

Market Conduct Annual Statement 2020 Data Year Filings

*Property & Casualty
Data Elements and Validations*



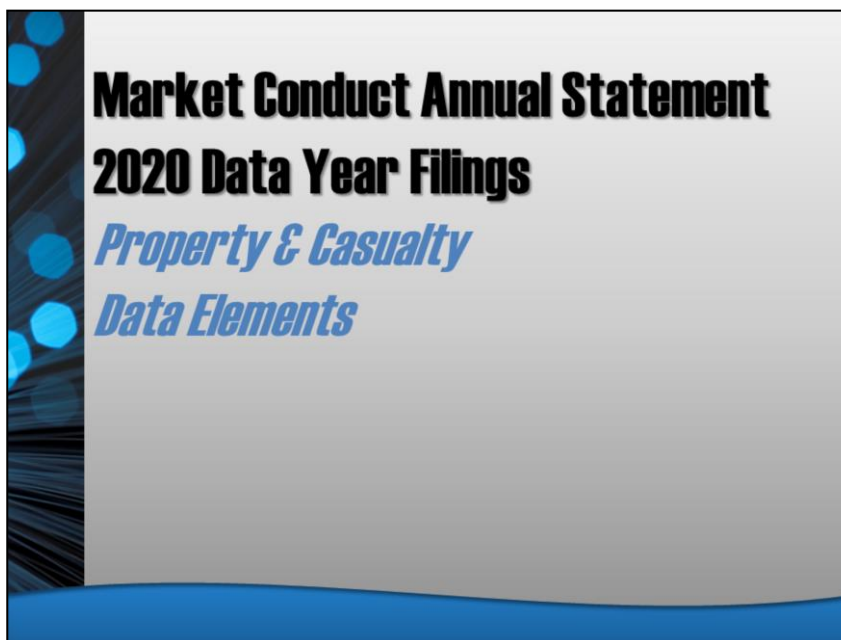
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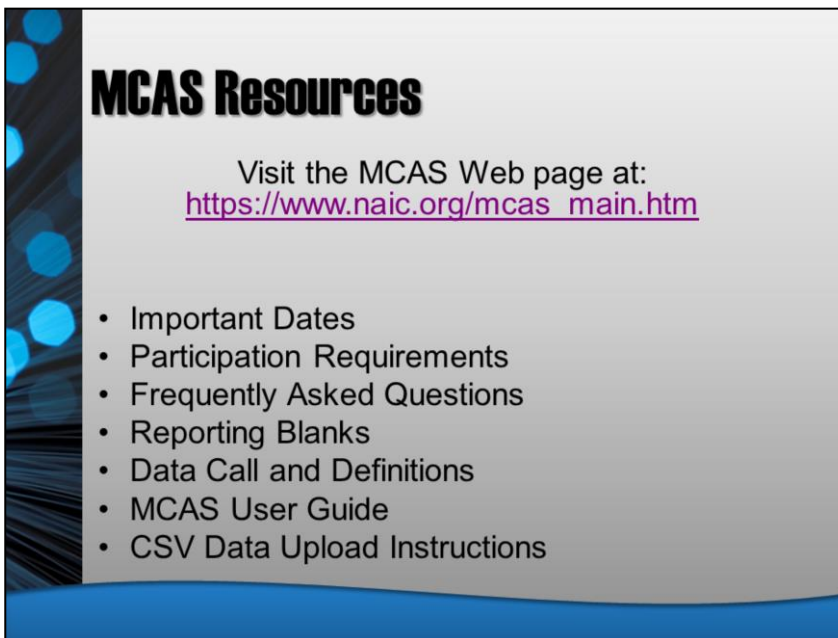
Hi. I'm Tressa Smith, Senior Market Analyst at the NAIC.

In this section of the Market Conduct Annual Statement training we will be reviewing the data elements that must be provided for the Private Passenger Auto MCAS and the Homeowners MCAS.



We are covering the Private Passenger Auto (PPA) and Homeowners (HO) lines of business at the same time, because most of the data elements are the same. When we arrive at a data element that differs between the two, we will point out the difference and explain how the data element applies to each line of business. In most cases these differences are obvious, however, and have no real substantive bearing on the definition of the data element itself.

There are a few general items that need to be mentioned before we begin:



MCAS Resources

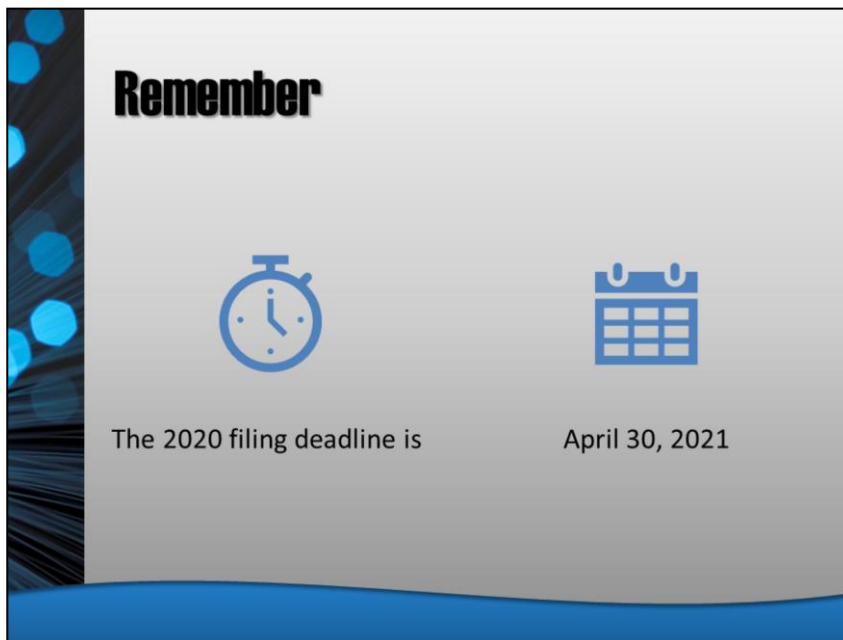
Visit the MCAS Web page at:
https://www.naic.org/mcas_main.htm

- 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



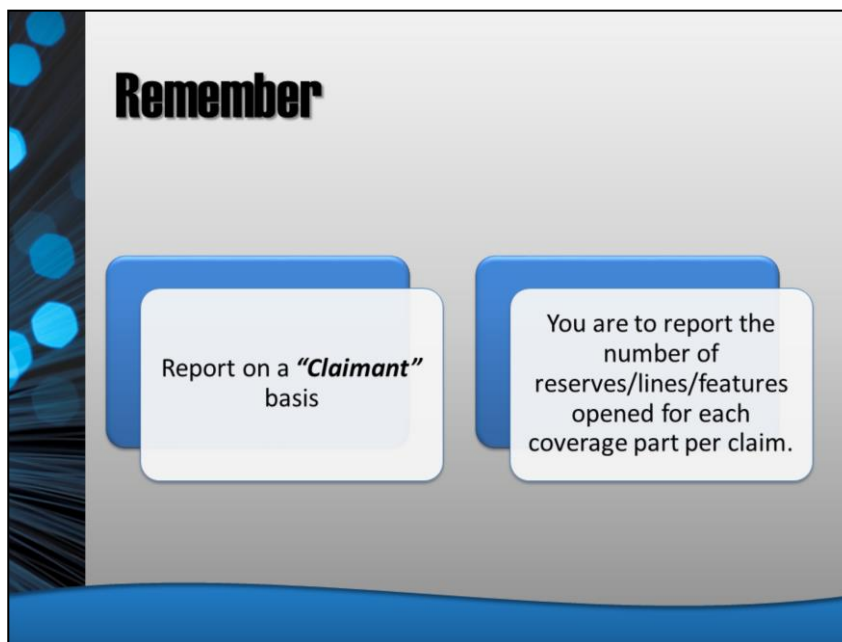
Before we begin, please be sure to remember that the current data year filing deadline is April 30th.

Remember

MCAS Threshold:

- \$50,000 in direct written premium

and second, the Auto and Home reporting threshold for all jurisdictions is \$50,000 in premium.

A graphic slide with a grey background and a blue wavy border at the bottom. On the left, there is a vertical decorative strip with blue circles and light rays. The word "Remember" is written in bold black text at the top left. Below it are two white rounded rectangular boxes with blue borders. The first box contains the text "Report on a 'Claimant' basis". The second box contains the text "You are to report the number of reserves/lines/features opened for each coverage part per claim."

Remember

Report on a **"Claimant"** basis

You are to report the number of reserves/lines/features opened for each coverage part per claim.

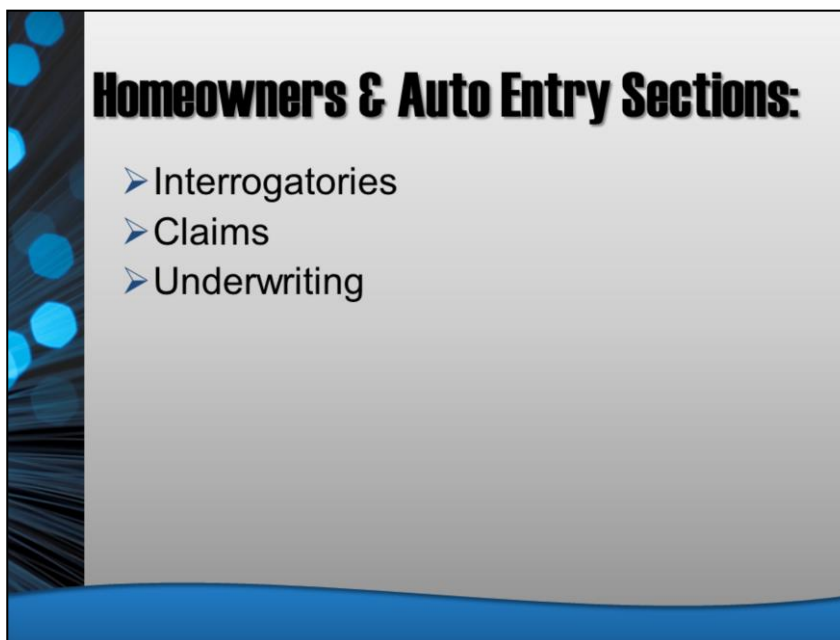
Also, the PPA and HO reporting is to be done on a claimant basis. The Data Call and Definitions explains what is meant by "claimant basis". You are to report the number of reserves/lines/features opened for each coverage part per claim.

Reporting on a Claimant Basis

- HO Claim Received by company includes:
- Liability – 2 lines
- MedPay – 2 lines
- Dwelling – 1 line
- Pers. Prop – 1 line
- Number of Claims Reported in MCAS:
- Liability – 2
- MedPay – 2
- Dwelling – 1
- Pers. Prop. – 1

For example, if one claim results in a line or reserve opened for two liability claimants, two medical payment claims, one dwelling claim for the insured, and one personal property claim for the insured, you would report 2 liability claims, 2 medical payments claims, 1 dwelling claim, and 1 personal property claim.

The aging or the number of days to final payment (if payment is made) would be calculated separately for each claimant reported in MCAS.



Once you are in the data entry area you will see that both the Homeowners and Auto MCAS data elements are divided into three sections – interrogatories, claims and underwriting.

Interrogatories

| | | Yes | No | |
|-------|--|----------|----------|-------------|
| | | Response | Response | Explanation |
| 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): | -- | | |
| 20 | Additional state specific Underwriting comments (optional): | -- | | |

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

The image shows a screenshot of a web-based form titled "INTERROGATORIES". The form is set against a background of blue circles and light rays. It contains a table with 9 rows of questions. Each row has a question on the left and a "Choose One" dropdown menu on the right. Above the table, there are columns for "Yes", "No", and "Response".

| | Yes | No | Response |
|---|-----|----|------------|
| 1 Were there policies in force during the reporting period that provided Collision coverage? | | | Choose One |
| 2 Were there policies in force during the reporting period that provided Comprehensive coverage? | | | Choose One |
| 3 Were there policies in force during the reporting period that provided Bodily Injury coverage? | | | Choose One |
| 4 Were there policies in force during the reporting period that provided Property Damage coverage? | | | Choose One |
| 5 Were there policies in force during the reporting period that provided UMBI and UIMBI coverage? | | | Choose One |
| 6 Were there policies in force during the reporting period that provided UMPD and UIMPD coverage? | | | Choose One |
| 7 Were there policies in force during the reporting period that provided Medical Payments coverage? | | | Choose One |
| 8 Were there policies in force during the reporting period that provided Combined Single Limits coverage? | | | Choose One |
| 9 Were there policies in force during the reporting period that provided Personal Injury Protection coverage? | | | Choose One |

The first interrogatory questions ask if there were policies in force during the reporting period that provided coverage for each of the claims coverage parts. The wording of these questions takes into consideration that some companies need to report underwriting data for Auto and/or Homeowners, but have no claims data to report. Companies can indicate the coverage or coverages for which their in-force policies provide coverage, and they can enter all zeros in the claims sections for these coverages if there were no claims and only underwriting data needs to be reported.

It should be noted that lender-placed or creditor-placed policies should NOT be included in the PPA or HO MCAS reporting. MCAS data is collected separately for Lender-Placed Auto and Home. A separate tutorial is available for review of the Lender-Placed Auto and Home data elements.

Interrogatories

| | | |
|----|--|-------------|
| 10 | Was the company actively writing policies in the state at year end? | Choose One |
| 11 | Does the company write in the non-standard market? | Choose One |
| 12 | If Yes, what percentage of your business is non-standard? | Explanation |
| 13 | If Yes, how is non-standard defined? | Explanation |
| 14 | Did the company have a significant event or business strategy change that would affect data for this reporting period? | Choose One |
| 15 | If yes, explain: | Explanation |
| 16 | Has all or part of this block of business been sold, closed, or moved to another company during the year? | Choose One |
| 17 | If yes, explain: | Explanation |
| 18 | How does the company treat subsequent supplemental or additional payments on previously closed claims? | Explanation |

The next interrogatories ask if you are actively writing business in the state, if you are writing business in the non-standard market, and provides the opportunity to comment on significant events or business strategies; such as blocks of business being sold, closed or moved to another company during the year.

To help the regulators better understand your reported claim counts, you are asked to explain how the insurer handles supplemental payments. For example, is a new claim opened or is the original claim re-opened. It is important that these questions be answered fully to allow regulators to have an understanding of your company's status and reporting methods.

If you indicate that your company does write non-standard business, you are then asked to provide a percentage of the business that is non-standard and how your company defines non-standard business.

Interrogatories

| | | Yes No | |
|-------|---|----------|-------------|
| | | Response | Explanation |
| 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 (UMPDI) 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): | -- | -- |
| 20 | Additional state specific Underwriting comments (optional): | -- | -- |

The final two interrogatory lines provide comment boxes where you may enter any state specific Claims and Underwriting comments. Any areas of your data that may cause questions, or that generated a warning message when validating your data, 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.



Homeowner & Auto Claims Data Elements



Homeowners Coverage Parts

- Dwelling
- Personal Property
- Liability
- Medical Payments
- Loss of Use



The Claims section data elements are divided into several types of coverages and you are expected to provide claims data at that level of detail. The five HO coverage parts are – Dwelling, Personal Property, Liability, Medical Payments and Loss of Use.

Auto Coverage Parts

- Collision
- Comprehensive/Other than Collision
- Bodily Injury
- Property Damage
- Uninsured/Underinsured Motorist Bodily Injury (UMBI)
- Uninsured/Underinsured Motorist Property Damage (UMPD)
- Medical Payments
- Combined Single Limits
- Personal Injury Protection



The nine Auto coverage parts are – Collision, Comprehensive (or Other than Collision), Bodily Injury, Property Damage, Uninsured Motorists and Underinsured Motorists Bodily Injury (UMBI), Uninsured Motorists and Underinsured Motorists Property Damage (UMPD), Medical Payments, Combined Single Limits and Personal Injury Protection.



When providing data on the claims data elements, you must remember to split the responses among the coverage parts. Do not mix Homeowners dwelling claims with Homeowners liability claims, or Auto Property Damage with Auto Bodily Injury.

Opened & Closed Claims

| | |
|----|---|
| 21 | Number of claims open at the beginning of the period. |
| 22 | Number of claims opened during the period. |
| 23 | Number of claims closed with payment during the period |
| 24 | Number of claims closed without payment during the period |
| 25 | Number of claims remaining open at the end of the period |
| 26 | Median days to final payment. |
| 27 | Number of claims closed with payment within 0-30 days. |
| 28 | Number of claims closed with payment within 31-60 days. |
| 29 | Number of claims closed with payment within 61-90 days. |

January 1, 2020 – December 31, 2020

The claims questions begin by asking for the number of claims opened and closed throughout the current reporting period. The current reporting period is January 1st to December 31st.

You are asked to indicate the number of claims open at the beginning of the period, the number of claims opened DURING the period, the number of claims closed DURING the period WITH payment, the number of claims closed DURING the period WITHOUT payment and the number of claims remaining open at the end of the period.

Auto/Homeowners Data Call & Definitions

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

- Includes both first and third party claims.



According to the Data Call and Definitions, the definition of a claim is:

A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy. Each claimant/insured reporting a loss is counted separately. This includes both first, and third party claims.

Auto/Homeowners Data Call & Definitions

Claims

Exclude:

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

It's very important to remember, however, that you must not report an event that is reported to you as “information only”; an inquiry of coverage if a claim has not actually been presented (or opened) for payment; or any potential claimant if that individual has not actually made a claim nor had a claim made on his or her behalf.

Precautionary Reserves



Do Not Count as Opened or Closed Claims

If it is your company's practice to open precautionary reserves on all potential claimants and then close them without payment as the investigation progresses, then you should not include those in the count of claims opened or the count of claims closed without payment.

Transportation Expense Claims

Collision Claim

One claim

Do Not Count as Separate Claims

The image is a graphic with a blue and grey background. At the top, the title 'Transportation Expense Claims' is written in bold black font. Below the title, there are three images: on the left, a photograph of two silver cars in a collision with the text 'Collision Claim' above it; in the center, a blue sign with a white arrow pointing left and the text 'Rental Car Pick-Up'; and on the right, a photograph of a red tow truck carrying a silver car. A large blue banner with the text 'One claim' in white is overlaid across the images, with two blue arrows pointing from the banner to the collision and tow truck images. At the bottom, the text 'Do Not Count as Separate Claims' is written in blue.

For the Private Passenger Auto MCAS, rental and towing expenses which result from a collision loss or a comprehensive/other than collision loss should be considered part of the original claim and not reported as a separate claim. For example, if a collision claim is received and an additional claim is received for towing expenses, you would only report 1 claim on your MCAS.

Auto Data Call & Definitions

Clarification:

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

The definitions of “Coverage – Collision Insurance” and “Coverage – Comprehensive/Other than Collision Insurance” have clarifications noting that rental, transportation and towing expenses should not be counted as separate claims.

Auto/Homeowners Data Call & Definitions

Claims Closed with Payment – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received.



Remember that “Claims Closed WITH Payment” should include only those claims where the claim was **closed** during the reporting period.

Also, it does not matter that the claim may have been opened in any prior period, if it is closed in the company’s claims system during the reporting period and a payment was made, it is counted as a Claim Closed WITH Payment.

Auto/Homeowners Data Call & Definitions

Final Claim Payment made December 20, 2020

**Claim closed in company's claims system
January 5, 2021**

| | |
|--|--|
| Report as Open at end of 2020 | Report as Closed With Payment in 2021 |
|--|--|

For example, if the final claim payment is made on December 20, during the reporting period, and the claim is closed in the company's claims system on January 5, of the next reporting period, The claim would not be reported as closed with payment until the next MCAS data year is reported.

Total Payment to Insured = \$50,000
Subrogation Recovered = \$50,000
Net Loss = 0

1025

DATE _____

PAY TO THE ORDER OF _____ \$ _____

MEMO _____

1025

Also, if you made a payment to the insured, but were able to subrogate the entire amount so that your net payment was zero, it would still be counted as a claim closed WITH payment.

Auto/Homeowners Data Call & Definitions

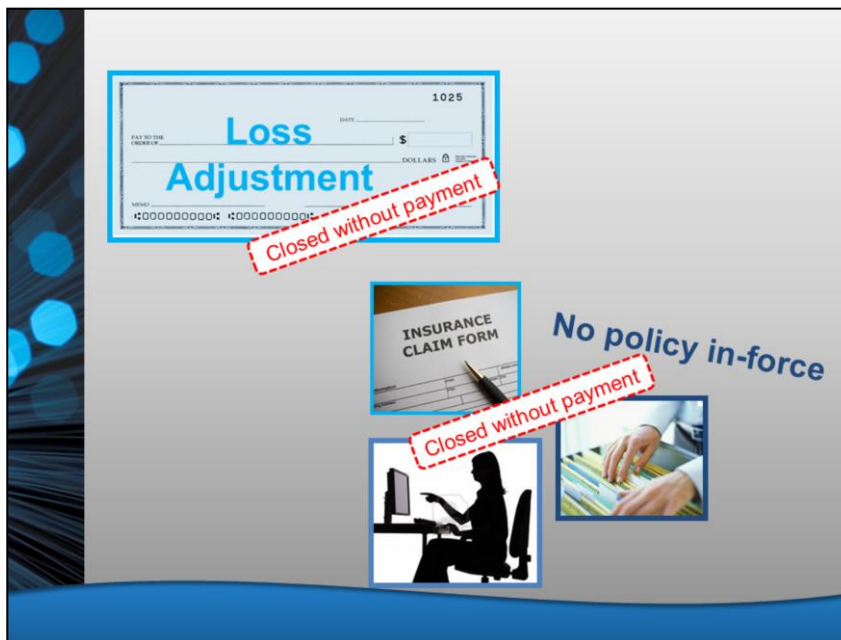
Claims Closed WITHOUT Payment –

Include:

- Claims that are closed because the amount claimed is below the insured's deductible.



Claims that were closed because the amount claimed was below the insured's deductible are to be included in the count of "Claims Closed WITHOUT Payment".

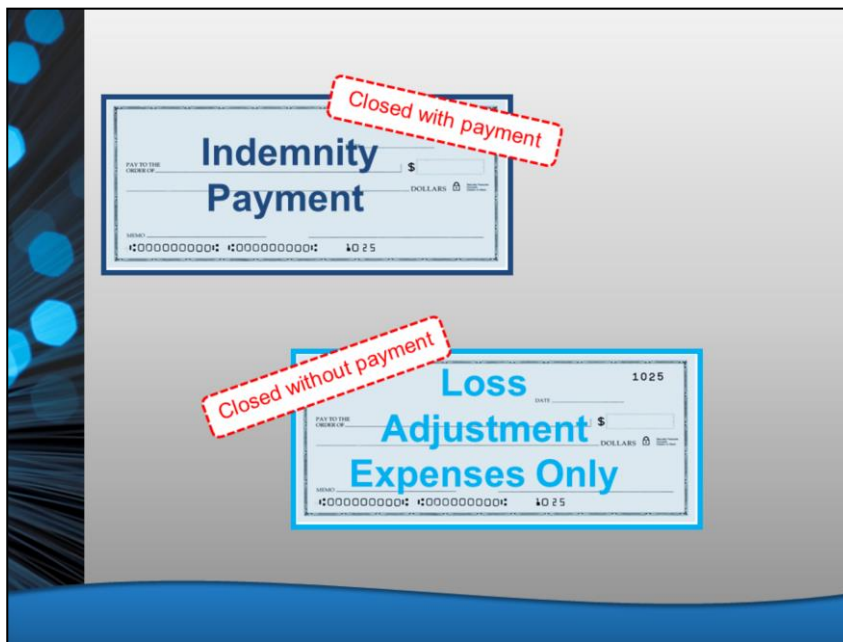


In addition to claims closed below the deductible, other types of claims that should be reported as “closed **without** payment” are those where the only payments made on the claim were loss adjusting expenses, or if a claim is made, a claim file is set up and investigated, and it is then determined that no policy was in-force at the time of loss.

During the reporting period

Claims closed with and without payment should include all claims that were closed DURING the reporting period regardless of the date of loss or when the claim was received

As with the “claims closed **with** payment”, “claims closed **without** payment” include all claims that were closed without payment during the reporting period regardless of the date of loss or when the claim was received.



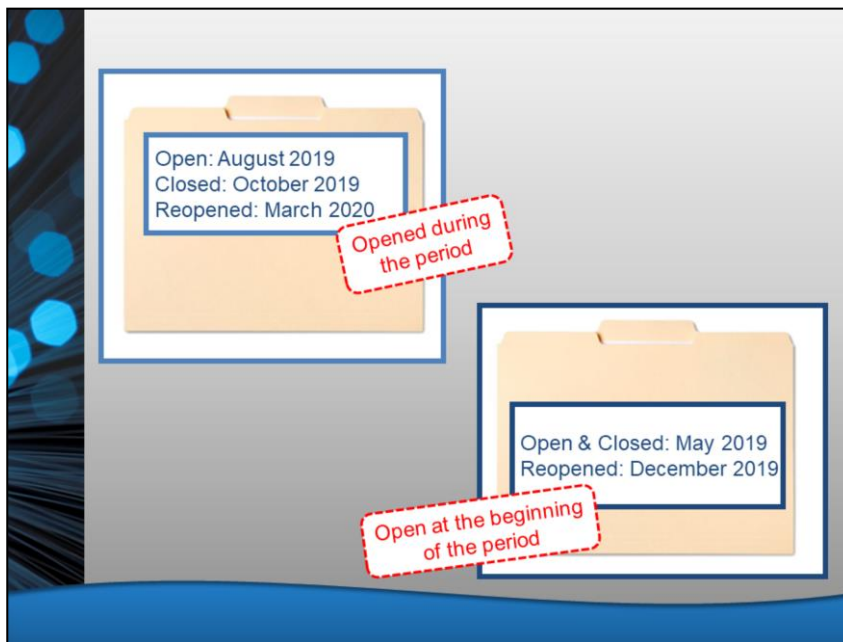
The basic thought to keep in mind when determining whether a claim was closed with or without payment is that any claim that has an indemnity payment, regardless of subrogation, is considered as closed “with payment” and any claim that had no indemnity payment, even if it had loss adjusting expenses, is considered as closed “without payment”



Reopened Claims

If a claim is closed and is later re-opened, the re-opened claim should be counted as a new and distinct claim.

Let's talk a little bit about re-opened claims. If the claim has been closed and is later re-opened, the re-opened claim should be counted as a new and distinct claim.



So if a claim is re-opened during the current period, it would be counted among the “claims opened during the period”, and if the claim had been re-opened in a prior period, but not yet closed, it would be counted among the “claims open at the beginning of the period”.

Reopened Claims

- Closed With Payment or Closed Without Payment



Since the re-opened claim is its own distinct claim and counted separately as a new claim, it must also be recorded as “closed with payment” or “closed without payment” when it is finally closed.

1025

Deductible Reimbursement

PAY TO THE ORDER OF \$ _____ DOLLARS

1025

Do not report a claim as opened and closed:

- If the claim is reopened to reimburse an insured's deductible
- or to process a subrogation recovery

Subrogation Recovery

However, if a claim was re-opened just so an insured's deductible can be reimbursed, or a subrogation recovery can be processed, or for another similar reason, it does not need to be reported as opened and closed.



Always Remember...

You cannot close more claims than you have received

Always remember that in all cases, the number of claims closed with payment plus the number of claims closed without payment will never be greater than the number of claims open at the beginning and opened during the year. That is, you cannot close more claims than you have received.

Speed of Claim Settlements

| | |
|----|--|
| 26 | Median days to final payment. |
| 27 | Number of claims closed with payment within 0-30 days. |
| 28 | Number of claims closed with payment within 31-60 days. |
| 29 | Number of claims closed with payment within 61-90 days. |
| 30 | Number of claims closed with payment within 91-180 days. |
| 31 | Number of claims closed with payment within 181-365 days. |
| 32 | Number of claims closed with payment beyond 365 days. |
| 33 | Number of claims closed without payment within 0-30 days. |
| 34 | Number of claims closed without payment within 31-60 days. |
| 35 | Number of claims closed without payment within 61-90 days. |
| 36 | Number of claims closed without payment within 91-180 days. |
| 37 | Number of claims closed without payment within 181-365 days. |
| 38 | Number of claims closed without payment beyond 365 days. |

After the questions regarding the claims you have received and paid, you are asked a series of questions pertaining to the speed of claim settlements.

Median Days

| | |
|----|---|
| 26 | Median days to final payment. |
| 27 | Number of claims closed with payment within 0-30 days. |
| 28 | Number of claims closed with payment within 31-60 days. |
| 29 | Number of claims closed with payment within 61-90 days. |

The first of these questions ask you to provide the median days to final payment.

Auto/Homeowners Data Call & Definitions

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

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

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

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

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

Exclude:

- Subrogation payments should not be included.

Calculation Clarification / Example:

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

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”.

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, and enter that amount.

Number of days to settlement

- The number of days from when the claim was reported



Reported

Remember, the number of days to settlement is the number of days from when the claim was REPORTED (not opened or reserved), to the date the final payment was made.

Aging on supplemental payments

- The time the request for supplemental payment was received to the date of payment of the supplement



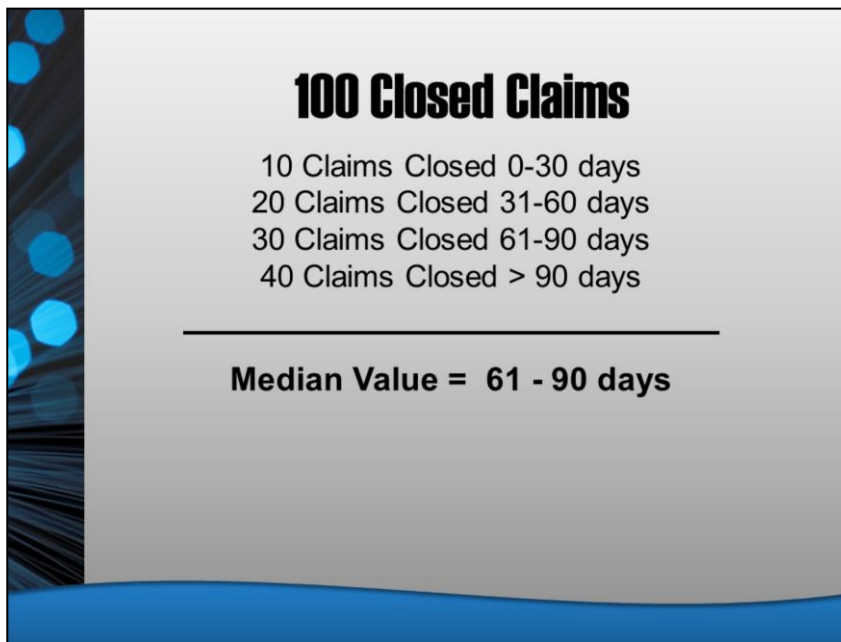
The aging on re-opened claims (that is, on supplemental payments) should be calculated using the time between when the request for supplemental payment was received and the date the final payment was made.

Subrogation claims

- Should be removed from set of claims used to calculate median



A special note regarding subrogation claims – they should be removed from the set of claims used to calculate your median days to settlement even though you would include them in your count of claims closed with payment. They should be excluded from the median days calculation because they tend to take longer to settle than claims settled directly with the claimant.



To double check your work regarding the median days to settlement, you can divide your total closed count in half and find in which category that value would fall. For example, if you have 100 closed claims and

10 are in 0-30 days,
20 are in 31- 60 days,
30 are in 61 to 90 days, and
40 are in greater than 90 days,

you know that counting up 50 from the “0-30”, puts the median value somewhere in the 61-90 category. So, your median should be a value of between 61 and 90.

95 Closed Claims

15 Claims Closed 0-30 days
25 Claims Closed 31-60 days
30 Claims Closed 61-90 days
25 claims closed >90 days

Median Value = 61 - 90 days

As another example for an odd number of claims, if we have 95 total closed claims, the median claim is the 48th claim which puts the median in the 61-90 days value.

Claims Closed With & Without Payment

| | |
|----|--|
| 26 | Median days to final payment. |
| 27 | Number of claims closed with payment within 0-30 days. |
| 28 | Number of claims closed with payment within 31-60 days. |
| 29 | Number of claims closed with payment within 61-90 days. |
| 30 | Number of claims closed with payment within 91-180 days. |
| 31 | Number of claims closed with payment within 181-365 days. |
| 32 | Number of claims closed with payment beyond 365 days. |
| 33 | Number of claims closed without payment within 0-30 days. |
| 34 | Number of claims closed without payment within 31-60 days. |
| 35 | Number of claims closed without payment within 61-90 days. |
| 36 | Number of claims closed without payment within 91-180 days. |
| 37 | Number of claims closed without payment within 181-365 days. |
| 38 | Number of claims closed without payment beyond 365 days. |

The next 12 data elements in the claims section ask you to provide the number of claims that were settled WITH payment and WITHOUT payment within “0-30 days”, “31-60 days”, “61-90 days”, “91-180 days”, “181-365 days” and finally the number that were settled beyond 365 days.

Claims Closed With & Without Payment

| | |
|----|--|
| 26 | Median days to final payment. |
| 27 | Number of claims closed with payment within 0-30 days. |
| 28 | Number of claims closed with payment within 31-60 days. |
| 29 | Number of claims closed with payment within 61-90 days. |
| 30 | Number of claims closed with payment within 91-180 days. |
| 31 | Number of claims closed with payment within 181-365 days. |
| 32 | Number of claims closed with payment beyond 365 days. |
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| 34 | Number of claims closed without payment within 31-60 days. |
| 35 | Number of claims closed without payment within 61-90 days. |
| 36 | Number of claims closed without payment within 91-180 days. |
| 37 | Number of claims closed without payment within 181-365 days. |
| 38 | Number of claims closed without payment beyond 365 days. |

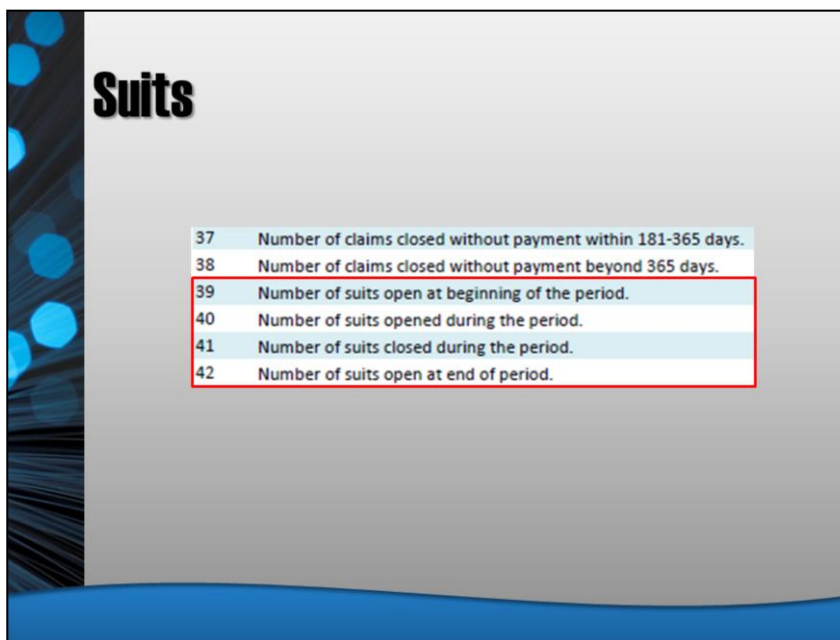
January 1, 2020 – December 31, 2020

As with the previous data elements, the claims settled questions in MCAS are only asking for counts of claims settled DURING the January 1 to December 31 reporting period.

Claims Closed With & Without Payment

| | | | |
|----|--|---|--|
| 21 | Number of claims open at the beginning of the period. | | |
| 22 | Number of claims opened during the period. | | |
| 23 | Number of claims closed with payment during the period | Number of claims closed with payment during the period | |
| 24 | Number of claims closed without payment during the period | | |
| 25 | Number of claims remaining open at the end of the period | | |
| 26 | Median days to final payment. | | |
| 27 | Number of claims closed with payment within 0-30 days. | | |
| 28 | Number of claims closed with payment within 31-60 days. | | |
| 29 | Number of claims closed with payment within 61-90 days. | | |
| 30 | Number of claims closed with payment within 91-180 days. | | |
| 31 | Number of claims closed with payment within 181-365 days. | | |
| 32 | Number of claims closed with payment beyond 365 days. | | |
| 33 | Number of claims closed without payment within 0-30 days. | Number of claims closed without payment during the period | |
| 34 | Number of claims closed without payment within 31-60 days. | | |
| 35 | Number of claims closed without payment within 61-90 days. | | |
| 36 | Number of claims closed without payment within 91-180 days. | | |
| 37 | Number of claims closed without payment within 181-365 days. | | |
| 38 | Number of claims closed without payment beyond 365 days. | | |

Remember, that earlier you were asked to provide the number of claims that were closed with payment and without payment during the reporting period. The total of all the claims closed with payment in the 6 different time categories must match the number of claims that you reported as closed with payment. Likewise, the total of all claims closed without payment in the 6 different time categories must match the number of claims that you reported as closed without payment.



Suits:

There are four remaining claims related data elements collected in the Homeowner and Auto MCAS. These concern claims-related lawsuits received by your company. They ask for the: number of suits that are open at the beginning of the reporting period, the number of suits opened during the period, the number of suits closed during the period, and the number of suits open at the end of the period.

Auto/Homeowners Data Call & Definitions

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

Exclude:

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

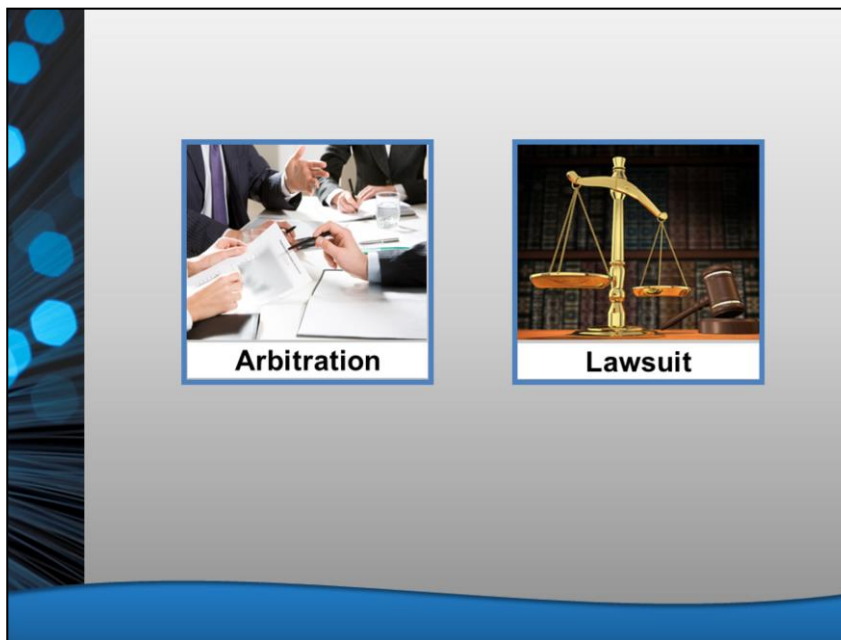
The MCAS definition of a suit can be found in the Data Call and Definitions. When counting suits, you will count those lawsuits filed to enforce a right to a claim. It does not include subrogation claims where a suit is filed by the company against the tortfeasor.

Auto/Homeowners Data Call & Definitions

Calculation Clarification:

- Suits should be reported on the same basis as claims. One suit should be reported for each / claimant / coverage combination, regardless of the number of actual suits filed.
- One suit with two claimants would be reported as two suits as any awards/payments made would be made to the claimants individually.
- One suit filed seeking damages for multiple coverages should be reported as one suit for each applicable coverage.
- Suits should be reported in the state in which the claim was reported on this statement.
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission and state the number of class action lawsuits included in the data and the general cause of the action.

Please note suits should be reported on the same basis as claims. One suit should be reported for each / claimant / coverage combination, regardless of the number of actual suits filed.

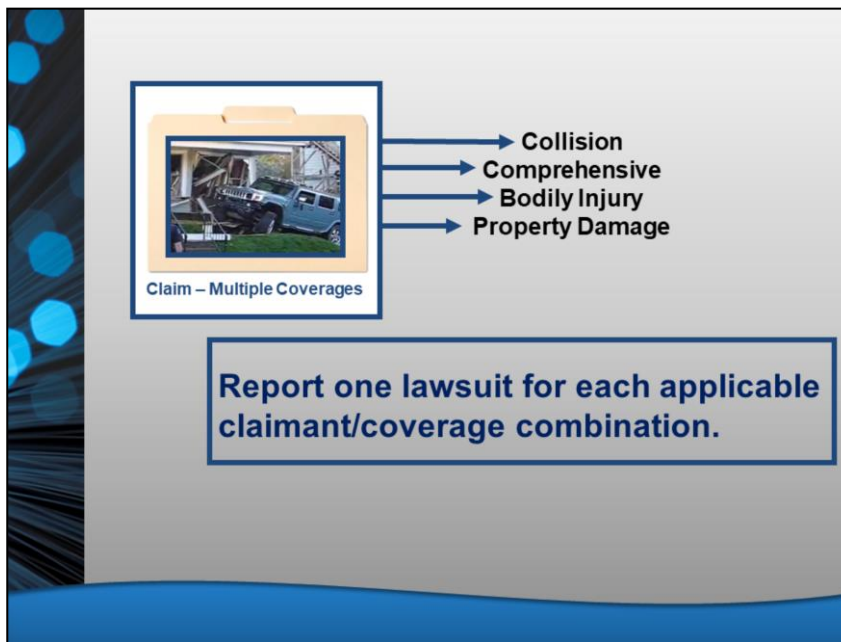


If a suit is a result of, or a precursor to, an arbitration case, it should be counted as a suit. If no suit arises from arbitration, then no suit is counted.



If there are multiple plaintiffs in a lawsuit, you will count each plaintiff as one lawsuit, since each plaintiff can possibly receive a recovery.

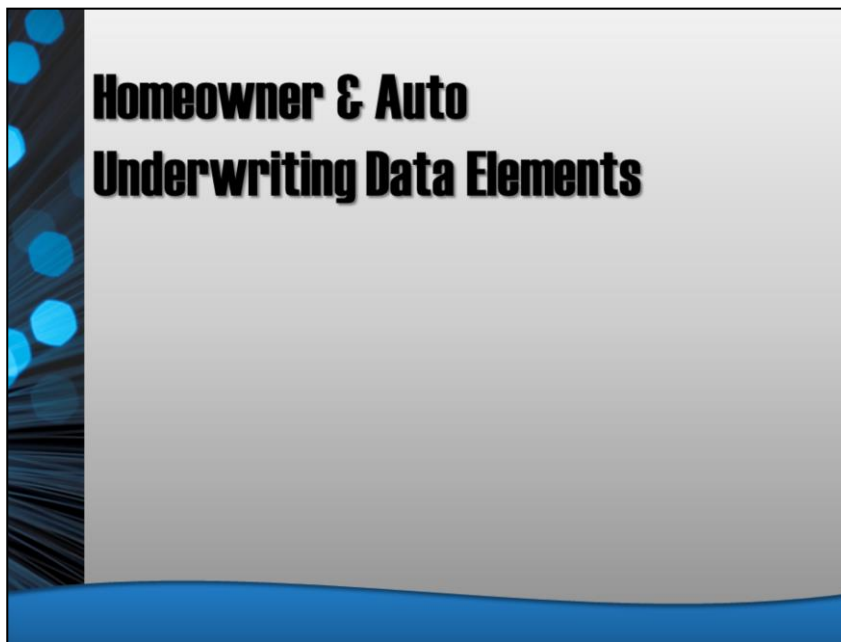
In regards to class action suits, you are to report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. You are then asked to include an explanatory note with your submission and state the number of class action lawsuits included in the data and the general cause of the action.



You should report one suit for each applicable claimant/coverage combination. So, if a suit seeks an award under Auto Bodily Injury and Auto Property Damage, you would report the suit under both the BI coverage and the PD coverage. If the suit seeks award on multiple policies, you will count a suit for each policy.

The slide features a central map of the United States with state abbreviations. Two blue arrows originate from the top corners: one from an icon of a scale of justice labeled 'Lawsuit' pointing to the state of Arkansas, and another from an icon of a document labeled 'Claim' pointing to the state of Tennessee. Below the map, the text 'Report Lawsuit to Tennessee' is displayed in a bold, dark blue font. The slide has a blue decorative border on the left and bottom.

If you are reporting to more than one state, you should report the lawsuit to the state in which the claim was reported on the MCAS. For example, if your MCAS reports a claim received in Tennessee, but the lawsuit was filed in Arkansas, you would report the lawsuit to Tennessee.



That's it for the claims questions. The claims questions are the same for Auto and for Homeowners - the only difference being the coverage parts to which claims are applicable.

Now I'll turn it over to Leana Massey to review the Underwriting data elements.

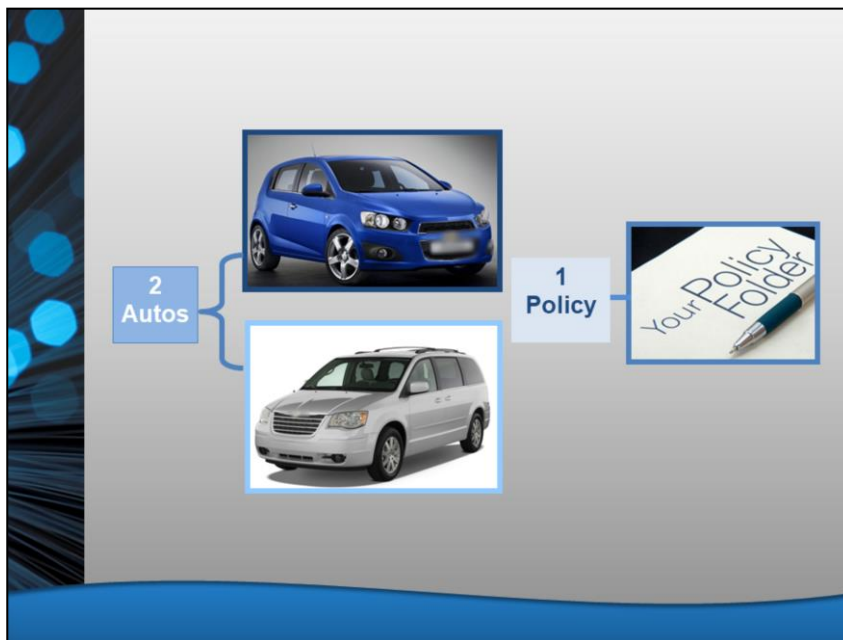
| Homeowners Underwriting Activity | |
|--|--|
| 39 | Number of dwellings which have policies in force at the end of the period. |
| 40 | Number of policies in force at the end of the period. |
| 41 | Number of new policies written during the period. |
| 42 | Dollar amount of direct premium written during the period. |
| 43 | Number of company-initiated non-renewals during the period. |
| 44 | Number of cancellations for non-pay or non-sufficient funds. |
| 45 | Number of cancellations at the insured's request |
| 46 | Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company. |
| 47 | Number of company-initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to a related company. |
| 48 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 49 | Number of complaints received directly from any person or entity other than the DOI. |
| Private Passenger Auto Underwriting Activity | |
| 43 | Number of autos which have policies in force at the end of the period. |
| 44 | Number of policies in force at the end of the period. |
| 45 | Number of new policies written during the period. |
| 46 | Dollar amount of direct written premium during the period. |
| 47 | Number of company-initiated non-renewals during the period. |
| 48 | Number of cancellations for non-pay or non-sufficient funds. |
| 49 | Number of cancellations at the insured's request |
| 50 | Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company. |
| 51 | Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company. |
| 52 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 53 | Number of complaints received directly from any person or entity other than the DOI. |

Hello. This is Leana Massey, Market Regulation trainer for the NAIC.

The Underwriting questions for both Homeowner and Auto *combine* all the coverage parts; you do not have to distinguish between coverage parts when answering the underwriting questions. The underwriting questions are basically the same between Homeowner and Auto. We will cover all the underwriting elements for Homeowner and Auto at the same time and make a note of any differences as we discuss the question.

| Homeowners Underwriting Activity | |
|--|--|
| 39 | Number of dwellings which have policies in force at the end of the period. |
| 40 | Number of policies in force at the end of the period. |
| 41 | Number of new policies written during the period. |
| 42 | Dollar amount of direct premium written during the period. |
| 43 | Number of company-initiated non-renewals during the period. |
| 44 | Number of cancellations for non-pay or non-sufficient funds. |
| 45 | Number of cancellations at the insured's request |
| 46 | Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company. |
| 47 | Number of company-initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to a related company. |
| 48 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 49 | Number of complaints received directly from any person or entity other than the DOI. |
| Private Passenger Auto Underwriting Activity | |
| 43 | Number of autos which have policies in force at the end of the period. |
| 44 | Number of policies in force at the end of the period. |
| 45 | Number of new policies written during the period. |
| 46 | Dollar amount of direct written premium during the period. |
| 47 | Number of company-initiated non-renewals during the period. |
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| 52 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 53 | Number of complaints received directly from any person or entity other than the DOI. |

The first two underwriting questions ask you to provide the total number of policies in force at the end of the period AND the total number of autos or dwellings being insured under those policies.



For example, if 2 autos are insured under 1 policy, you would report 2 autos for the 1st question and 1 policy for the next question.

| Homeowners Underwriting Activity | |
|--|--|
| 39 | Number of dwellings which have policies in force at the end of the period. |
| 40 | Number of policies in force at the end of the period. |
| 41 | Number of new policies written during the period. |
| 42 | Dollar amount of direct premium written during the period. |
| 43 | Number of company-initiated non-renewals during the period. |
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| 48 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 49 | Number of complaints received directly from any person or entity other than the DOI. |
| Private Passenger Auto Underwriting Activity | |
| 43 | Number of autos which have policies in force at the end of the period. |
| 44 | Number of policies in force at the end of the period. |
| 45 | Number of new policies written during the period. |
| 46 | Dollar amount of direct written premium during the period. |
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| 52 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 53 | Number of complaints received directly from any person or entity other than the DOI. |

The next two questions we will treat separately for Auto and Homeowners. These questions ask for the number of new policies written during the period and the dollar amount of direct written premium during the period.

| Homeowners Underwriting Activity | |
|--|--|
| 39 | Number of dwellings which have policies in force at the end of the period. |
| 40 | Number of policies in force at the end of the period. |
| 41 | Number of new policies written during the period. |
| 42 | Dollar amount of direct premium written during the period. |
| 43 | Number of company-initiated non-renewals during the period. |
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| 48 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 49 | Number of complaints received directly from any person or entity other than the DOI. |
| Private Passenger Auto Underwriting Activity | |
| 43 | Number of autos which have policies in force at the end of the period. |
| 44 | Number of policies in force at the end of the period. |
| 45 | Number of new policies written during the period. |
| 46 | Dollar amount of direct written premium during the period. |
| 47 | Number of company-initiated non-renewals during the period. |
| 48 | Number of cancellations for non-pay or non-sufficient funds. |
| 49 | Number of cancellations at the insured's request |
| 50 | Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company. |
| January 1, 2020 – December 31, 2020 | |

Again, *during* the period means policies written between January 1 and December 31.

Auto/Homeowners Data Call & Definitions

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

Exclude:

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

“New policies written” put insurance coverage into effect during the reporting period and excludes renewals. It also excludes ‘re-written’ policies unless there was a lapse in coverage. Since MCAS is asking for **direct** business, do not include premium additions or deductions on account of reinsurance assumed or ceded by the reporting carrier.



Homeowners



Private Passenger

In order to know what to report for these two questions, you need to know what qualifies as an Auto policy and what qualifies as a Homeowners policy in MCAS.



Homeowners

Include:

- Mobile/manufactured homes intended for use as a dwelling.
- Renters insurance, policies covering log homes, land homes, and site-built homes are included.
- Inland Marine or Personal Articles endorsements.

Exclude:

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

Let's start with homeowners:

MCAS requires that you report on personal line homeowner and dwelling policies that combine liability insurance with one or more other types of insurance such as property damage, personal property damage, medical payments and additional living expenses. They must be policies on dwellings that are personally occupied by the owner of the policy.

Renter's insurance policies are included. Also, policies on mobile or manufactured homes intended for use as a dwelling, log homes, land homes, and site-built homes are included.

Homeowner fair plan policies should only be reported on the MCAS if the policies are serviced by the reporting company. Policies that the company is assessed for participation in the fair plan should not be reported.

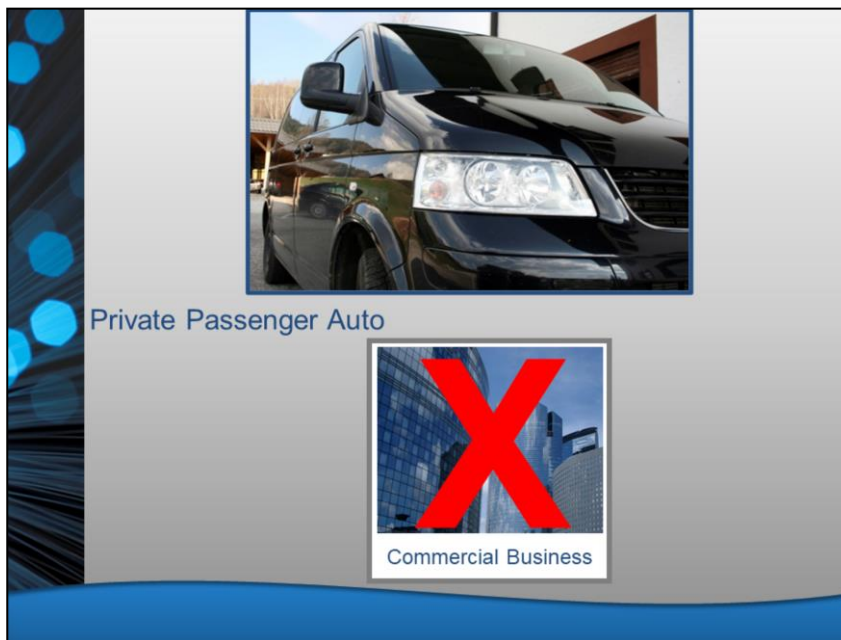


Private Passenger Auto

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

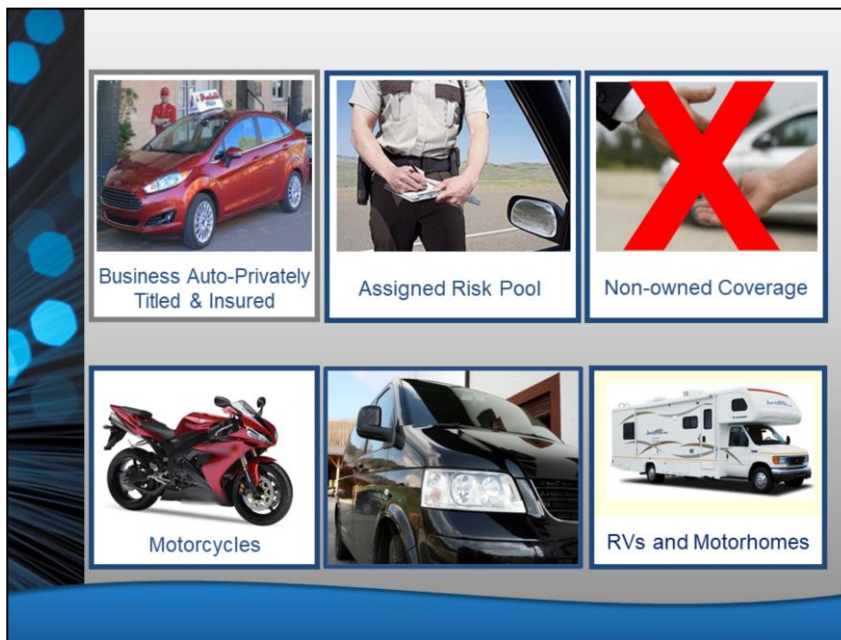
For the Private Passenger Auto MCAS, any policies that are reported on the Financial Annual Statement state page lines 19.1, 19.2 and 21.1 should also be reported in MCAS. These lines are for personal auto physical damage and liability coverages.

Please note that if lender-placed policies are included in the financial annual statement reporting on lines 19.1, 19.2 and 21.1, these should not be included in the MCAS reporting. Lender-placed auto policies are to be reported separately on the lender-placed insurance MCAS.



As with homeowners, MCAS is not collecting any information on commercial business.

There are some clarifications that you should be familiar with:



The first important thing to note is that motorcycles **are** to be included in the MCAS filing. If the vehicle is privately titled it should be reported to MCAS even if it is used in business, UNLESS it is covered on a commercial policy.

Any policies written through an assigned risk pool or other residual market should be reported. Non-owned auto coverage should **not** be reported on the MCAS. RV's and motorhomes that are reported on lines 19.1, 19.2 and 21.1 should be reported also, but only if they are licensed and fall under the state Motor Vehicle Responsibility laws. If a vehicle is reported on these lines but is not subject to the state Motor Vehicle Responsibility laws, it would NOT be reported.



Finally, even though they may be subject to state motor vehicle laws and may be reported in lines 19.1, 19.2 and 21.1, the following types of vehicles are not included in MCAS:

- Policies written on antiques, collectibles, all terrain vehicles, snowmobiles, trailers and dune buggies,
- Miscellaneous vehicles written on Inland Marine policies,
- Other vehicles classified by ISO as miscellaneous that do not fall under the various states' Motor Vehicle Responsibility laws

'Fleet' policies are generally considered to be a commercial policy and would not be included unless the premium for these policies is being reported as 'private passenger auto' insurance on lines 19.1, 19.2 or 21.1 of the state page.

Non-Renewed and Cancelled Policies

Private Passenger Auto Underwriting Activity

| | |
|----|--|
| 43 | Number of autos which have policies in force at the end of the period. |
| 44 | Number of policies in force at the end of the period. |
| 45 | Number of new policies written during the period. |
| 46 | Dollar amount of direct written premium during the period. |
| 47 | Number of company-initiated non-renewals during the period. |
| 48 | Number of cancellations for non-pay or non-sufficient funds. |
| 49 | Number of cancellations at the insured's request. |
| 50 | Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company. |
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| 52 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 53 | Number of complaints received directly from any person or entity other than the DOI. |

After the questions surrounding new business and direct premiums, MCAS asks for counts of policies non-renewed and cancelled.

Non-Renewals



Company Initiated



Insured's Request

For non-renewals, MCAS is only interested in the count of the policies that were non-renewed at the company's initiative within the reporting period. If a renewal offer was made but rejected, or if the insured requested the non-renewal, do not count it as a non-renewal.

Non-Renewals



Company Initiated



Insured's Request

Be sure to only count policies, not the number of dwellings or autos. So, if an auto policy with 2 cars is non-renewed, this counts as just 1 non-renewal.

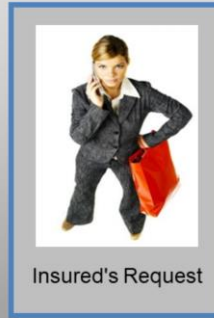
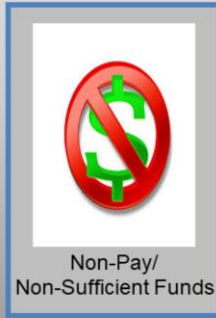
Cancellations

Private Passenger Auto Underwriting Activity

| | |
|----|--|
| 43 | Number of autos which have policies in force at the end of the period. |
| 44 | Number of policies in force at the end of the period. |
| 45 | Number of new policies written during the period. |
| 46 | Dollar amount of direct written premium during the period. |
| 47 | Number of company-initiated non-renewals during the period. |
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| 52 | Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company. |
| 53 | Number of complaints received directly from any person or entity other than the DOI. |

The next questions are to report cancellations for non-pay or non-sufficient funds separate from those that are cancelled at the insured's request.

Cancellations- Non-Payment, Non-Sufficient Funds, Insured's Request



Although the reporting has been broken into two separate lines on the MCAS, these cancellations should still be reported **every** time a policy cancels for non-payment of premium, non-sufficient funds or at the insured's request.

Cancellations



3 Cancellations
January - non-pay
April - non-pay
November - non-pay

So, if a policy cancels for non-pay three times in a policy period, and is reinstated each time; each cancellation should be counted.

Cancellations-

Non-Payment, Non-Sufficient Funds, Insured's Request



Non-Pay/
Non-Sufficient Funds



Insured's Request



Company Initiated

These lines are not where you report cancellations that were initiated by the company. These questions are only interested in cancellations that were the result of the consumer's actions.

Cancellations - Company Initiated



Company Initiated



The **next** cancellation questions ask for the cancellations that are company-initiated. These are to be reported in the same manner as non-renewals. They must be company initiated to be counted for this question.

Cancellations - Company Initiated



Company Initiated



If a policy was cancelled just to be re-written and there is no lapse in coverage, it does not need to be reported. Also, if a policy is reinstated without any lapse in coverage, it should not be counted as a cancellation.

Cancellations - Company Initiated



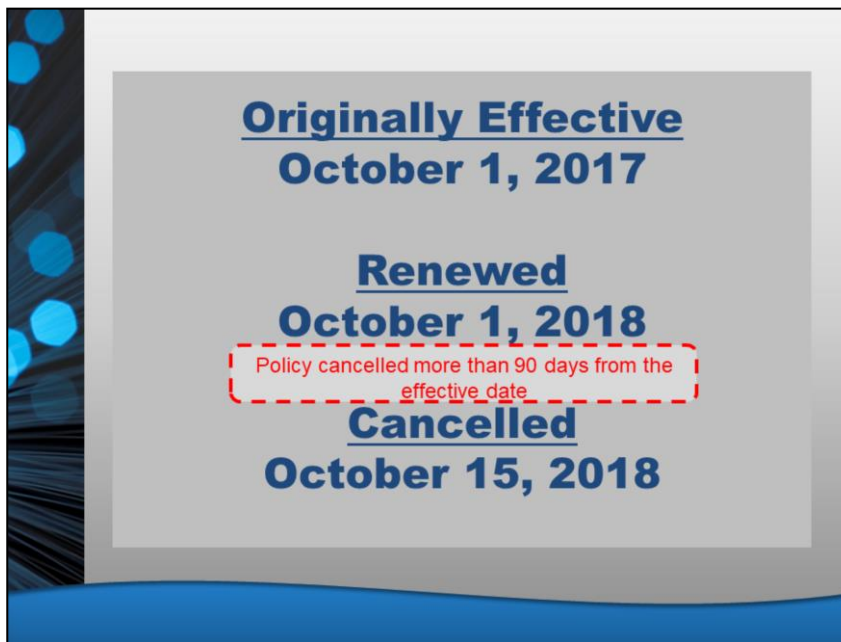
Company Initiated



Cancelled:
< 60 days
60 – 90 Days
> 90 days

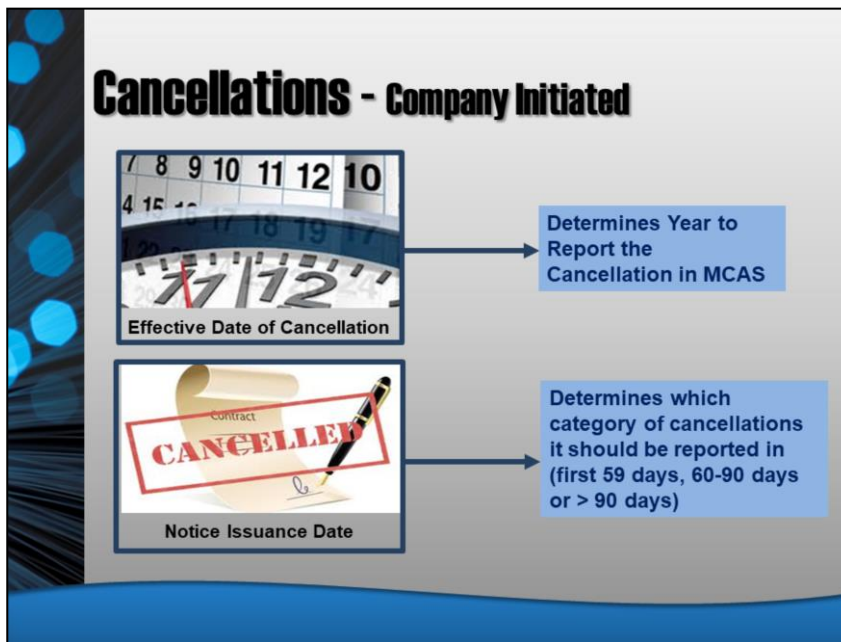


Additionally, cancellations are reported by those cancelled within 59 days of the effective date, those reported 60-90 days from the effective date and those reported more than 90 days from the effective date.

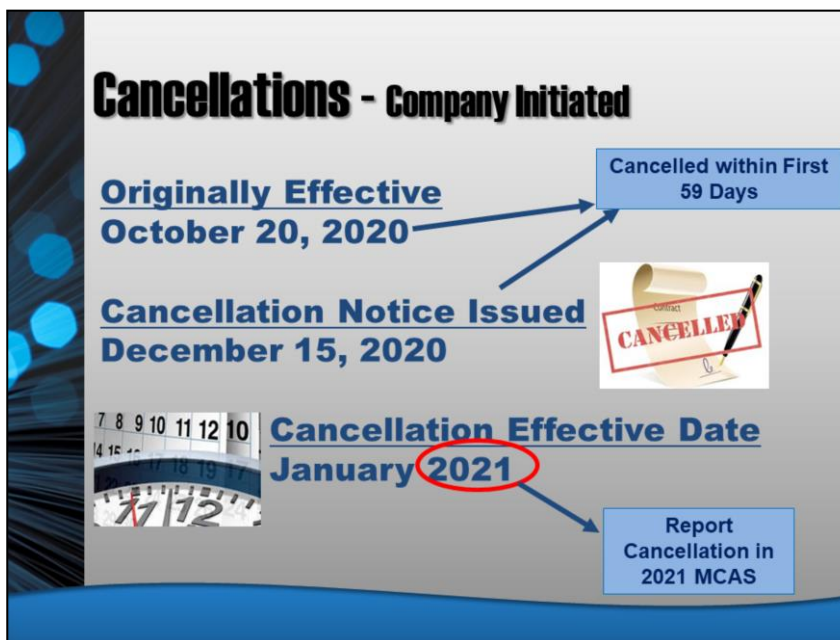


Even if there is a renewal of the policy, you must count from the **original** effective date, not the renewal date. So, if a policy is originally effective on October 1st of the previous reporting period, and is renewed on October 1st during the reporting period, and then cancelled 15 days after the renewal during the reporting period, it would be reported as a policy cancelled more than 90 days from the effective date.

Cancellations - Company Initiated



The effective date of the cancellation is used to determine which year the cancellation is reported in, while the date that the cancellation notice was mailed to the insured determines which category of cancellation it should be reported in (first 59 days, 60-90 days or greater than 90 days).



For example...If a policy is originally effective October 20th, during the reporting period, and a cancellation notice is mailed on December 15th, also during the reporting period, with an effective cancellation date in January of the next reporting period, then you would report the cancellation in the next reporting period as cancelled within the first 59 days.

If your underwriting system does not capture the actual mailing date of the cancellation, you can use the date that the cancellation was processed. Please note in the comment section if you are using the processed date rather than the mailing date.

Complaints

Private Passenger Auto Underwriting Activity

- 43 Number of autos which have policies in force at the end of the period.
- 44 Number of policies in force at the end of the period.
- 45 Number of new policies written during the period.
- 46 Dollar amount of direct written premium during the period.
- 47 Number of company-initiated non-renewals during the period.
- 48 Number of cancellations for non-pay or non-sufficient funds.
- 49 Number of cancellations at the insured's request
- 50 Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
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- 52 Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.
- 53 Number of complaints received directly from any person or entity other than the DOI.



The final MCAS data element is for the reporting of complaints. You are asked to report the number of complaints received directly from any entity other than the Department of Insurance.



Auto/Homeowners Data Call & Definitions

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

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

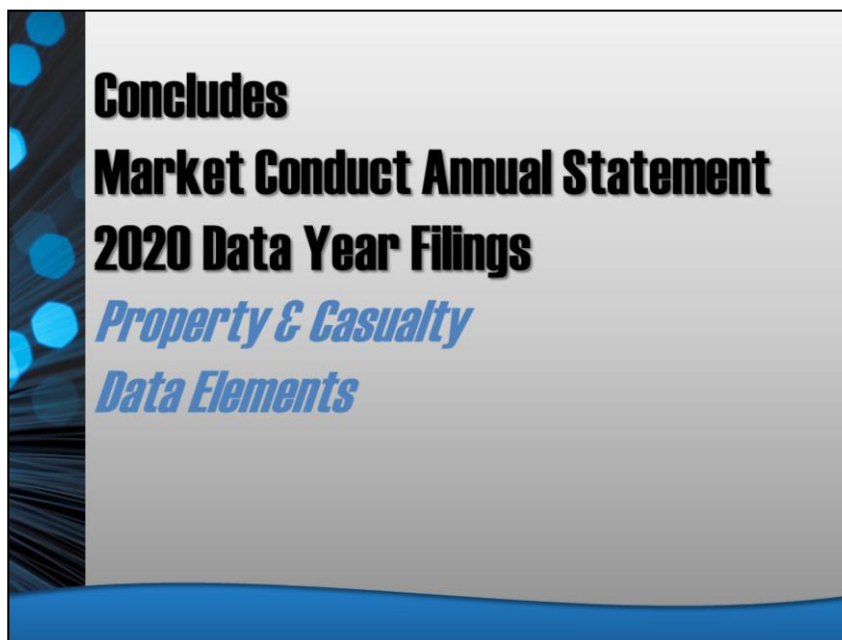
Auto/Homeowners Data Call & Definitions

Complaints Include:

- From social media sites if specific enough to meet the definition of complaint
- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties

Any complaints that are **directly** received by the company through social media applications should be included if the complaint has enough specificity to meet the definition of a complaint.

Even though the number of complaints is reported in the Underwriting section of the data, complaints should be included in the complaint count regardless of the subject of the complaint. So, whether it is regarding claims, underwriting, marketing, or another area, it should be included.



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.

| | | Total Errors: 0 | Total Warnings: 2 | | |
|---------------------------|-------------|-----------------|-------------------|----------|-----------|
| | 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 | |

| | 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 interface 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 | |
|--|--|----------|-------------|-----------------|
| | | Response | Explanation | |
| 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**

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

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**

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

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

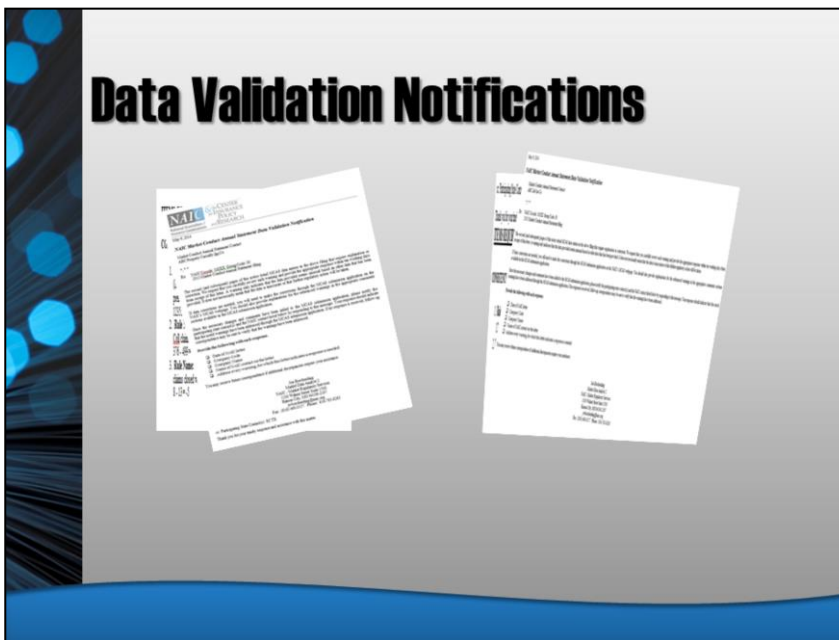
- [Data Collection Worksheets \(Blanks\)](#) - Table layout representation of the required data elements
- [Data Call and Definitions \(Instructions\)](#) - Listing of MCAS data elements and definitions to follow when preparing data for submission
- [MCAS User Guide](#) - Information about how to use 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.

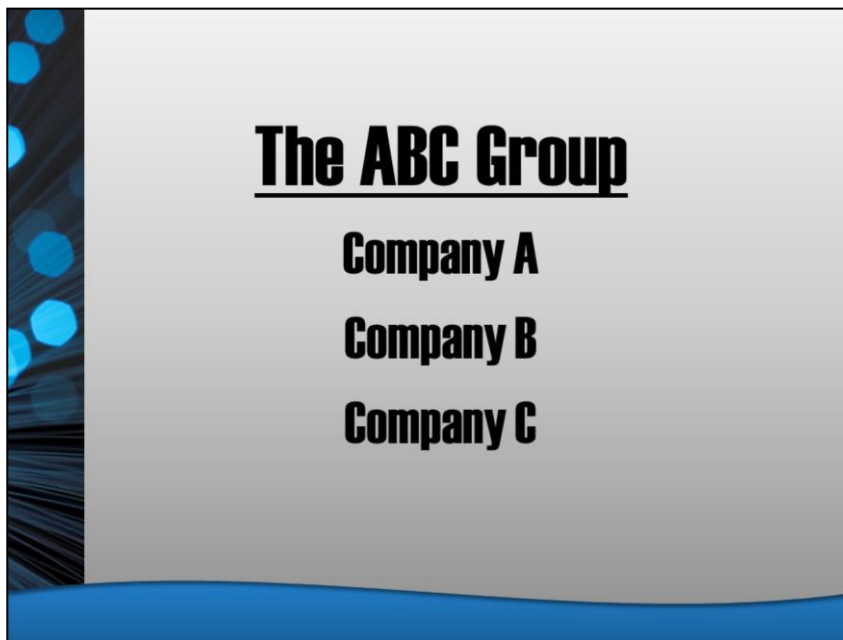
State Regulators have Oversight



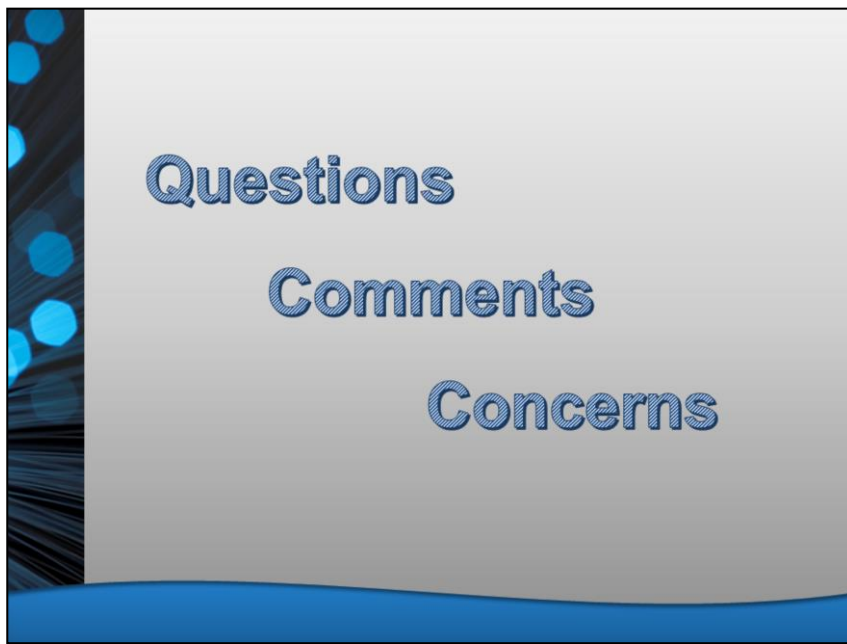
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within **multiple** states.



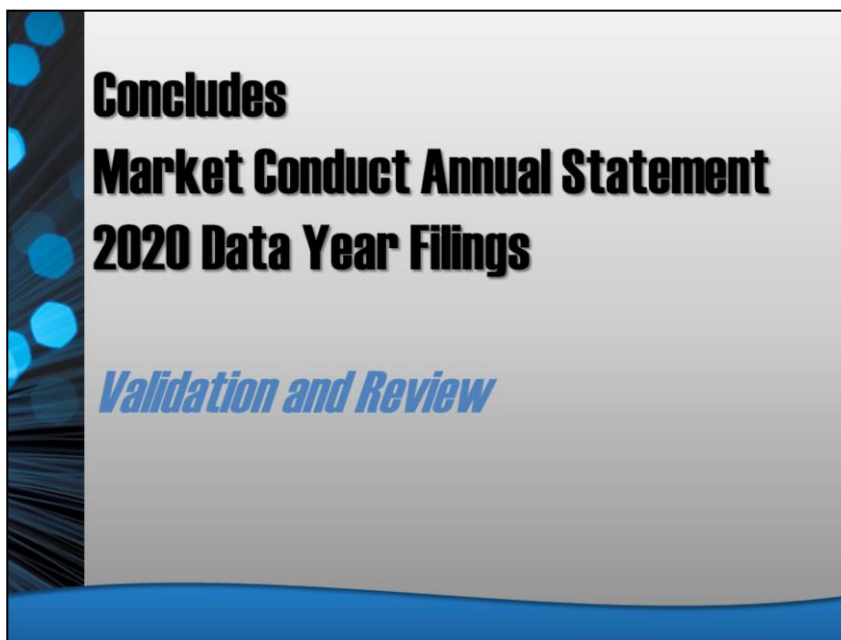
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence.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