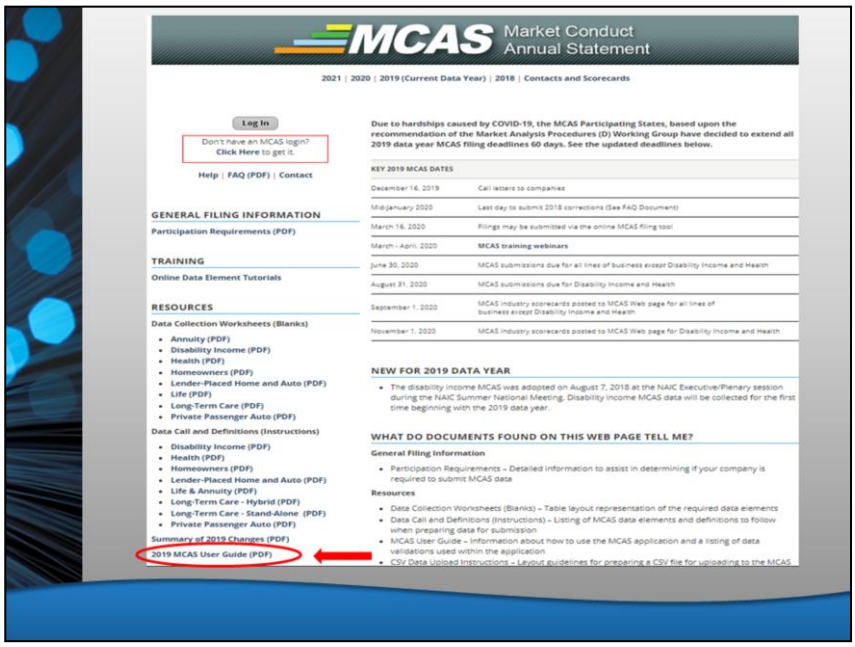
The company's standard ratio results are also reviewed. A listing of the scorecard ratios can be found on the MCAS web page.

During review of a company's ratio results, values that are significantly different than the expected value are identified, along with any significant changes in a company's ratio values year to year. Companies will be notified of these anomalies to allow verification of the submitted data.



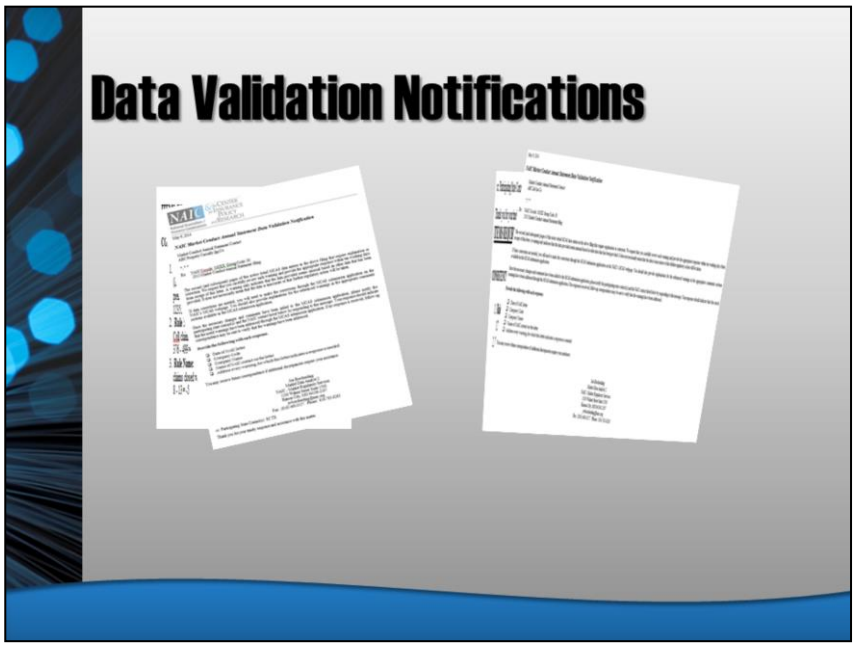
In addition to warnings and ratios, data relationships within the submission are reviewed. An example would be a comparison of policies in-force to the number of claims. Another example would be the comparison of polices in-force to written premiums. If an unusual data relationship is identified, the company will be asked to explain.

A final review is a general review of the data for potential data inaccuracies. An example of this might be the submission of a data element that contains a value much larger than expected; perhaps too many zeros were added, or two data elements were transposed. Again, if these anomalies are identified, the company will be asked to review the data.

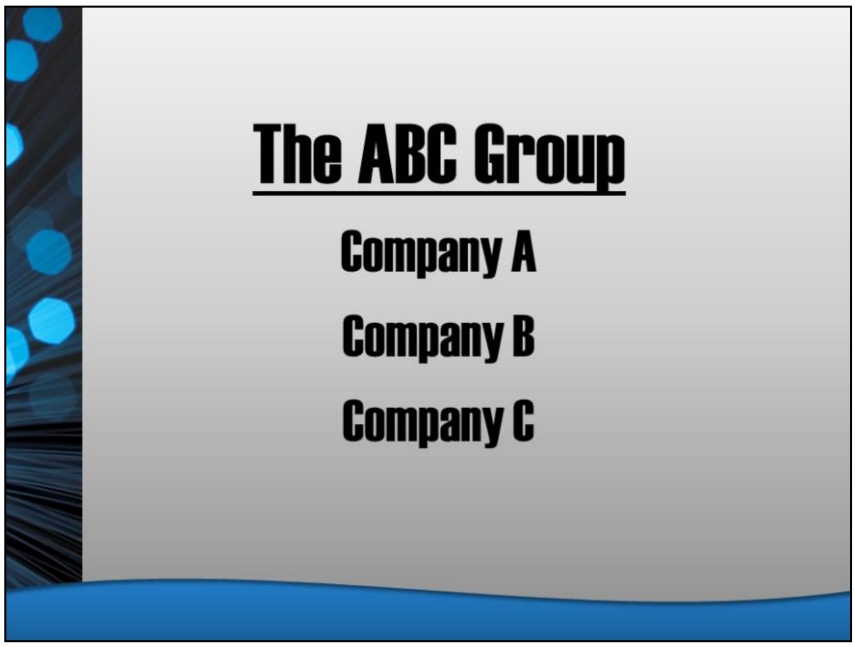


The MCAS User Guide, (found on the MCAS webpage) lists the data validation messages that may be encountered while validating data. This includes both “Error” and “Warning” messages. Use the listing to prepare data and to determine comments that will be needed to explain “Warning” messages received during the data validation process.

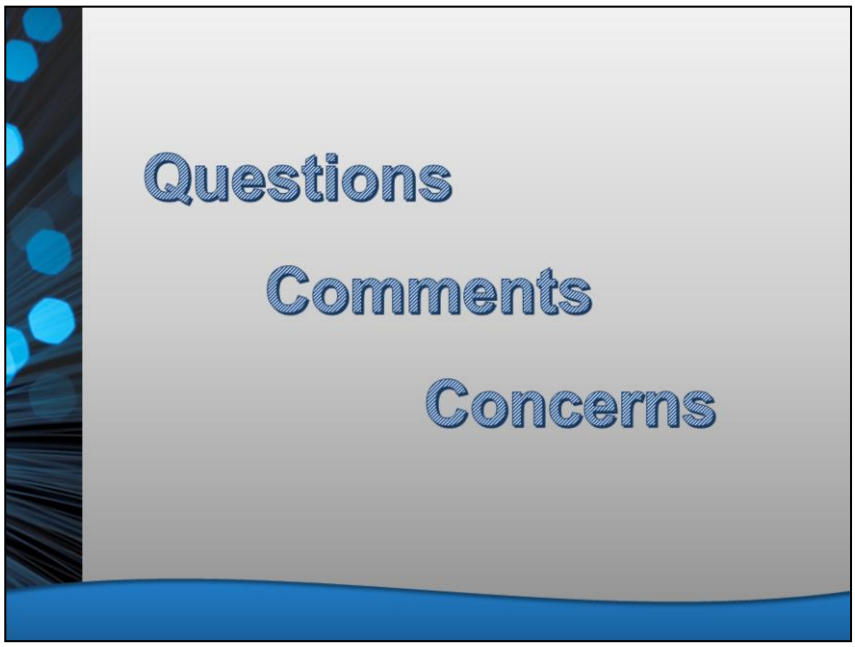
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within **multiple** states.



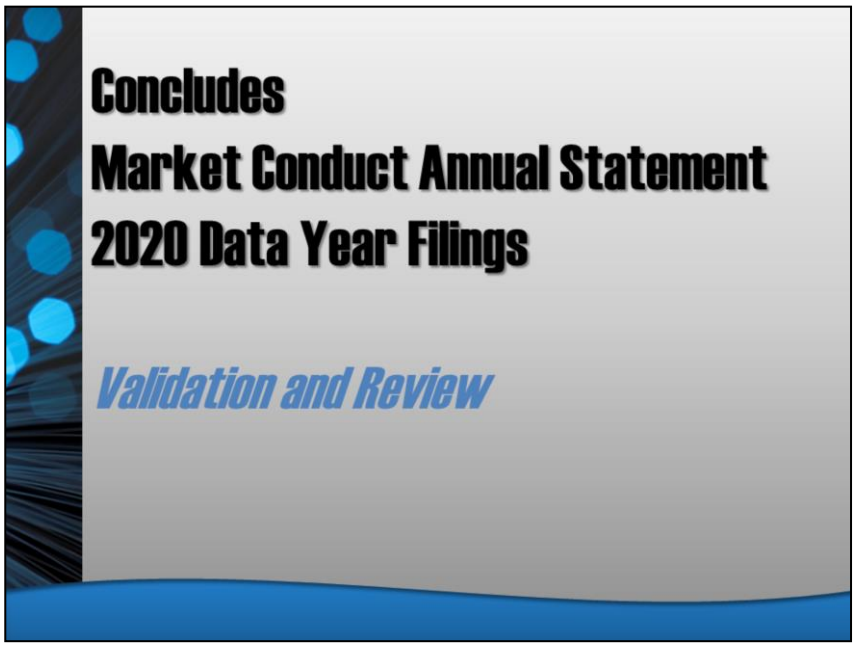
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence. If they have additional questions or concerns, they may also contact the company. However, keeping state regulators in the line of communication, should lessen the number of inquiries received for any particular data concern.



If company A is part of ABC group, and the same observations are made for other companies within the group, then separate correspondence will be sent to each company. It is important to respond to requests in a timely manner to avoid follow up from the NAIC or state regulators. In the company response to the NAIC, please include comments on what action the company will take.



If you receive correspondence from an NAIC analyst, we encourage you to reach out to the analyst with any questions, comments or concerns you may have regarding the correspondence, the validations, or other MCAS filing related issues.



Thank you for your time. This concludes the filing validation and review discussion. Additional questions may be sent to mcas@naic.org.