



Market Conduct Annual Statement


2020 Data Year Filings

Disability Income

Data Elements & Validation



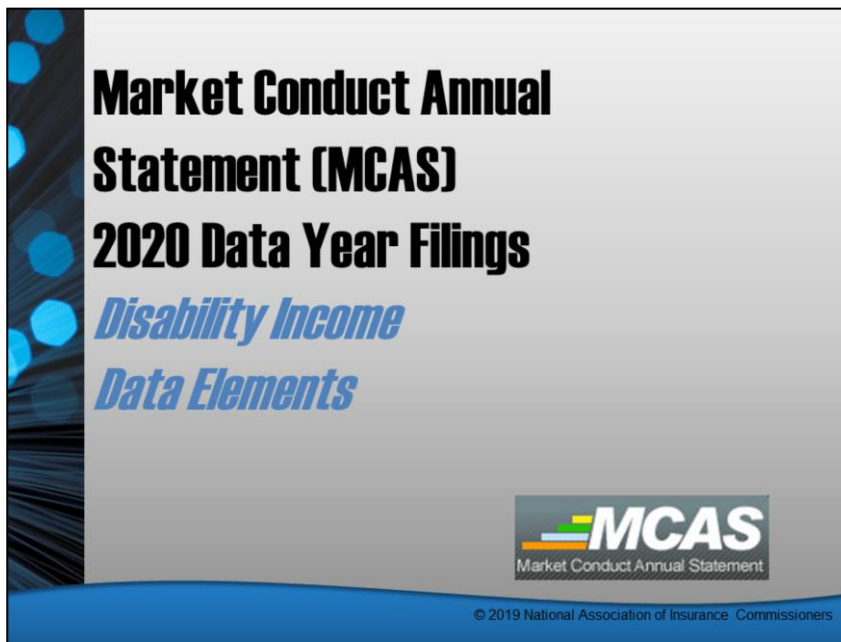
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Hello. I'm Leana Massey.

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.

MCAS Resources

Visit the MCAS Web page at:

https://www.naic.org/mcas_main.htm

- Important Dates
- Participation Requirements
- Frequently Asked Questions
- Reporting Blanks
- Data Call and Definitions
- MCAS User Guide
- CSV Data Upload Instructions

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.

Remember



The filing deadline is
April 30, 2021

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



Remember

MCAS Threshold:

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.

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.

Disability Income Data Call and Definitions

Disability Income Insurance:

- 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.

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 Data Call and Definitions

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.

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.

Disability Income Data Call and Definitions

Disability Income

- 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

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.

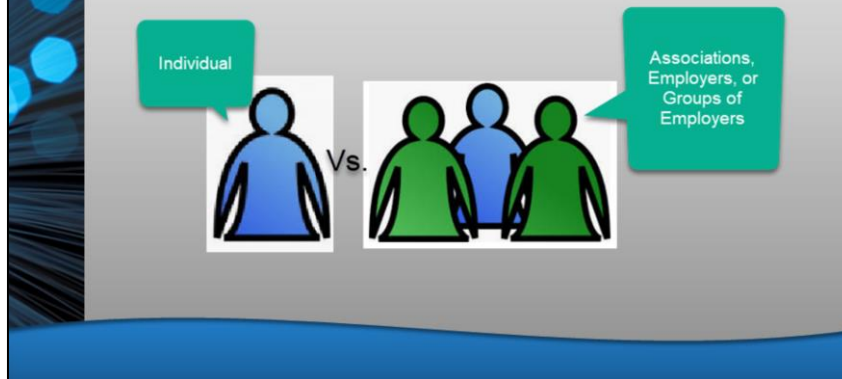
The Disability Income MCAS requests market conduct data on eight different types of products:

- 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

Disability Income Data Call and Definitions

Disability Income

- Individual vs. Group Policies



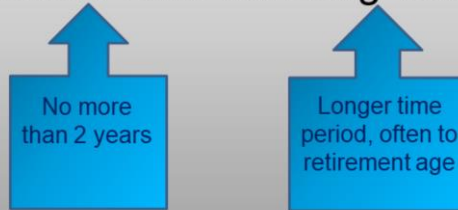
The difference between Individual and Group Policies, is that individual policies are marketed to, or purchased directly by individuals, and Group policies are sold and purchased by or through group sponsors such as associations, employers, or groups of employers.

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.

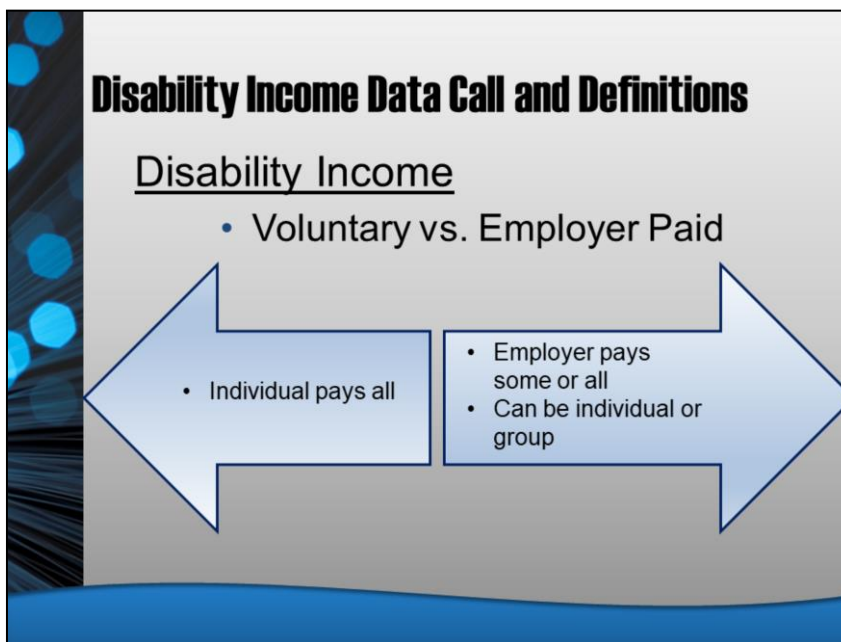
Disability Income Data Call and Definitions

Disability Income

- Short-Term vs. Long-Term



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.

Disability Income Interrogatories

Disability Income Interrogatories		Yes No Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?	--	
02	Does the company have Individual Voluntary Long-Term coverage to report?	--	
03	Does the company have Individual Employer-Paid Short-Term coverage to report?	--	
04	Does the company have Individual Employer-Paid Long-Term coverage to report?	--	
05	Does the company have Group Voluntary Short-Term coverage to report?	--	
06	Does the company have Group Voluntary Long-Term coverage to report?	--	
07	Does the company have Group Employer-Paid Short-Term coverage to report?	--	
08	Does the company have Group Employer-Paid Long-Term coverage to report?	--	
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?	--	
10	If Yes, explain.	--	
11	Has all or part of the reporting entity's disability income protection business been sold, closed or moved to another insurer during the reporting period?	--	
12	If Yes, explain.	--	
13	Number of class action lawsuits?	--	
14	Additional state specific Underwriting comments (optional):	--	
15	Additional state specific claims comments (optional):	--	
16	Additional comments (optional):	--	

January 1, 2020 to December 31, 2020

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.

MCAS DISABILITY INCOME INTERROGATORIES					Next		
Response (Yes/No)							
MCAS DISABILITY INCOME CLAIMS > INDIVIDUAL					Previous	Next	Summary
	Individual Voluntary Short-Term	Individual Voluntary Long-Term	Individual Employer-Paid Short-Term	Individual Employer-Paid Long-Term			
MCAS DISABILITY INCOME CLAIMS > GROUP					Previous	Next	Summary
	Group Voluntary Short-Term	Group Voluntary Long-Term	Group Employer-Paid Short-Term	Group Employer-Paid Long-Term			
MCAS DISABILITY INCOME UNDERWRITING ACTIVITY > INDIVIDUAL					Previous	Next	Summary
	Individual Voluntary Short-Term	Individual Voluntary Long-Term	Individual Employer-Paid Short-Term	Individual Employer-Paid Long-Term			
MCAS DISABILITY INCOME UNDERWRITING ACTIVITY > GROUP					Previous	Summary	
	Group Voluntary Short-Term	Group Voluntary Long-Term	Group Employer-Paid Short-Term	Group Employer-Paid Long-Term			

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.

Disability Income Interrogatories

Disability Income Interrogatories

		Yes	No	
		Response	Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?			--
02	Does the company have Individual Voluntary Long-Term coverage to report?			--
03	Does the company have Individual Employer-Paid Short-Term coverage to report?			--
04	Does the company have Individual Employer-Paid Long-Term coverage to report?			--
05	Does the company have Group Voluntary Short-Term coverage to report?			--
06	Does the company have Group Voluntary Long-Term coverage to report?			--
07	Does the company have Group Employer-Paid Short-Term coverage to report?			--
08	Does the company have Group Employer-Paid Long-Term coverage to report?			--
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?			--
10	if Yes, explain.			--
11	Has all or part of the reporting entity's disability income protection business been sold, closed or moved to another insurer during the reporting period?			--
12	if Yes, explain.			--
13	Number of class action lawsuits?			--
14	Additional state specific Underwriting comments (optional):			--
15	Additional state specific claims comments (optional):			--
16	Additional comments (optional):			--

January 1, 2020 to December 31, 2020

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.

1	Does the company have Individual Voluntary Short-Term coverage to report?	<input type="checkbox"/>	Y
2	Does the company have Individual Voluntary Long-Term coverage to report?	<input type="checkbox"/>	Y
3	Does the company have Individual Employer-Paid Short-Term coverage to report?	<input type="checkbox"/>	Y
4	Does the company have Individual Employer-Paid Long-Term coverage to report?	<input type="checkbox"/>	Y
5	Does the company have Group Voluntary Short-Term coverage to report?	<input type="checkbox"/>	Y
6	Does the company have Group Voluntary Long-Term coverage to report?	<input type="checkbox"/>	Y
7	Does the company have Group Employer-Paid Short-Term coverage to report?	<input type="checkbox"/>	Y
8	Does the company have Group Employer-Paid Long-Term coverage to report?	<input type="checkbox"/>	Y

Disability Income Claims Information

	Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
17	Pending benefit determinations, beginning of reporting period.							
18	Active paid claims, beginning of reporting period.							
19	Claims received during reporting period.							
20	New paid claim determinations during reporting period.							
21	Claim denials during reporting period.							
22	Paid claims closed during reporting period.							
23	Pending benefit determinations, end of reporting period.							
24	Active paid claims, end of reporting period.							

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

1	Does the company have Individual Voluntary Short-Term coverage to report?	<input type="checkbox"/> Y
2	Does the company have Individual Voluntary Long-Term coverage to report?	<input type="checkbox"/> Y
3	Does the company have Individual Employer-Paid Short-Term coverage to report?	<input type="checkbox"/> Y
4	Does the company have Individual Employer-Paid Long-Term coverage to report?	<input type="checkbox"/> Y
5	Does the company have Group Voluntary Short-Term coverage to report?	<input type="checkbox"/> Y
6	Does the company have Group Voluntary Long-Term coverage to report?	<input type="checkbox"/> N
7	Does the company have Group Employer-Paid Short-Term coverage to report?	<input type="checkbox"/> N
8	Does the company have Group Employer-Paid Long-Term coverage to report?	<input type="checkbox"/> N

		Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
		Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
17	Pending benefit determinations, beginning of reporting period.								
18	Active paid claims, beginning of reporting period.								
19	Claims received during reporting period.								
20	New paid claim determinations during reporting period.								
21	Claim denials during reporting period.								
22	Paid claims closed during reporting period.								
23	Pending benefit determinations, end of reporting period.								
24	Active paid claims, end of reporting period.								

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.

Disability Income Interrogatories

Disability Income Interrogatories

		Yes	No	
		Response	Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?		--	
02	Does the company have Individual Voluntary Long-Term coverage to report?		--	
03	Does the company have Individual Employer-Paid Short-Term coverage to report?		--	
04	Does the company have Individual Employer-Paid Long-Term coverage to report?		--	
05	Does the company have Group Voluntary Short-Term coverage to report?		--	
06	Does the company have Group Voluntary Long-Term coverage to report?		--	
07	Does the company have Group Employer-Paid Short-Term coverage to report?		--	
08	Does the company have Group Employer-Paid Long-Term coverage to report?		--	
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?		--	
10	if Yes, explain.		--	
11	Has all or part of the reporting entity's disability income protection business been sold, closed or moved to another insurer during the reporting period?		--	
12	if Yes, explain.		--	
13	Number of class action lawsuits?		--	
14	Additional state specific Underwriting comments (optional):		--	
15	Additional state specific claims comments (optional):		--	
16	Additional comments (optional):		--	

January 1, 2020 to December 31, 2020

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.

Disability Income Interrogatories

Disability Income Interrogatories

		Yes No Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?	--	--
02	Does the company have Individual Voluntary Long-Term coverage to report?	--	--
03	Does the company have Individual Employer-Paid Short-Term coverage to report?	--	--
04	Does the company have Individual Employer-Paid Long-Term coverage to report?	--	--
05	Does the company have Group Voluntary Short-Term coverage to report?	--	--
06	Does the company have Group Voluntary Long-Term coverage to report?	--	--
07	Does the company have Group Employer-Paid Short-Term coverage to report?	--	--
08	Does the company have Group Employer-Paid Long-Term coverage to report?	--	--
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?	--	--
10	If Yes, explain.	--	--
11	Has all or part of the reporting entity's disability income protection business been sold, closed or moved to another insurer during the reporting period?	--	--
12	If Yes, explain.	--	--
13	Number of class action lawsuits?	--	--
14	Additional state specific Underwriting comments (optional):	--	--
15	Additional state specific claims comments (optional):	--	--
16	Additional comments (optional):	--	--

January 1, 2020 to December 31, 2020

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.

Disability Income Interrogatories

Disability Income Interrogatories

		Yes	No	
		Response	Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?		--	
02	Does the company have Individual Voluntary Long-Term coverage to report?		--	
03	Does the company have Individual Employer-Paid Short-Term coverage to report?		--	
04	Does the company have Individual Employer-Paid Long-Term coverage to report?		--	
05	Does the company have Group Voluntary Short-Term coverage to report?		--	
06	Does the company have Group Voluntary Long-Term coverage to report?		--	
07	Does the company have Group Employer-Paid Short-Term coverage to report?		--	
08	Does the company have Group Employer-Paid Long-Term coverage to report?		--	
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?		--	
10	if Yes, explain.		--	
11	Has all or part of the reporting entity's disability income protection business been sold, closed or moved to another insurer during the reporting period?		--	
12	if Yes, explain.		--	
13	Number of class action lawsuits?		--	
14	Additional state specific Underwriting comments (optional):		--	
15	Additional state specific claims comments (optional):		--	
16	Additional comments (optional):		--	

January 1, 2020 to December 31, 2020

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.

Disability Income Interrogatories

Disability Income Interrogatories		Yes No Response	Explanation
01	Does the company have Individual Voluntary Short-Term coverage to report?	--	
02	Does the company have Individual Voluntary Long-Term coverage to report?	--	
03	Does the company have Individual Employer-Paid Short-Term coverage to report?	--	
04	Does the company have Individual Employer-Paid Long-Term coverage to report?	--	
05	Does the company have Group Voluntary Short-Term coverage to report?	--	
06	Does the company have Group Voluntary Long-Term coverage to report?	--	
07	Does the company have Group Employer-Paid Short-Term coverage to report?	--	
08	Does the company have Group Employer-Paid Long-Term coverage to report?	--	
09	Did the reporting entity have a significant event or business strategy change that would affect the data for this reporting period?	--	
10	if Yes, explain.	--	
11	Has all or part of the reporting entity's disability income protection business been sold, closed or moved to another insurer during the reporting period?	--	
12	if Yes, explain.	--	
13	Number of class action lawsuits?	--	
14	Additional state specific Underwriting comments (optional):	--	
15	Additional state specific claims comments (optional):	--	
16	Additional comments (optional):	--	

January 1, 2020 to December 31, 2020

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.

Disability Income Claims Information

Disability Income Claims Information

	Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
17	Pending benefit determinations, beginning of reporting period.							
18	Active paid claims, beginning of reporting period.							
19	Claims received during reporting period.							
20	New paid claim determinations during reporting period.							
21	Claim denials during reporting period.							
22	Paid claims closed during reporting period.							
23	Pending benefit determinations, end of reporting period.							
24	Active paid claims, end of reporting period.							

January 1, 2020 to December 31, 2020

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

Disability Income Claims Information



Claim:

Request or demand for payment of benefits under a disability income policy. For purposes of 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.

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.

Disability Income Claims Information

- Reopened Claims

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

Note: 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, **not** to a reporting entity's decision to continue payment or to close a claim that has been in previous payment status.

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.

Disability Income Claims Information

Disability Income Claims Information

17	Pending benefit determinations, beginning of reporting period.
18	Active paid claims, beginning of reporting period.
19	Claims received during reporting period.
20	New paid claim determinations during reporting period.
21	Claim denials during reporting period.
22	Paid claims closed during reporting period.
23	Pending benefit determinations, end of reporting period.
24	Active paid claims, end of reporting period.

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


Disability Income Claims Information

Pending benefit determinations, beginning of reporting period

Report 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 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.



Disability Income Claims Information

Active paid claims, beginning of reporting period

Report 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

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.


Disability Income Claims Information

Claims received during reporting period

The number of new claims received by the reporting entity during the reporting period.

New Claims

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



Disability Income Claims Information

New paid claim determinations during reporting period

Report 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

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

Disability Income Claims Information

Claim denials during reporting period

Report the number of initial benefit determinations made at any time during the reporting period that resulted in a decision to deny payment.

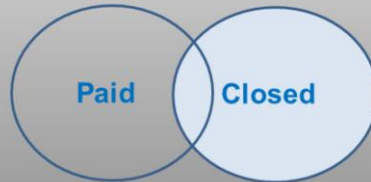


Next you will see the line for Claim denials during reporting period. This is for the number of initial benefit determinations made at any time during the reporting period that resulted in a decision to deny payment.

Disability Income Claims Information

Paid claims closed during reporting period

Report 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 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.

Disability Income Claims Information

Pending benefit determinations, end of reporting period

Report 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.

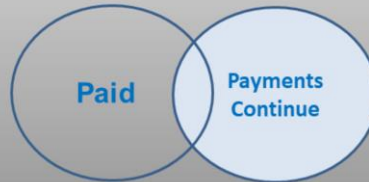


The seventh line is Pending benefit determinations, end of reporting period, which are the number of open or pending claims for which no decision to pay or deny has been made as of the end of the reporting period or December 31st.

Disability Income Claims Information

Active paid claims, end of period

Report the number of claims for which payment is continuing to be made at 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.

Disability Income Claims Data

Disability Income Claims Decisions Processed

25	Number of claims processed with initial claim decision within 1-14 days.
26	Number of claims processed with initial claim decision within 15-30 days.
27	Number of claims processed with initial claim decision within 31-45 days.
28	Number of claims processed with initial claim decision over 45 days.
29	Median Processing Time: The median processing time for claims resulting in payments reported in lines 25 through 28.
30	Number of claims processed with initial claim decision within 1-30 days.
31	Number of claims processed with initial claim decision within 31-60 days.
32	Number of claims processed with initial claim decision within 61-90 days.
33	Number of claims processed with initial claim decision over 90 days.
34	Median Processing Time: The median processing time for claims resulting in payments reported in lines 30 through 33.

NOTE: These questions include paid (processed) claims.

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.

Disability Income Claims Data

Disability Income Resulting in Closed Without Payment

	Individual Voluntary	
	Short-Term	Long-Term
35	Number of claims closed without payment within 1-14 days.	
36	Number of claims closed without payment within 15-30 days.	
37	Number of claims closed without payment within 31-45 days.	
38	Number of claims closed without payment over 45 days.	
39	Median Processing Time: The median processing time for claims closed without payment reported in lines 35 through 38.	
40	Number of claims closed without payment within 1-30 days.	
41	Number of claims closed without payment within 31-60 days.	
42	Number of claims closed without payment within 61-90 days.	
43	Number of claims closed without payment over 90 days.	
44	Median Processing Time: The median processing time for claims closed without payment reported in lines 40 through 43.	

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

Disability Income Claims Data

		Individual Voluntary	
		Short-Term	Long-Term
35	Number of claims closed without payment within 1-14 days.	--	--
36	Number of claims closed without payment within 15-30 days.	--	--
37	Number of claims closed without payment within 31-45 days.	--	--
38	Number of claims closed without payment over 45 days.	--	--
39	Median Processing Time: The median processing time for claims closed without payment reported in lines 35 through 38.	--	--
40	Number of claims closed without payment within 1-30 days.	--	--
41	Number of claims closed without payment within 31-60 days.	--	--
42	Number of claims closed without payment within 61-90 days.	--	--
43	Number of claims closed without payment over 90 days.	--	--
44	Median Processing Time: The median processing time for claims closed without payment reported in lines 40 through 43.	--	--

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.

Disability Income Claims Data

Disability Income Claims Decisions Processed

Disability Income Resulting in Closed Without Payment

- Both schedules 3 and 4 capture information about claims processing times
- All processing times should be calculated as the number of days from receipt of a claim in the mailroom or other claims intake method, until a decision is made to pay or deny the claim.
- Do NOT include any additional days until payment is actually made to the claimant or received by the claimant.

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.

Disability Income Claims Data

Claims Decisions Processed Data Questions:

Disability Income Claims Decisions Processed

25	Number of claims processed with initial claim decision within 1-14 days.
26	Number of claims processed with initial claim decision within 15-30 days.
27	Number of claims processed with initial claim decision within 31-45 days.
28	Number of claims processed with initial claim decision over 45 days.
29	Median Processing Time: The median processing time for claims resulting in payments reported in lines 25 through 28.
30	Number of claims processed with initial claim decision within 1-30 days.
31	Number of claims processed with initial claim decision within 31-60 days.
32	Number of claims processed with initial claim decision within 61-90 days.
33	Number of claims processed with initial claim decision over 90 days.
34	Median Processing Time: The median processing time for claims resulting in payments reported in lines 30 through 33.

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.

SPEED OF CLAIM SETTLEMENT

The median is the value above which and below which there are an equal number of values.

30 days to settlement
45 days to settlement
60 days to settlement

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.

Median Processing Times

	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 the above 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 below.

	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 = $(5 + 6)/2 = 5.5$

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.

Median Processing Times

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

Closing Time # of Claims	
< 30	22
31-60	13
61-90	18
>90	16

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

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.

Claim Denials - Reasons

Disability Income Claims Denied - Reasons

45	Claimant not covered under the policy as of date of disability onset.
46	Claimant returned to work during elimination period.
47	Pre-existing condition.
48	Claimant not disabled under the policy definition of disabled.
49	Lack of documentation.
50	Disability arising from diagnosis excluded under the policy.
51	Disability due to work-related injury or condition excluded under the policy.
52	Disability caused by excluded circumstance other than a work-related injury.
53	Misrepresentation.
54	All other denials.

January 1, 2020 to December 31, 2020

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.



Disability Income Claim Denial Categories

Claimant not covered under the policy

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 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.



Disability Income Claim Denial Categories

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 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.



Disability Income Claim Denial Categories

Pre-existing condition

A medical condition of the insured that existed prior to eligibility for coverage under a disability income policy.

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.



Disability Income Claim Denial Categories

Claimant not disabled under the policy definition of disabled

The claimant is not disabled as per policy definitions. Include in this line 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 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.

Disability Income Claim Denial Categories

Lack of Documentation

Instances in which a claimant fails to submit requested documentation sufficient to demonstrate disability.



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.



Disability Income Claim Denial Categories Cont'd.

Disability arising from diagnosis excluded under the policy

An injury or condition specifically identified in the policy as excluded from coverage.

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.

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.



Disability Income Claim Denial Categories Cont'd.

Disability due to work-related injury or condition excluded under the policy

Claims denied under an exclusion or injuries or condition arising from paid employment.

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.



Disability Income Claim Denial Categories Cont'd.

Disability caused by excluded condition or circumstance other than a work-related injury

A 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.

Excludes denials due to a work-related injury reported in category 7

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.



Disability Income Claim Denial Categories Cont'd.

Misrepresentation

Claim denials due to false or incorrect information on an application for coverage or in the application for policy benefits.

Other denials

All claim denials not reported in the other categories should be accounted for.

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.

Claims Closed After Initial Payment

Disability Income Claims Closed After Initial Payment(s)

	Individual Voluntary		Individual Employer-Paid		Group Voluntary		Group Employer-Paid	
	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term	Short-Term	Long-Term
55	Claimant returned to work - own occupation/job.							
56	Claimant returned to work - any occupation/job.							
57	Lack of documentation.							
58	Non-participation in evaluation.							
59	Death of claimant.							
60	Failure to participate in rehabilitation.							
61	Misrepresentation.							
62	Claimant had offsetting compensation.							
63	Maximum benefit reached.							
64	Not disabled with respect to "own occupation" but <u>has not returned to work.</u>							
65	Not disabled with respect to "any occupation" but <u>has not returned to work.</u>							
66	Other closed after payment.							

January 1, 2020 to December 31, 2020

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.

Claims Closed After Initial Payment

Disability Income Claims Closed After Initial Payment(s)

		Individual Voluntary	
		Short-Term	Long-Term
55	Claimant returned to work - own occupation/job.		
56	Claimant returned to work - any occupation/job.		

- Includes claims for which payment has been terminated because an individual formerly considered disabled has returned to employment sufficient to end coverage.
- "Own Occupation" refers to when a claimant returns to previous employment or employment of the same class.
- "Any Occupation" refers to when a claimant returns to a materially different job class.

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.

Claims Closed After Initial Payment

Disability Income Claims Closed After Initial Payment(s)

		Individual Voluntary	
		Short-Term	Long-Term
55	Claimant returned to work - own occupation/job.		
56	Claimant returned to work - any occupation/job.		
57	Lack of documentation.		
58	Non-participation in evaluation.		
59	Death of claimant.		
60	Failure to participate in rehabilitation.		
61	Misrepresentation.		
62	Claimant had offsetting compensation.		
63	Maximum benefit reached.		
64	Not disabled with respect to "own occupation" but <u>has not returned to work.</u>		
65	Not disabled with respect to "any occupation" but <u>has not returned to work.</u>		
66	Other closed after payment.		

- These lines should only include benefit terminations in which the insured has not returned to employment of a kind necessary to end disability coverage.

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.



Claims Closed After Initial Payment

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.

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.



Claims Closed After Initial Payment

Non-participation in evaluation

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.

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.



Claims Closed After Initial Payment

Death of claimant

Failure to participate in rehabilitation

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.

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.



Claims Closed After Initial Payment

Misrepresentation

Claimant had offsetting compensation

Claims for 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.

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.



Claims Closed After Initial Payment

Maximum benefit reached

- Claim payments terminated because the maximum level of benefits afforded by the policy has been reached
- Includes all claims terminated due to maximum payment amount, maximum benefit period, or other cap defined in the policy

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.



Claims Closed After Initial Payment

**Not disabled with respect to own occupation
but has not returned to work**

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

- These 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.
- Both categories exclude claims which are more appropriately reported in the previous lines in this schedule.

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.



Claims Closed After Initial Payment

Other closed after payment

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 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.

Disability Insurance Underwriting Activity

Disability Income Underwriting Activity (Group & Individual)

		Individual Voluntary	
		Short-Term	Long-Term
67	Number of policies in force at the beginning of the reporting period.		
68	Number of new policies issued during the reporting period.		
69	Dollar amount of direct written premium.		
70	Number of policyholder cancellations and non-renewals.		
71	Number of insurer non-renewals.		
72	Number of insurer cancellations.		
73	Number of rescissions within two years from policy issue.		
74	Number of rescissions after two years from policy issue.		
75	Number of policies in force at the end of the reporting period.		

January 1, 2020 to December 31, 2020

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.

Disability Insurance Underwriting Activity

Policies in force at the beginning of the reporting period (January 1st)

Policies Issued

- New policies issued at any time during the reporting period
- Excludes policy renewals



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.



Disability Insurance Underwriting Activity

Direct written premium

- The actual amount of direct premiums written during the reporting period
- Should be determined in the same manner used for the financial annual statement

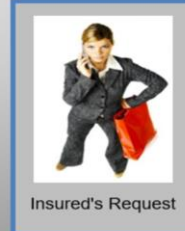
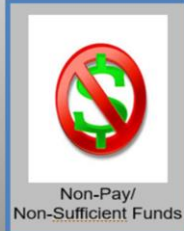
The third line is where the dollar amount of Direct written premium is reported.

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.

Disability Insurance Underwriting Activity

Policyholder cancellations and non-renewals

- Policies cancelled or non-renewed at any point during the reporting at the request of, or in response to the policyholder.
- Includes policies terminated for nonpayment of premium.



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.

Disability Insurance Underwriting Activity

Insurer non-renewals

- Non-renewals initiated by the reporting entity
- Excludes non-renewals occurring as a result of nonpayment of premium, as that data is reported in the previous line



Company Initiated

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.

Disability Insurance Underwriting Activity

Insurer cancellations



- A cancellation is the termination of an in-force policy during the policy contract period
- Excludes cancellations resulting from nonpayment of premium, as that data is reported in 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.



Disability Insurance Underwriting Activity

Rescissions within two years

Occurring within two years of the date the policy was first issued.

Rescissions after two years

Occurring beyond two years after the date a policy was first issued.

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

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.

Disability Insurance Underwriting Activity

Policies in force at the end of reporting period

The number of in force policies at the end of the reporting period, or December 31st



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.


Covered Lives Related to Underwriting Activity – Group Only

Disability Income Covered Lives Related to Underwriting Activity (Group Only)

	Individual Voluntary		Individual Employer-Paid	
	Short-Term	Long-Term	Short-Term	Long-Term
76 Number of lives covered under policies in force at the beginning of the reporting period.	--	--	--	--
77 Number of lives covered under new policies issued during the reporting period.	--	--	--	--
78 Number of lives covered under policyholder cancellations and non-renewals.	--	--	--	--
79 Number of lives covered under insurer non-renewals.	--	--	--	--
80 Number of lives covered under insurer cancellations.	--	--	--	--
81 Number of lives covered under rescinded policies.	--	--	--	--
82 Number of lives covered under policies in force at the end of the reporting period.	--	--	--	--

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.



Covered Lives Related to Underwriting Activity – Group Only

Lives covered under policies in force beginning of period (January 1)

- These are lives covered under the 1st line of schedule 7 (policies in force at the beginning of the reporting period)

The first line in this section is for the number of lives covered under policies 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.



Covered Lives Related to Underwriting Activity – Group Only

Lives covered under new policies issued

- Number of lives covered under new policies issued at any time during the reporting period
- Corresponds 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 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.



Covered Lives Related to Underwriting Activity – Group Only

Lives covered under policyholder cancellations and non-renewals

- Number of lives covered under policies that were terminated at the request of, or in response to the policyholder
- Includes policies cancelled or non-renewed at any time during the reporting period
- Number of covered lives as of the date coverage ended is what should be reported here
- This number should correspond to the policy terminations reported in line 4 of schedule 7 (policyholder cancellations and non-renewals)

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.



Covered Lives Related to Underwriting Activity – Group Only

Lives covered under insurer non-renewals

- Number of lives covered under policies subject to non-renewals initiated by a reporting entity, as of the date that coverage terminated
- Lives reported here should correspond to the 5th line in schedule 7, which is for insurer non-renewals
- Excludes non-renewals due to nonpayment of premium, as they are reported in the previous line

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.



Covered Lives Related to Underwriting Activity – Group Only

Lives covered under insurer cancellations

- Number of Lives on cancellations initiated by the reporting entity, as of the date that coverage terminated
- Should correspond to the number of policies reported on line 6 for schedule 7 (insurer cancellations)
- Exclude cancellations resulting from non-payment of premiums, as those are reported in line 3 of this section (lives covered under policyholder cancellations and non-renewals)

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.



Covered Lives Related to Underwriting Activity – Group Only

Lives covered under rescinded policies

- Report the number of lives as of the date that the rescission occurred
- Should 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 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.



Covered Lives Related to Underwriting Activity – Group Only

**Lives covered under policies in force at the
end of the reporting period (December 31)**

- 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 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.

Disability Income Complaints and Lawsuits

Disability Income Complaints and Lawsuits

83	Number of complaints received directly from any entity other than the DOI.
84	Number of lawsuits open as of the beginning of the reporting period.
85	Number of new lawsuits opened during the reporting period.
86	Number of lawsuits closed during the reporting period (total).
87	Number of lawsuits closed during the reporting period with consideration for the consumer.
88	Number of lawsuits open as of the end of the period.

January 1, 2020 to December 31, 2020

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

Disability Income Complaints and Lawsuits



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, will meet the definition of a complaint for this purpose.

- Note: Only complaints 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 should be reported.

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.

Disability Income Complaints and Lawsuits

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



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.



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 occurs.
- Do **not** include arbitrations of any sort.
- Report lawsuits in the jurisdiction in which the policy was issued, with the exception of class action lawsuits.

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.

Reporting Lawsuits in the Disability Income MCAS

If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of 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.

Reporting Lawsuits in the Disability Income MCAS

If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits.

Example: if one lawsuit has three complainants, report three lawsuits, unless it is a class action lawsuit which has separate instructions.



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.

Reporting Lawsuits in the Disability Income MCAS

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 of the interrogatories stating the general cause of action.



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.

Disability Income Complaints and Lawsuits

Disability Income Complaints and Lawsuits	
83	Number of complaints received directly from any entity other than the DOI.
84	Number of lawsuits open as of the beginning of the reporting period.
85	Number of new lawsuits opened during the reporting period.
86	Number of lawsuits closed during the reporting period (total).
87	Number of lawsuits closed during the reporting period with consideration for the consumer.
88	Number of lawsuits open as of the end of the period.

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.



Disability Income Complaints and Lawsuits

Lawsuits open

The number of lawsuits in process that have not been resolved or closed at the beginning of the reporting period or January 1st.

New lawsuits

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

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.

Disability Income Complaints and Lawsuits

Lawsuits closed

Includes all lawsuits closed at any time during the reporting period, regardless of the manner that the lawsuit was resolved



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.



Disability Income Complaints and Lawsuits

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, policy holder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought

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.

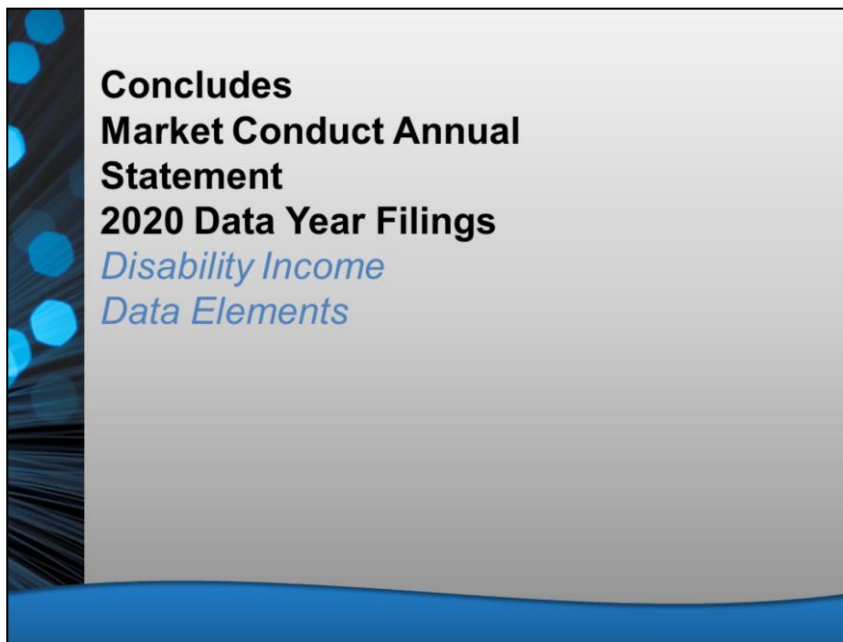
Disability Income Complaints and Lawsuits

Lawsuits open at the end of the period

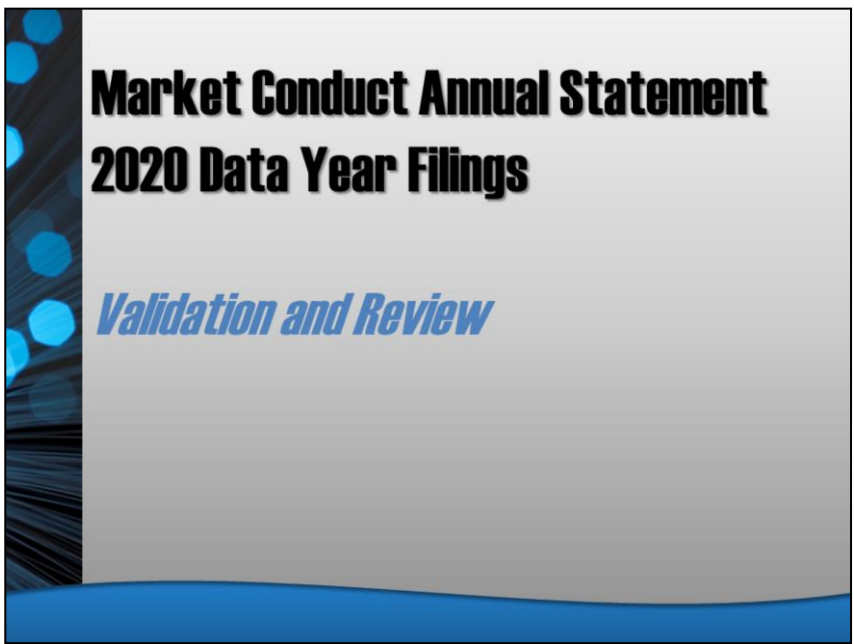
Total of lawsuits that remain open or active at the end of the reporting period (December 31)



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

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

Errors - some validations are considered to be errors and must be corrected before submission of data is allowed.

Warnings - other validations are considered to be warnings. Filings containing Warnings can be successfully submitted.

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 Validation Warnings

MCAS Validations assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended.

MCAS Validations assist state insurance regulators and NAIC staff in reviewing submitted MCAS data.

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.



MCAS Validation Warnings

It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances.

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 screenshot displays two tables from the MCAS system filing matrix. The top table shows filings with various statuses and counts of warnings and errors. A red arrow points to the 'WARNINGS' column for the 'Health*' row. The bottom table shows filings that are 'Not Started'.

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Total Errors: 20 Total Warnings: 20					
Health *	Filed	2	0		
Lender-Placed Insurance	In Progress	16	17		
Homeowners	In Progress	1	1		
Private Passengers Auto *	In Progress	1	2	PENDING	
Long Term Care *	In Progress	0	0		
Disability Income *	In Progress	0	0	APPROVED	
	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Health *	Not Started	0	0		
Lender-Placed Insurance	Not Started	0	0		
Homeowners	Not Started	0	0		
Private Passengers Auto *	In Progress	0	0		PENDING

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.

The screenshot displays a filing matrix with two tables. The top table shows the following data:

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Health *	Filed	2	0		
Lender-Placed Insurance	In Progress	16	17		
Homeowners	In Progress	1	1		
Private Passengers Auto *	In Progress	1	2	PENDING	
Long Term Care *	In Progress	0	0		
Disability Income *	In Progress	0	0	APPROVED	

The bottom table shows the following data:

	STATUS	WARNINGS	ERRORS	WAIVER	EXTENSION
Health *	Not Started	0	0		
Lender-Placed Insurance	Not Started	0	0		
Homeowners	Not Started	0	0		
Private Passengers Auto *	In Progress	0	0		PENDING

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.

Private Passenger Auto Interrogatories		Yes	No	Explanation
		Response		
01	Were there policies in force during the reporting period that provided Collision coverage?		--	
02	Were there policies in force during the reporting period that provided Comprehensive coverage?		--	
03	Were there policies in force during the reporting period that provided Bodily Injury coverage?		--	
04	Were there policies in force during the reporting period that provided Property Damage coverage?		--	
05	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMBI) coverage?		--	
06	Were there policies in force during the reporting period that provided Uninsured Motorists and Underinsured Motorists (UMPD) coverage?		--	
07	Were there policies in force during the reporting period that provided Medical Payments coverage?		--	
08	Were there policies in force during the reporting period that provided Combined Single Limits coverage?		--	
09	Were there policies in force during the reporting period that provided Personal Injury Protection coverage?		--	
10	Was the company actively writing policies in the state at year end?		--	
11	Does the company write in the non-standard market?		--	
12	If Yes, what percentage of your business is non-standard?	--		
13	If Yes, how is non-standard defined?	--		
14/15	Has the company had a significant event/business strategy that would affect data for this reporting period?		--	
16/17	Has all or part of this block of business been sold, closed or moved to another company during the year?		--	
18	How does the company treat subsequent supplemental or additional payments on previously closed claims?		--	
19	Additional state specific Claims comments (optional):			Comments
20	Additional state specific Underwriting comments (optional):			

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

By checking the "I attest" box below, I understand, agree and certify on behalf of the named company that:

1. I am 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. I am 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 my 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. I am 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. I 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.

I Attest First name MI Last name Suffix Title Clear

I Attest First name MI Last name Suffix Title Clear

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 attesters 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.

Overall comments for the filing year 2020

Close Submit Attestation

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.

Lender Placed Insurance (Auto and Home)

Both Single Interest and Dual Interest

Claims

Ratio 1. **Number of claims closed without payment to total number of claims closed**

$$\frac{(\text{\# of claims closed without payment})}{(\text{\# of claims closed with payment}) + (\text{\# of claims closed without payment})}$$

Ratio 2. **Claims open at the end of the period to total claims during the period**

$$\frac{(\text{\# of claims open at the beginning of period} + \text{\# of claims opened during period} - \text{\# of claims closed with payment} - \text{\# of claims closed without payment})}{(\text{\# of claims open at the beginning of period} + \text{\# of claims opened during the period})}$$

Ratio 3. **Claims paid beyond 60 days to total claims closed with payment**

$$\frac{(\text{\# of claims settled 61 - 90 days} + \text{\# of claims settled 91 - 180 days} + \text{\# of claims settled 181 - 365 days} + \text{\# of claims settled beyond 365 days})}{\text{total \# of claims closed with payment}}$$

Ratio 4. **Loss Ratio - Incurred claims to earned premium**

$$\frac{(\text{dollars of claims incurred during the period})}{(\text{dollar amount of premium earned during the period})}$$

Cancellations

Ratio 5. **Master policy cancellations to master policies in force at beginning of the period**

$$\frac{(\text{total \# of master policy cancellations})}{(\text{total \# of master policies in force at beginning of period})}$$

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.

Validation and Review

- Listed warnings
- Ratios
- Data comparisons
- General review



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 policies 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.

2021 | 2020 | 2019 (Current Data Year) | 2018 | Contacts and Scorecards

Log In

Don't have an MCAS login?
Click Here to get it.

Help | [FAQ \(PDF\)](#) | [Contact](#)

GENERAL FILING INFORMATION

[Participation Requirements \(PDF\)](#)

TRAINING

[Online Data Element Tutorials](#)

RESOURCES

[Data Collection Worksheets \(Blanks\)](#)

- [Annuity \(PDF\)](#)
- [Disability Income \(PDF\)](#)
- [Health \(PDF\)](#)
- [Homeowners \(PDF\)](#)
- [Lender-Placed Home and Auto \(PDF\)](#)
- [Life \(PDF\)](#)
- [Long-Term Care \(PDF\)](#)
- [Private Passenger Auto \(PDF\)](#)

[Data Call and Definitions \(Instructions\)](#)

- [Disability Income \(PDF\)](#)
- [Health \(PDF\)](#)
- [Homeowners \(PDF\)](#)
- [Lender-Placed Home and Auto \(PDF\)](#)
- [Life & Annuity \(PDF\)](#)
- [Long-Term Care - Hybrid \(PDF\)](#)
- [Long-Term Care - Stand-Alone \(PDF\)](#)
- [Private Passenger Auto \(PDF\)](#)

[Summary of 2019 Changes \(PDF\)](#)

[2019 MCAS User Guide \(PDF\)](#)

KEY 2019 MCAS DATES

December 16, 2019	Call letters to companies
Mid-January 2020	Last day to submit 2018 corrections (See FAQ Document)
March 16, 2020	Filings may be submitted via the online MCAS filing tool
March - April, 2020	MCAS training webinars
June 30, 2020	MCAS submissions due for all lines of business except Disability Income and Health
August 31, 2020	MCAS submissions due for Disability Income and Health
September 1, 2020	MCAS industry scorecards posted to MCAS Web page for all lines of business except Disability Income and Health
November 1, 2020	MCAS industry scorecards posted to MCAS Web page for Disability Income and Health

NEW FOR 2019 DATA YEAR

- The disability income MCAS was adopted on August 7, 2018 at the NAIC Executive/Plenary session during the NAIC Summer National Meeting. Disability Income MCAS data will be collected for the first time beginning with the 2019 data year.

WHAT DO DOCUMENTS FOUND ON THIS WEB PAGE TELL ME?

General Filing Information

- [Participation Requirements](#) - Detailed information to assist in determining if your company is required to submit MCAS data

Resources

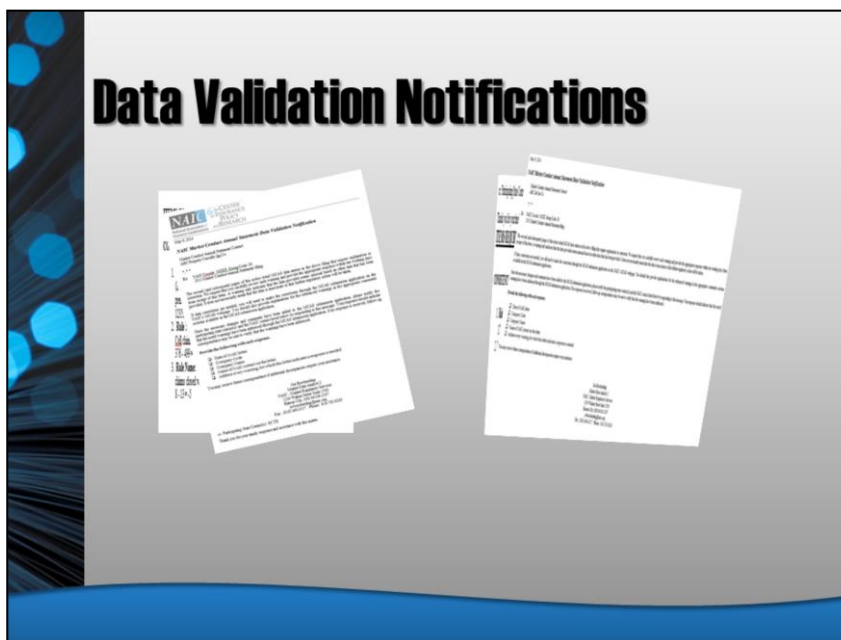
- [Data Collection Worksheets \(Blanks\)](#) - Table layout representation of the required data elements
- [Data Call and Definitions \(Instructions\)](#) - Listing of MCAS data elements and definitions to follow when preparing data for submission
- [MCAS User Guide](#) - Information about how to use the MCAS application and a listing of data validations used within the application
- [CSV Data Upload Instructions](#) - Layout guidelines for preparing a CSV file for uploading to the MCAS

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.

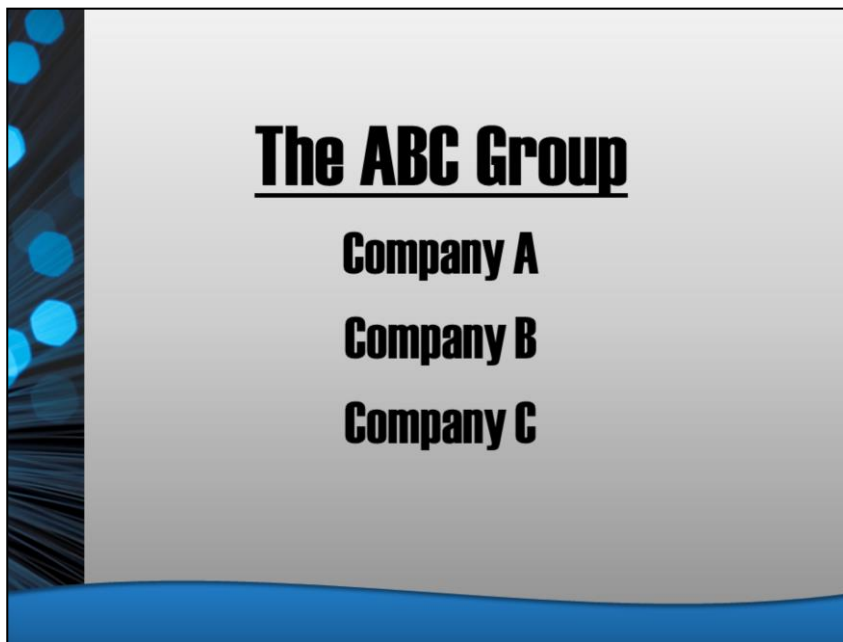
State Regulators have Oversight



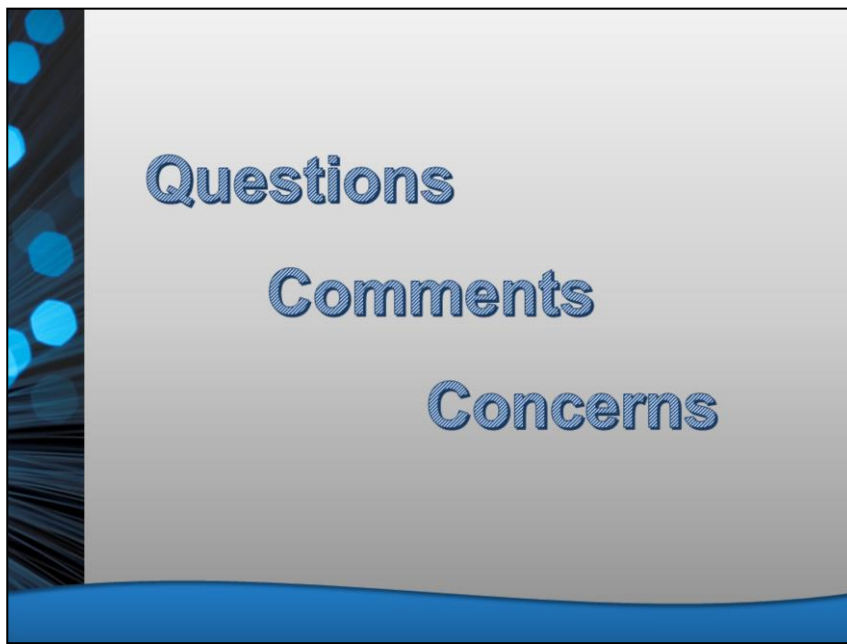
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within **multiple** states.



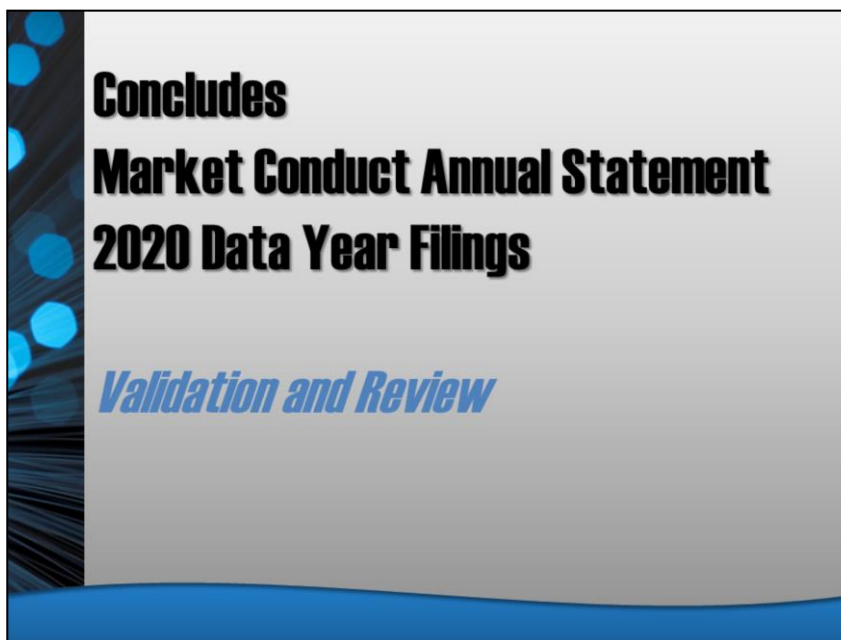
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence. 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.