This product, including its associated materials, content, subject matter, visual elements, and text, is the exclusive property of the National Association of Insurance Commissioners (NAIC) and is fully subject to the ownership rights of the NAIC under copyright laws of the United States.

The NAIC grants you a non-exclusive, non-transferable license to use this electronic NAIC product for your own personal, non-commercial use. Neither concurrent use on two or more computers, nor use in a local area network or other network is permitted without separate authorization and the payment of other license fees.

Distributing, transmitting, or posting the electronic document in any electronic or printed form, or presenting or adapting product content for the purposes of public presentation, delivery, or publication is strictly prohibited without written permission of the NAIC.
Hello. I’m Leana Massey, Market Regulation Trainer for 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 Flood MCAS.
Before we begin, please be sure to remember that the current data year filing deadline is April 30th.
Private Flood MCAS reporting began with the 2020 data year.

Private Flood Insurance is defined as coverage that insures residential property against the peril of flood.
Private Flood Insurance includes: mobile or manufactured homes intended for use as a dwelling, individual unit condo coverage, stand-alone policies, endorsements or riders to residential property insurance policies, and first dollar and excess policies.

Private Flood Insurance does NOT include: National Flood Insurance Program (NFIP) policies, commercial policies, condo master policies, lender-placed or creditor-placed policies, and private flood written on a surplus lines basis.
The Private Flood MCAS reporting threshold for all jurisdictions is $50,000. This amount applies to all Private Flood premium and is an aggregate total, so it includes all individual sub-lines that were developed for the Private Flood MCAS blanks.

Experience for Private Flood should be reported regardless of whether the coverage is provided as a stand-alone policy or endorsement or rider to another residential property insurance policy, and regardless of the line of business in the statutory annual statement in which the experience is reported, and regardless of whether the coverage is first dollar or excess.
There are six coverages for the Private Flood MCAS: Stand-Alone Policies (First Dollar Coverage), Stand-Alone Policies (Excess Coverage), Endorsements to a Homeowners Policy (First Dollar Coverage), Endorsements to a Homeowners Policy (Excess Coverage), Endorsements to a Policy Other than Homeowners (First Dollar Coverage) and Endorsements to a Policy Other than Homeowners (Excess Coverage).
We will review the definitions of the private flood coverages later in the tutorial, but let's briefly review the difference between first dollar coverage and excess coverage here.

First dollar private flood insurance provides payment for covered losses up to the specified policy limit without use of deductibles, while excess private flood insurance policies provides payment on covered losses above the maximum amount available on first dollar policies.
Once you are in the data entry area of the MCAS, you will see that the Private Flood data elements are divided into four sections: Interrogatories, Claims, Underwriting, and Lawsuits and Complaints.
The interrogatories provide one location for all comments and questions that require a text response.

The wording of the questions for interrogatories takes into consideration that some companies need to report underwriting data for Private Flood 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.
The first two interrogatory questions ask if the company writes private flood policies or endorsements, and if there were policies in force during the reporting period.

<table>
<thead>
<tr>
<th>Interrogatories - General</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
</tr>
<tr>
<td>02</td>
</tr>
<tr>
<td>03</td>
</tr>
<tr>
<td>04</td>
</tr>
<tr>
<td>05</td>
</tr>
<tr>
<td>06</td>
</tr>
<tr>
<td>07</td>
</tr>
</tbody>
</table>
The 3rd question asks the company to list which annual statement lines of business on the state page of the statutory annual statement, the company reports private flood experience.

For example, the line of business number for Private Flood is 2.5, but it is possible your company reports Private Flood experience under a different line of business on the annual statement.
The next two interrogatories (questions 4 & 5) ask if there were private flood policies or endorsements in force during the reporting period that provided Personal Property Coverage or Loss of Use coverage.

Question 6 asks if your company was still actively writing private flood coverage in the state at the end of the year, and the last general question asks how your company treats subsequent supplemental payments on previously closed claims (or additional payments on a previously reported claim).

The purpose of question 7 is to help regulators better understand your reported claim counts. 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.
After the general interrogatories, there are additional questions for the six different Private Flood coverages which were listed earlier.

The first question asks if your company is reporting data for that particular coverage.
If you respond yes, the questions that follow are the same under each coverage.

First you are asked if your company had a significant event/business strategy that would affect the coverage data for the reporting period. If you respond yes, you are asked to explain.

Next you are asked if the block of business for that coverage or part of that block of business has been sold, closed or moved to another company during the year. Again, an explanation will need to be provided if you answer yes.

The last question if you are reporting a particular private flood coverage, asks if the policies in force at the beginning of the reporting period in this report match the number of policies or endorsements in force at the end of the reporting period for the first prior year report. If the answer to this question is no, the difference must also be explained.

---

**Interrogatories – Specific Coverages**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the reporting company have stand-alone (first dollar coverage) to report?</td>
<td>Y</td>
</tr>
<tr>
<td>If yes, has the company had a significant event/business strategy that would affect stand-alone (first dollar coverage) data for this reporting period?</td>
<td>Y/N</td>
</tr>
<tr>
<td>If yes, explain.</td>
<td></td>
</tr>
<tr>
<td>Does the reporting company have stand-alone (excess coverage) to report?</td>
<td>Y</td>
</tr>
<tr>
<td>If yes, has the company had a significant event/business strategy that would affect stand-alone (excess coverage) data for this reporting period?</td>
<td>Y/N</td>
</tr>
<tr>
<td>If yes, explain.</td>
<td></td>
</tr>
<tr>
<td>Does the reporting company have the number of stand-alone (first dollar coverage) policies in force at the beginning of the reporting period for the first prior year report?</td>
<td>Y/N</td>
</tr>
<tr>
<td>If yes, explain.</td>
<td></td>
</tr>
<tr>
<td>Does the block of business for that coverage or part of that block of business have been sold, closed or moved to another company during the year?</td>
<td>Y/N</td>
</tr>
<tr>
<td>If yes, explain.</td>
<td></td>
</tr>
<tr>
<td>Does the number of stand-alone (excess coverage) policies in force at the beginning of the reporting period for the first prior year report?</td>
<td>Y/N</td>
</tr>
<tr>
<td>If yes, explain.</td>
<td></td>
</tr>
</tbody>
</table>

© 2022 The National Association of Insurance Commissioners. All Rights Reserved
If you respond “NO” when asked if you are reporting a particular coverage, 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.
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.
Next, we’ll review the Private Flood Claims Data Elements.
The Claims section data elements are also divided into the several types of Private Flood coverages, and you are expected to provide claims data at that level of detail.
The first type of Private Flood coverage shown to enter claims information for is Stand-alone policies.

Per the data call and definitions, stand-alone private flood, is private flood insurance provided through a policy providing only coverage for the peril of flood.
The next Private Flood coverage data is collected for, is Endorsement to a Homeowners Policy.

Endorsement to a Homeowners Policy means the offer of private flood through an addition to a homeowners policy through endorsement, rider, amendment or any other means.
The final Private Flood coverage part that data is collected for is endorsement to a Policy Other than Homeowners.

Endorsement to a Property Insurance Policy Other than Homeowners means the offer of private flood through an addition to a property insurance policy other than a homeowners policy through endorsement, rider, amendment or any other means.
When providing data on the claims data elements, you must remember to split the responses among the coverage parts. For example, do not mix stand-alone private flood claims with endorsements to a Homeowners policy claims, or Endorsements to a Homeowners Policy claims with stand-alone claims. Data for each coverage part must be reported separately.
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. Now let’s review the definitions for this section.
Per the Data Call and Definitions, 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 or endorsement. Each insured reporting a loss is counted separately. Each reserve opened is counted separately; a single event may result in multiple private flood claims if there are multiple coverages provided in the policy or endorsement.

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/her behalf.

It is important to remember that the following are excluded from the definition of a claim:
➢ an event reported for “information only”,
➢ an inquiry of coverage if a claim has not actually been presented (or opened) for payment, and
➢ a potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.
“Claims Closed WITH Payment” should include only those claims where the claim was closed during the reporting period. It doesn’t matter if the claim may have been opened in a 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.

The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported, or between the date of the final payment and the request for supplemental payment was received. The date of final payment is the date final payment was issued to the insured/claimant.
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.
There are a few clarifications you should keep in mind regarding claims closed with payment:

➢ If a claim is reopened for the sole purpose of refunding the insured’s deductible do not count it as a paid claim,

➢ For claims where the net payment is $0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims, and

➢ For each coverage identifier, the sum of the claims closed with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.
So, if you made a payment to the insured, but were able to subrogate the entire amount and the net payment was zero, it would still be counted as a claim closed WITH payment.
Please also keep in mind the types of claims that should be excluded from claims closed with payment. You should exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant, and
- Claims that are closed because the amount claimed is below the insured’s deductible.
“Claims Closed WITHOUT Payment” is defined as claims closed with no payment to an insured. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened.

As with claims closed WITH payment, for each coverage identifier, the sum of claims closed without payment across each closing time interval should equal the total number of claims closed without payment during the reporting period. Let’s review some examples on the next few slides.
Claims that are closed because the amount claimed was below the insured’s deductible, should 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.
As with the “claims closed with payment”, “claims closed without payment” includes 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”.
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”.
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.
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 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.
After the questions regarding claims you have received and paid, you are asked a series of questions pertaining to the speed of claim settlements.
The first of these questions asks you to provide the median days to final payment. The date of final payment is the date final payment was issued to the insured or claimant.
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, please take some to review the definition and this section of the data call and definitions.
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.
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.
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.
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.
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.
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.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>57</td>
<td>Median days to final payment.</td>
</tr>
<tr>
<td>58</td>
<td>Number of claims closed with payment within 0-30 days.</td>
</tr>
<tr>
<td>59</td>
<td>Number of claims closed with payment within 31-60 days.</td>
</tr>
<tr>
<td>60</td>
<td>Number of claims closed with payment within 61-90 days.</td>
</tr>
<tr>
<td>61</td>
<td>Number of claims closed with payment within 91-180 days.</td>
</tr>
<tr>
<td>62</td>
<td>Number of claims closed with payment within 181-365 days.</td>
</tr>
<tr>
<td>63</td>
<td>Number of claims closed with payment beyond 365 days.</td>
</tr>
<tr>
<td>64</td>
<td>Number of claims closed without payment within 0-30 days.</td>
</tr>
<tr>
<td>65</td>
<td>Number of claims closed without payment within 31-60 days.</td>
</tr>
<tr>
<td>66</td>
<td>Number of claims closed without payment within 61-90 days.</td>
</tr>
<tr>
<td>67</td>
<td>Number of claims closed without payment within 91-180 days.</td>
</tr>
<tr>
<td>68</td>
<td>Number of claims closed without payment within 181-365 days.</td>
</tr>
<tr>
<td>69</td>
<td>Number of claims closed without payment beyond 365 days.</td>
</tr>
</tbody>
</table>
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.
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.
That concludes the claims information review. Now let’s take a look at the Underwriting data elements.
The underwriting questions request information on each private flood coverage.
The first question asks you to provide the number of private flood policies or endorsements in force at the end of the reporting period in the first prior year report.

The second question asks you to provide the number of private flood policies or endorsements in force at the beginning of the reporting period.

Please note that question 74, is the difference between these two questions. So, to answer question 74, you will subtract the number entered for question 71, from the number entered for question 70.

Now let's review the definition of policies or endorsements in-force.
Policies or endorsements in-force, means coverage, through the relevant policy or endorsement, was in effect at some point in time during the specified time frame. Time frames used in the Private Flood MCAS includes at the end of the prior reporting period, at the beginning of the current reporting period, at any point during the current reporting period, and at the end of the current reporting period.
The next two questions ask for the number of private flood policies or endorsements written during the period and the number of private flood policies or endorsements in force at the end of the reporting period. **During** the period means policies or endorsements written between January 1 and December 31.
“New Business policies written” puts insurance coverage into effect during the reporting period and excludes re-written policies unless there was a lapse in coverage.
After answering the various questions for policies or endorsements in force and written, you are asked for the dollar amount of direct premium written during the reporting period for private flood policies or endorsements.
Direct written premium is defined as the total amount of direct written premium for all policies covered by the market conduct annual statement (new and renewal) written during the reporting period.

Premium amounts should be determined in the same manner as used for the financial annual statement state page exhibit.
Let’s review some additional calculation clarifications for direct written premium. If premium is refunded or additional premium is written during the reporting period (regardless of the applicable policy effective date), the net effect should be reported.

If there’s a difference of 20% or more between the Direct Written Premium for stand-alone private flood reported for market conduct annual statement and the direct written premium reported on the financial annual statement page exhibit line 2.5, you must provide an explanation for the difference when filing the MCAS to avoid inquiries from the regulator receiving the MCAS filing.

Reporting should not include premiums received from, or losses paid to other carriers on account of reinsurance assumed by the reporting carrier, nor shall any deductions be made by the reporting carrier for premiums added to, or for losses recovered from other carriers on account of reinsurance ceded.
In the remaining underwriting questions, MCAS asks for counts of policies or endorsements non-renewed and cancelled.

A non-renewal is defined as a policy for which the insurer elected not to renew the coverage for circumstances allowed under the “non-renewal” clause of the policy.
So, 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.
Be sure to only count policies, not the number of dwellings. So, if a private flood policy with 2 dwellings is non-renewed, this counts as just 1 non-renewal.
After reporting non-renewals, the next two questions are to report cancellations for non-pay or non-sufficient funds, and cancellations at the insured’s request.

Cancellations include all cancellations of the policies where the cancellation effective date is during the reporting year. The number of cancellations should be reported on a policy basis, regardless of the number of dwellings insured under the policy. This is similar to what we just reviewed regarding how non-renewals are counted.
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.
So, if a policy cancels for non-pay three times in a policy period and is reinstated each time, each cancellation should be counted.
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.
The **next few** 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 these questions.
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.
Additionally, cancellations are reported by those cancelled within 59 days of the effective date of the policy, those cancelled 60-90 days from the effective date of the policy, and those cancelled more than 90 days from the effective date of the policy.
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.
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.
The last set of questions for the Private Flood MCAS collects data on lawsuits and complaints.

You must provide the number of lawsuits that are open at the beginning of the reporting period, the number of lawsuits opened during the period, the number of lawsuits closed during the period, the number of lawsuits closed during the period with consideration for the consumer, and the number of suits open at the end of the period.
The MCAS definition of a lawsuit can be found in the Data Call and Definitions. Lawsuits Closed During the Period with Consideration for the Consumer is also defined there. This category is for lawsuits closed during the reporting period where a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value (in other words consideration), to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting company before the lawsuit was brought.
When reporting lawsuits in the MCAS blanks, you should 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. All lawsuits must be included, whether or not a hearing or proceeding before the court occurred.
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 under two policies, count the action as two lawsuits.
If one lawsuit has two or more complainants, you will report the number of complainants as the number of lawsuits, since each complainant can possibly receive a recovery. For example, if one lawsuit has five complainants, you will report five lawsuits.

When reporting class action lawsuits, 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.
Do not include arbitrations of any sort when reporting lawsuits in the Private Flood MCAS blanks.
Lawsuits must be reported in the jurisdiction in which the policy was issued, with the exception of class action lawsuits.

So, if a policy is issued in Tennessee, but the lawsuit related to the policy is filed in Arkansas, you would report the lawsuit to Tennessee.
The final MCAS data element is for the reporting of complaints. You are asked to report the number of complaints received directly from any person or entity other than the Department of Insurance.
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.
Complaints include any complaint regardless of the subject of the complaint. So, whether it is regarding claims, underwriting, marketing, or another area, it should be included. You should also include complaints received from third parties.
This concludes the data elements review portion of the tutorial. Now we'll discuss the MCAS data validations.
MCAS Validation and Review.
MCAS Validations are data checks programmed within the MCAS data submission application.

• Some validations are considered to be Errors and must be corrected before submission of data is allowed.
• Other validations are considered to be Warnings. Filings containing Warnings can be successfully submitted.
MCAS Validations have multiple purposes.

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

It is understood that some validation warning failures may be generated on accurate data that is the result of valid circumstances; for example, companies with small amounts of business to report, or runoff business to report may trigger validation warning failures that are not concerning.
The MCAS system filing matrix provides the MCAS user with information regarding their filings. The filing matrix displays the number of warnings found in submitted or started filings. Before a company submits each filing containing warnings, they are prompted to add comments regarding any outstanding warnings in the submission.
Once a company has filed the MCAS data, the filing matrix will display a status of “filed” for each state and line of business submitted. At this point in the process, NAIC staff will begin a review of the data, checking for data inconsistencies and anomalies.
As NAIC analysts review company filings, they view comments found in the interrogatories,
and in the attestation to determine if the warnings have been sufficiently addressed.

If a filing contains “warning messages,” and there are no comments entered by the company, it is more likely that the company will be contacted for an explanation by NAIC staff.
The location of the attestation is now the last set of questions for each MCAS line of business, rather than being a separate option within the MCAS submission application. The Attestor information and additional company comments will be provided within a separate schedule reported for each MCAS line of business and state. Please refer to the MCAS Blanks and Data Call and Definitions for further guidance on this reporting.
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.

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Description</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio 1</td>
<td>Number of claims closed without payment to total number of claims closed</td>
<td>( \frac{# \text{of claims closed without payment}}{# \text{of claims closed with payment} + # \text{of claims closed without payment}} )</td>
</tr>
<tr>
<td>Ratio 2</td>
<td>Claims open at the end of the period to total claims during the period</td>
<td>( \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}} )</td>
</tr>
<tr>
<td>Ratio 3</td>
<td>Claims paid beyond 60 days to total claims closed with payment</td>
<td>( \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{of claims closed with payment}} )</td>
</tr>
<tr>
<td>Ratio 4</td>
<td>Loss Ratio – Incurred claims to earned premium</td>
<td>( \frac{\text{dollars of claims incurred during the period}}{\text{dollar amount of premium earned during the period}} )</td>
</tr>
<tr>
<td>Ratio 5</td>
<td>Master policy cancellations to master policies in force at beginning of the period</td>
<td>( \frac{# \text{of master policy cancellations}}{# \text{of master policies in force at beginning of period}} )</td>
</tr>
</tbody>
</table>
In addition to warnings and ratios, data relationships within the submission are reviewed. An example would be a comparison of policies in-force to the number of claims. Another example would be the comparison of polices in-force to written premiums. If an unusual data relationship is identified, the company will be asked to explain.

A final review is a general review of the data for potential data inaccuracies. An example of this might be the submission of a data element that contains a value much larger than expected; perhaps too many zeros were added, or two data elements were transposed. Again, if these anomalies are identified, the company will be asked to review the data.
The MCAS User Guide, (found on the MCAS webpage) lists the data validation messages that may be encountered while validating data. This includes both “Error” and “Warning” messages. Use the listing to prepare data and to determine comments that will be needed to explain “Warning” messages received during the data validation process.
It is important to note, state regulators have full access to all data and will also review data for accuracy. State regulators will concentrate on submission for their states only, while the NAIC will review the data and look for potential trends in data filed within multiple states.
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence. If they have additional questions or concerns, they may also contact the company. However, keeping state regulators in the line of communication, should lessen the number of inquiries received for any particular data concern.
If company A is part of ABC group, and the same observations are made for other companies within the group, then separate correspondence will be sent to each company. It is important to respond to requests in a timely manner to avoid follow up from the NAIC or state regulators. In the company response to the NAIC, please include comments on what action the company will take.
If you receive correspondence from an NAIC analyst, we encourage you to reach out to the analyst with any questions, comments or concerns you may have regarding the correspondence, the validations, or other MCAS filing related issues.
Thank you for your time. This concludes the filing validation and review discussion. Additional questions may be sent to mcas@naic.org.