

Market Conduct Annual Statement **2021 Data Year Filings**

Property & Casualty
Data Elements & Validations



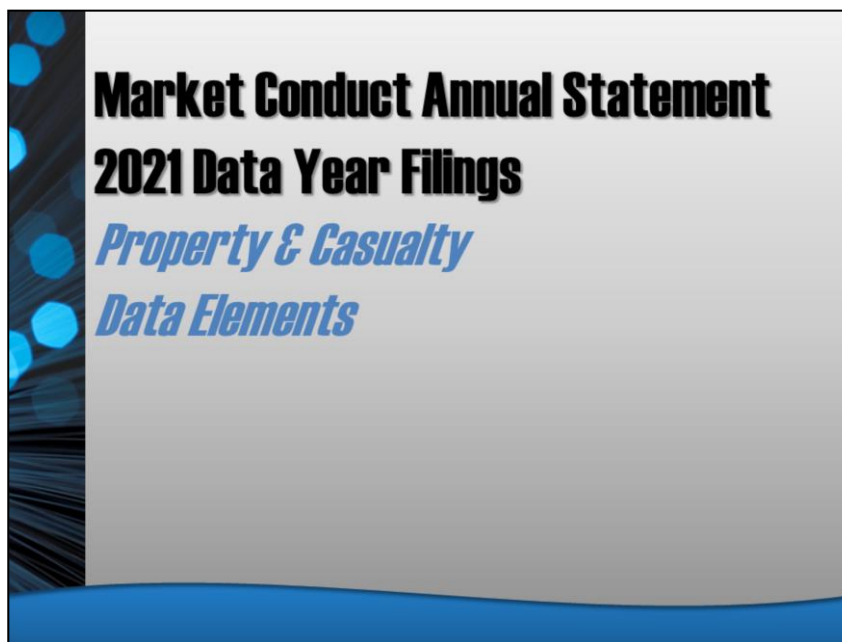
© 2022 National Association of Insurance Commissioners



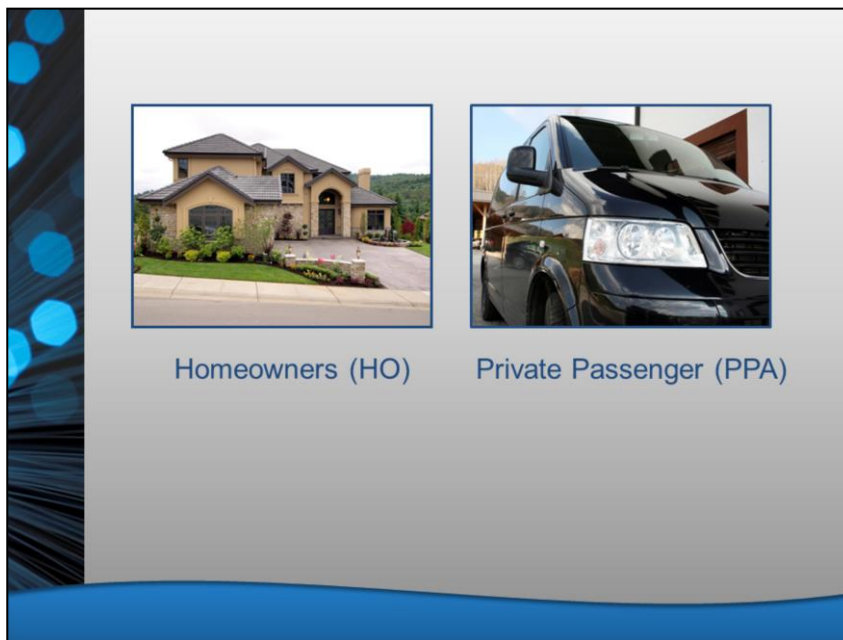
This product, including its associated materials, content, subject matter, visual elements, and text, is the exclusive property of the National Association of Insurance Commissioners (NAIC) and is fully subject to the ownership rights of the NAIC under copyright laws of the United States.

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.

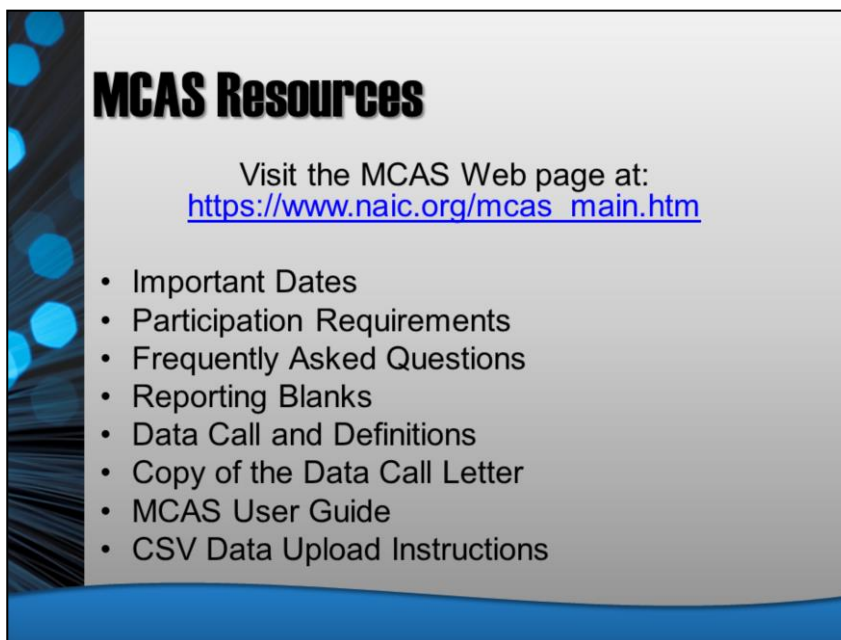


Hello. In this section of the Market Conduct Annual Statement training we will be reviewing the data elements that must be provided for the Private Passenger Auto MCAS and the Homeowners MCAS.



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 substantial bearing on the definition of the data element itself.

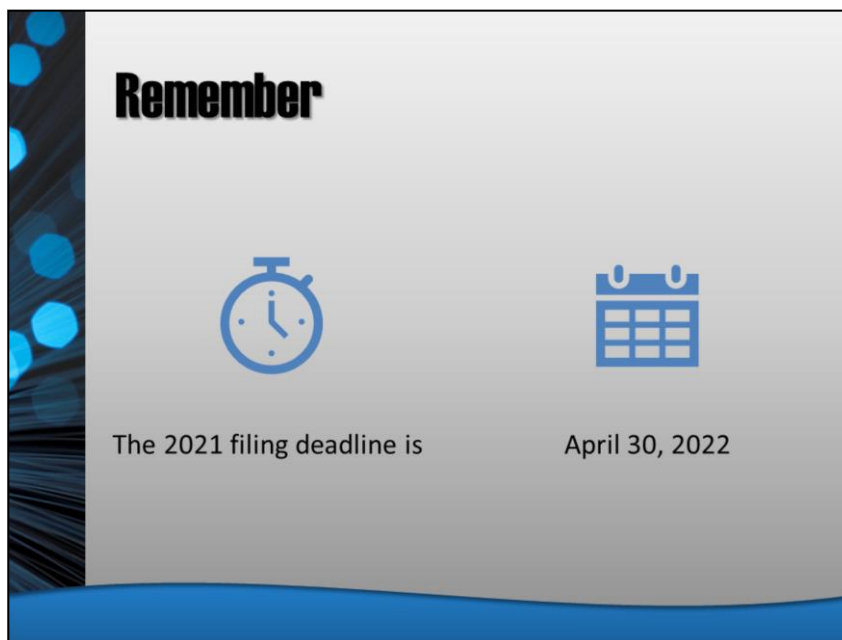
We'll begin by reviewing some general items.



The MCAS web page has many MCAS related resources available for your review. 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 Data Call Letter
- MCAS User Guide
- And CSV Data Upload Instructions



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



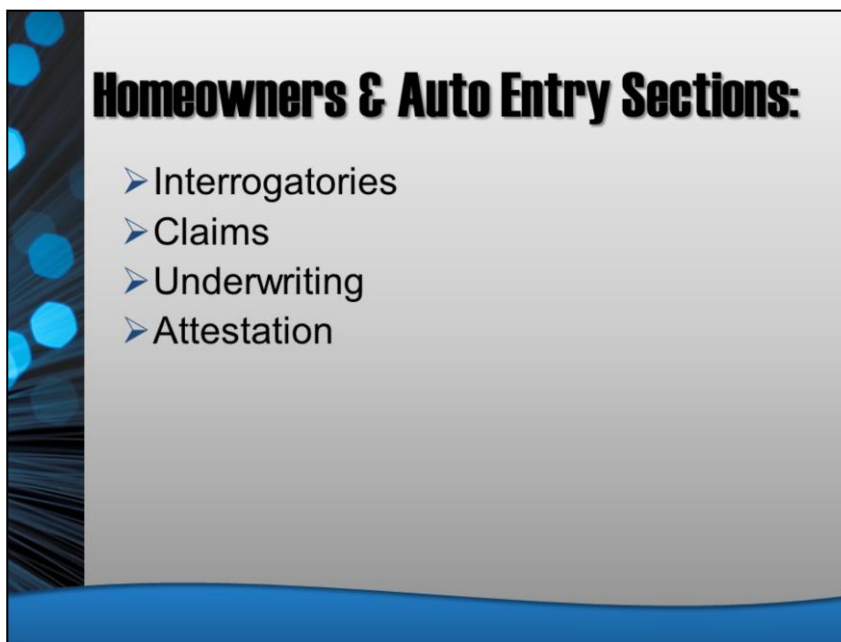
Private Passenger Auto and Homeowner reporting is to be done on a claimant basis. The Data Call and Definitions explains what is meant by "claimant basis". You are to report the number of reserves/lines/features opened for each coverage part per claim.

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 four sections – interrogatories, claims, underwriting and attestation.

Interrogatories

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	Has the company had a significant event/business strategy that would affect data for this reporting period?		---
15	If yes, add additional comments.	---	---
16	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?		---
17	If yes, add additional comments.	---	---
18	How does the company treat subsequent supplemental or additional payments on previously closed claims?		---
19	Does the company use Managing General Agents (MGAs)?		---
20	If yes, list the names of the MGAs	---	---
21	Does the company use Third Party Administrators (TPAs)?		---
22	If yes, list the names of the TPAs	---	---
23	Does the company use telematics or usage-based data?		---
24	Additional state specific Claims comments (optional):	---	---
25	Additional state specific Underwriting comments (optional):	---	---


***NOTE: Questions in red reflect new/edited information for the 2021 data year.**

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

INTERROGATORIES	
	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?
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	Has the company had a significant event/business strategy that would affect data for this reporting period?
15	If yes, add additional comments.
16	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?
17	If yes, add additional comments.
18	How does the company treat subsequent supplemental or additional payments on previously closed claims?

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 reporting period.

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				
02				
03				
04				
05				
06				
07				
08				
09				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

As previously noted, the interrogatory questions in red reflect questions that were edited or added for the current data reporting year. Both the Homeowners and Auto interrogatories now have questions related to the use of Managing General Agents or MGAs, and Third Party Administrators or TPAs. The question regarding telematics or usage-based data is specific to the Private Passenger Auto line of business.

Interrogatories



Telematics and Usage-Based Data (PPA line of business only)

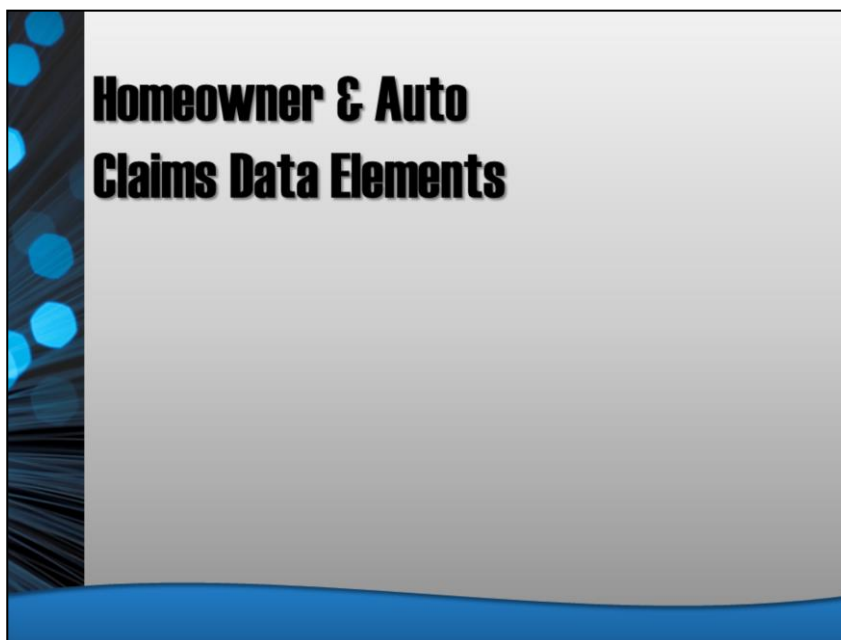
- Collected through devices installed in a vehicle, through mobile app or other method
 - Devices then transmit data back to insurers in real time
- Examples: miles driven, time of day, where the vehicle is driven, rapid acceleration, hard braking, hard cornering, and air bag deployment

Telematics or usage-based data is defined as data which is collected through devices installed in a vehicle, through mobile applications, or other method. These devices then transmit the data in real time back to insurers. Examples of usage-based data collected via telematics includes, but is not limited to: miles driven, time of day, where the vehicle is driven (Global Positioning System or GPS), rapid acceleration, hard braking, hard cornering and air bag deployment.

Interrogatories

	Yes	No	Response	Explanation
01				
02				
03				
04				
05				
06				
07				
08				
09				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

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.



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 Homeowners 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

26	Number of claims open at the beginning of the period.
27	Number of claims opened during the period.
28	Number of claims closed with payment during the period.
29	Number of claims closed without payment during the period.
30	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.
31	Number of claims remaining open at the end of the period.

Note: Question 30 is a subset of question 29 and is specific to the Private Passenger Auto line of business. It is not asked for in Homeowners.

January 1, 2021 – December 31, 2021

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, the number of closed during the period, without payment, because the amount claimed is below the insured's deductible, and the number of claims remaining open at the end of the period.

Please note that the question asking for the number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible, is a subset of the previous question. So, OF the total number of claims closed without payment during the period, you are being asked how many of those claims were closed because the amount claimed is below the insured's deductible. This question is specific to the Private Passenger Auto line of business and is not asked for in the Homeowners claims questions.

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.



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, 2021

**Claim closed in company's claims system
January 5, 2022**

Report as Open at end of 2021	Report as Closed With Payment in 2022
--	--

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

Payment
Subrogation

Closed with payment

PAY TO THE ORDER OF _____ \$ _____

MEMO _____

⑆000000000⑆ ⑆00000000 ⑆0 25

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:

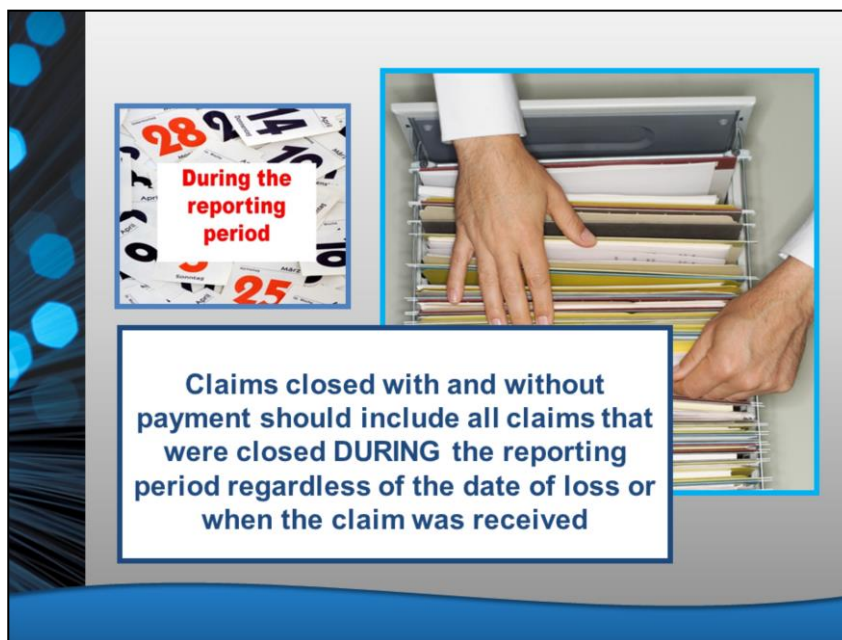
- Claims that are closed because the amount claimed is below the insured's deductible. (As noted previously, these are to be included in the total, and counted separately.)



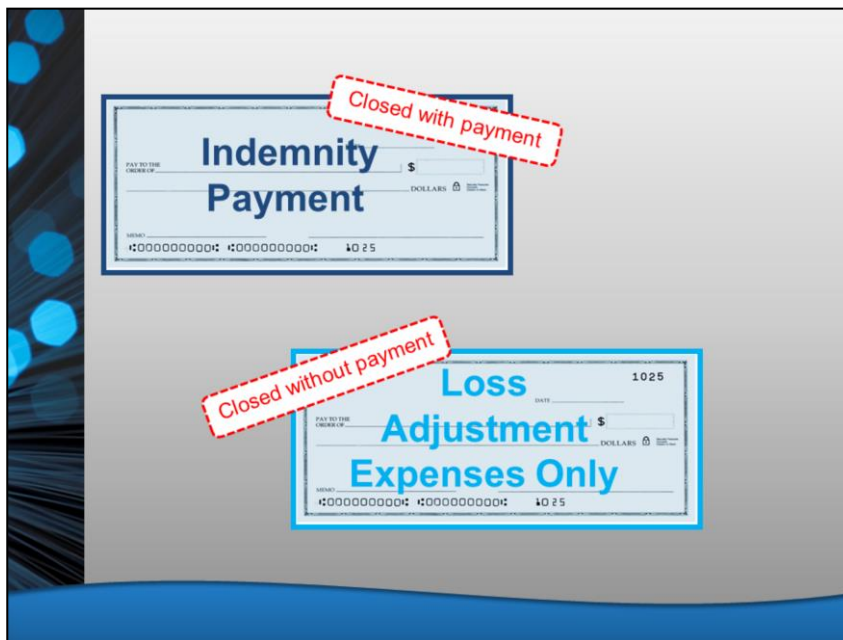
Claims that were closed because the amount claimed was below the insured's deductible are to be included in the count of "Claims Closed WITHOUT Payment". As explained previously, these types of claims should not only be included in the total of claims closed without payment, but also counted separately.



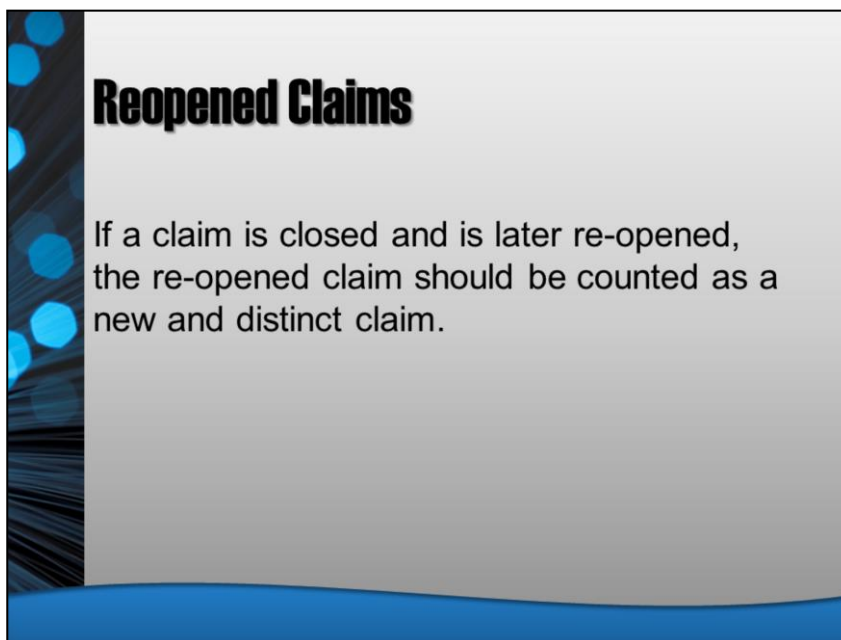
In addition to claims closed below the deductible, other types of claims that should be reported as “closed **without** payment” are those where the only payments made on the claim were loss adjusting expenses, or if a claim is made, a claim file is set up and investigated, and it is then determined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



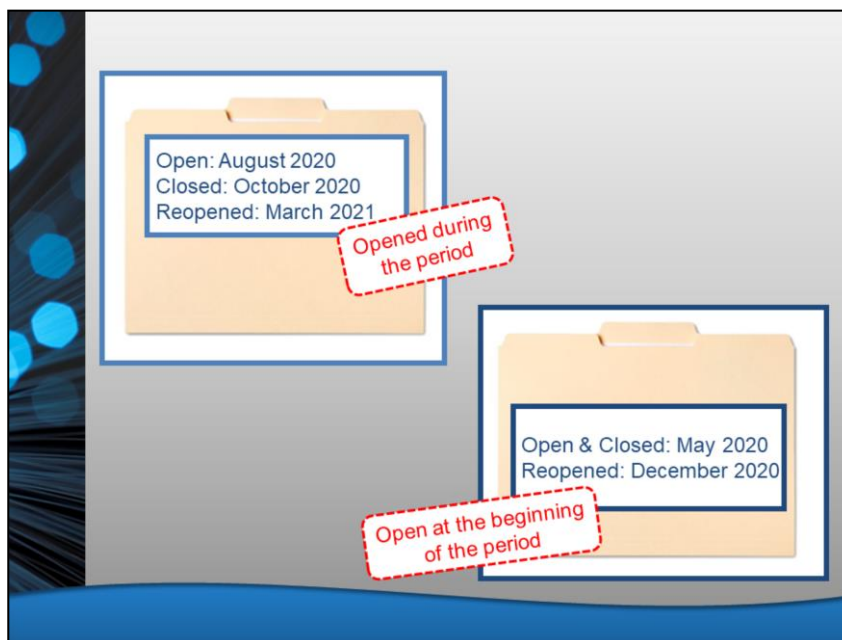
As with the “claims closed **with** payment”, “claims closed **without** payment” include all claims that were closed without payment during the reporting period regardless of the date of loss or when the claim was received.



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”.



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.



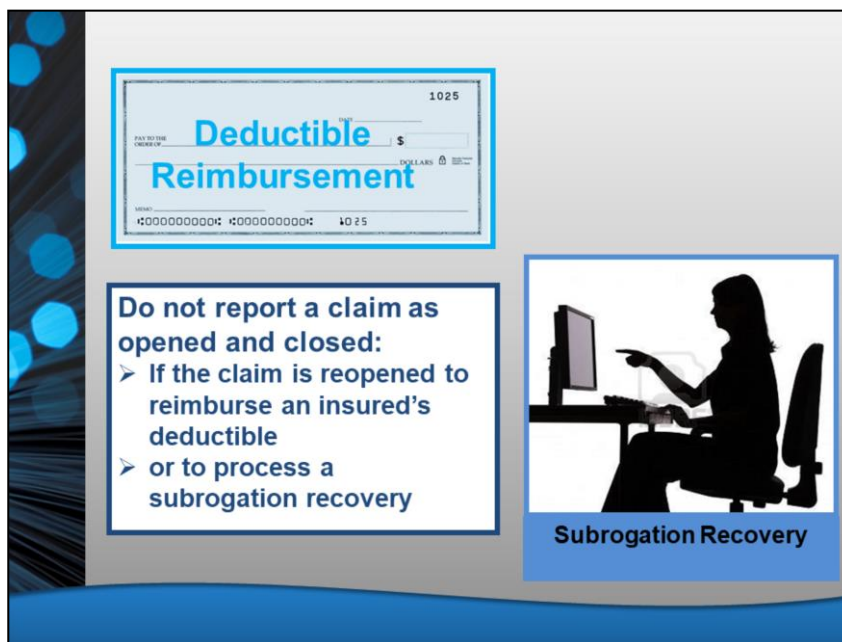
So, if a claim is re-opened during the current period, it would be counted among the “claims opened during the period”, and if the claim had been re-opened in a prior period, but not yet closed, it would be counted among the “claims open at the beginning of the period”.

Reopened Claims

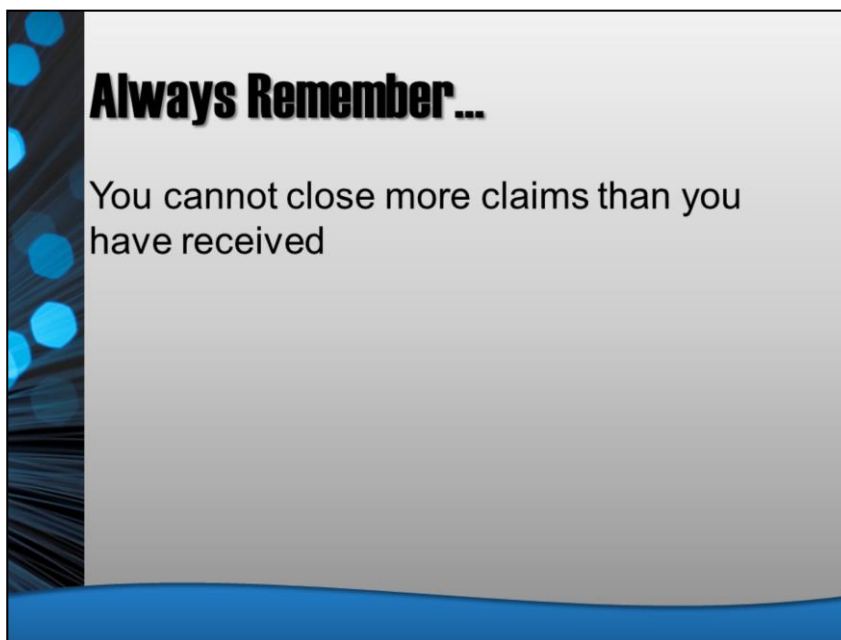
- Closed With Payment or Closed Without Payment



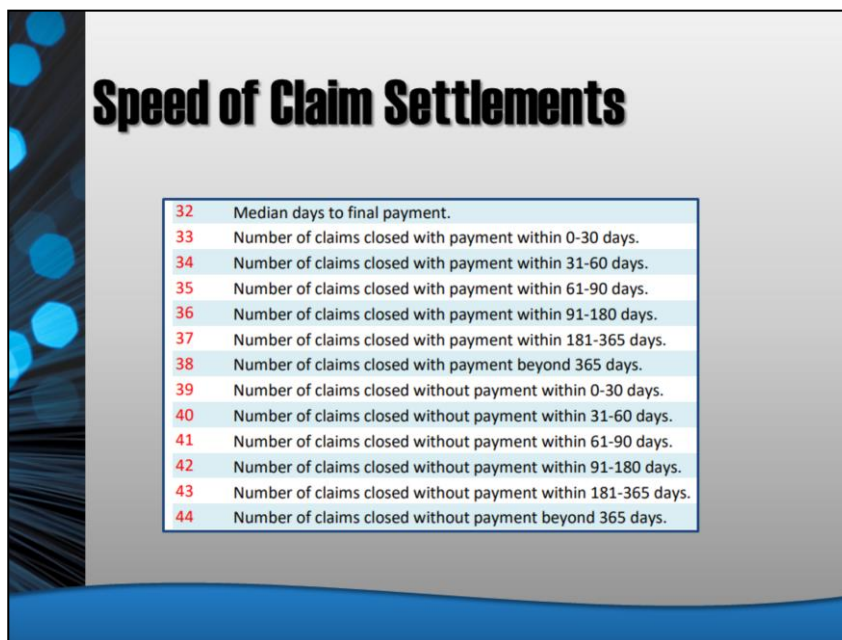
Since the re-opened claim is its own distinct claim and counted separately as a new claim, it must also be recorded as “closed with payment” or “closed without payment” when it is finally closed.



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

Median Days

32	Median days to final payment.
33	Number of claims closed with payment within 0-30 days.
34	Number of claims closed with payment within 31-60 days.
35	Number of claims closed with payment within 61-90 days.
36	Number of claims closed with payment within 91-180 days.
37	Number of claims closed with payment within 181-365 days.
38	Number of claims closed with payment beyond 365 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



Request Received

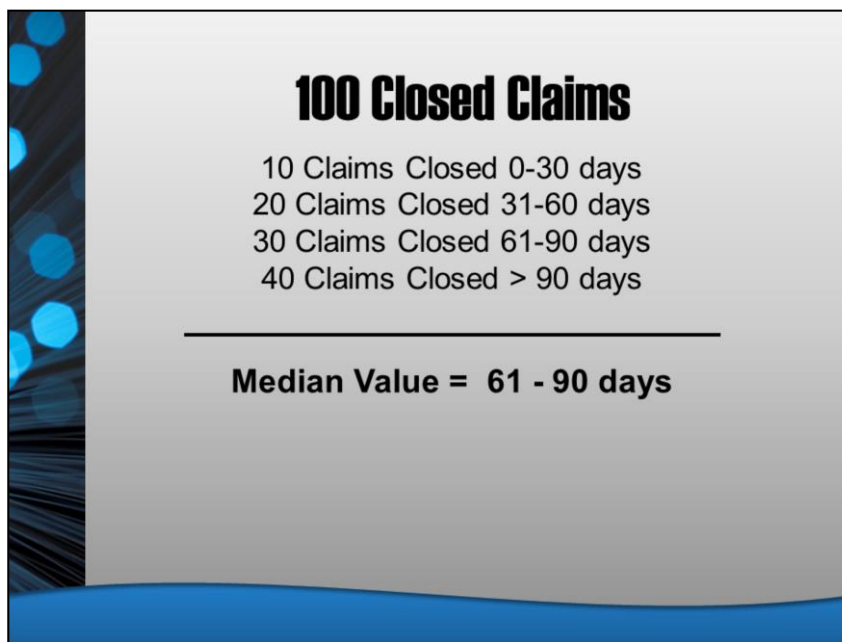
The aging on re-opened claims (that is, on supplemental payments) should be calculated using the time between when the request for supplemental payment was received and the date the final payment was made.

Subrogation claims

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



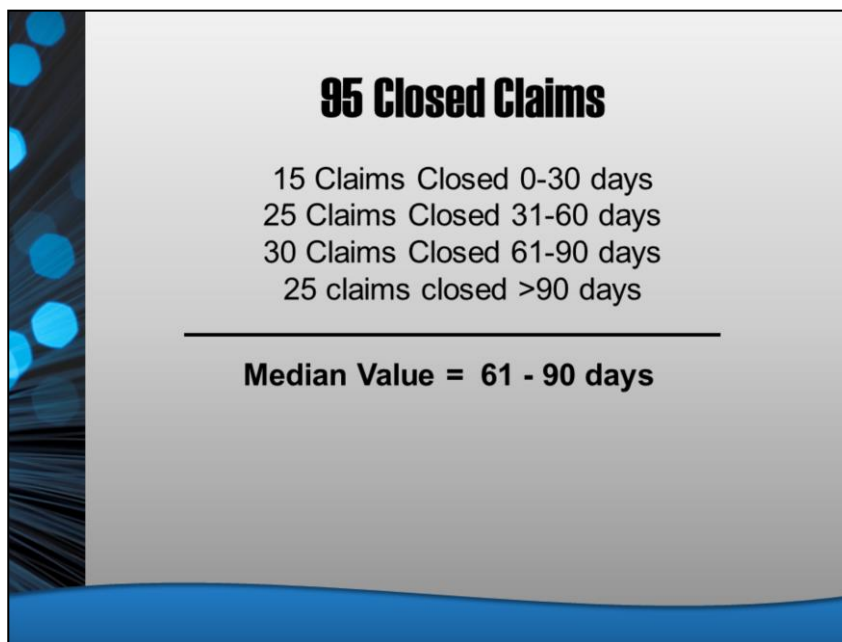
A special note regarding subrogation claims – they should be removed from the set of claims used to calculate your median days to settlement even though you would include them in your count of claims closed with payment. They should be excluded from the median days calculation because they tend to take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



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

32	Median days to final payment.
33	Number of claims closed with payment within 0-30 days.
34	Number of claims closed with payment within 31-60 days.
35	Number of claims closed with payment within 61-90 days.
36	Number of claims closed with payment within 91-180 days.
37	Number of claims closed with payment within 181-365 days.
38	Number of claims closed with payment beyond 365 days.
39	Number of claims closed without payment within 0-30 days.
40	Number of claims closed without payment within 31-60 days.
41	Number of claims closed without payment within 61-90 days.
42	Number of claims closed without payment within 91-180 days.
43	Number of claims closed without payment within 181-365 days.
44	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

32	Median days to final payment.
33	Number of claims closed with payment within 0-30 days.
34	Number of claims closed with payment within 31-60 days.
35	Number of claims closed with payment within 61-90 days.
36	Number of claims closed with payment within 91-180 days.
37	Number of claims closed with payment within 181-365 days.
38	Number of claims closed with payment beyond 365 days.
39	Number of claims closed without payment within 0-30 days.
40	Number of claims closed without payment within 31-60 days.
41	Number of claims closed without payment within 61-90 days.
42	Number of claims closed without payment within 91-180 days.
43	Number of claims closed without payment within 181-365 days.
44	Number of claims closed without payment beyond 365 days.

January 1, 2021 – December 31, 2021

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

Claims Closed With & Without Payment

28	Number of claims closed with payment during the period.	
29	Number of claims closed without payment during the period.	
30	Number of claims closed during the period, without payment, because the amount claimed is below the insured's deductible.	
31	Number of claims remaining open at the end of the period.	
32	Median days to final payment.	
33	Number of claims closed with payment within 0-30 days.	Number of claims closed with payment during the period
34	Number of claims closed with payment within 31-60 days.	
35	Number of claims closed with payment within 61-90 days.	
36	Number of claims closed with payment within 91-180 days.	
37	Number of claims closed with payment within 181-365 days.	Number of claims closed without payment during the period
38	Number of claims closed with payment beyond 365 days.	
39	Number of claims closed without payment within 0-30 days.	
40	Number of claims closed without payment within 31-60 days.	
41	Number of claims closed without payment within 61-90 days.	
42	Number of claims closed without payment within 91-180 days.	
43	Number of claims closed without payment within 181-365 days.	
44	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.

Lawsuits

39	Number of lawsuits open at beginning of the period.
40	Number of lawsuits opened during the period.
41	Number of lawsuits closed during the period.
42	Number of lawsuits open at end of period.
43	Number of lawsuits closed with consideration for the consumer.

New definition note: lawsuits closed with consideration for the consumer are those lawsuits closed during the reporting period where a court order, jury verdict, or settlement, resulted in payment, benefits or other thing of value (i.e., consideration), to the claimant in an amount greater than offered by the reporting insurer before the lawsuit was brought.

Lawsuits:

There are five 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 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 open at the end of the period, and the number of lawsuits closed with consideration for the consumer.

The last question is asking for those lawsuits that were closed during the reporting period in which a court order, jury verdict, or settlement, resulted in payment, benefits, or other thing of value (in other words, consideration), to the claimant in an amount **greater** than offered by the reporting insurer before the lawsuit was brought.

Auto/Homeowners Data Call & Definitions

Lawsuit – A court proceeding to recover a right to a claim, including lawsuits for arbitration cases.

Exclude:

- Subrogation claims where lawsuit is filed by the company against the tortfeasor.
- Non-lawsuit 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.

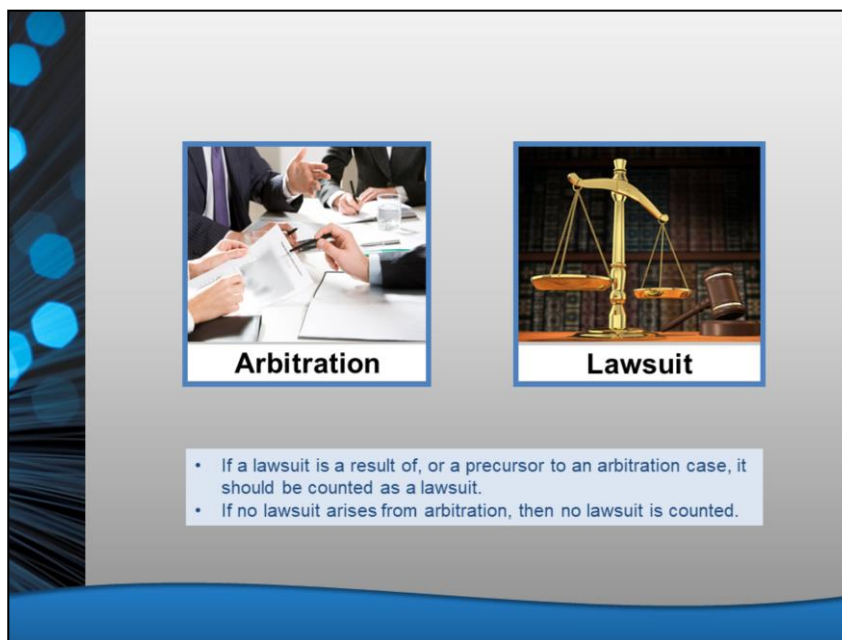
The MCAS definition of a lawsuit can be found in the Data Call and Definitions. When counting lawsuits, you will count those lawsuits filed to enforce a right to a claim. It does not include subrogation claims where a lawsuit is filed by the company against the tortfeasor.


Auto/Homeowners Data Call & Definitions

Calculation Clarification:


- Lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each / claimant / coverage combination, regardless of the number of actual lawsuits filed.
- One lawsuit with two claimants would be reported as two lawsuits as any awards/payments made would be made to the claimants individually.
- One lawsuit filed seeking damages for multiple coverages should be reported as one lawsuit for each applicable coverage.
- Lawsuits 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 lawsuits should be reported on the same basis as claims. One lawsuit should be reported for each / claimant / coverage combination, regardless of the number of actual lawsuits filed.





Arbitration



Lawsuit

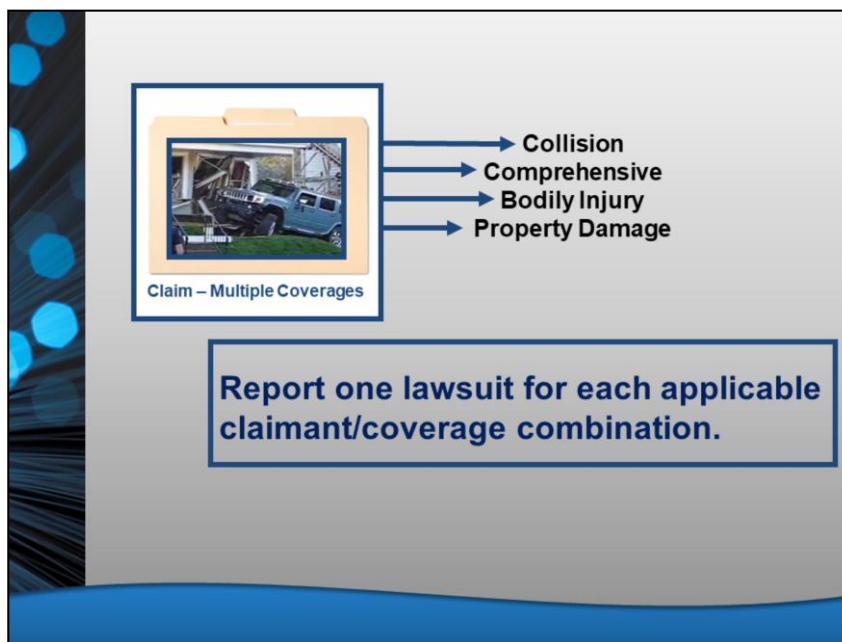
- If a lawsuit is a result of, or a precursor to an arbitration case, it should be counted as a lawsuit.
- If no lawsuit arises from arbitration, then no lawsuit is counted.

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

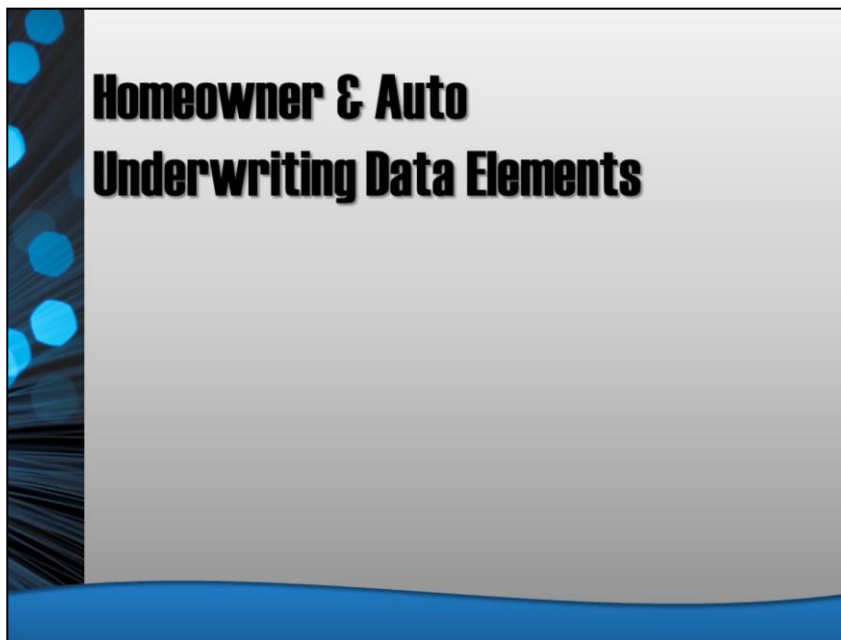
In regards to class action suits, you are to report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. You are then asked to include an explanatory note with your submission and state the number of class action lawsuits included in the data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



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




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 mostly the same for Auto and Homeowners, with the biggest difference being the coverage parts to which claims are applicable.

Please refer to the data call and definitions documents for each line of business for additional information.

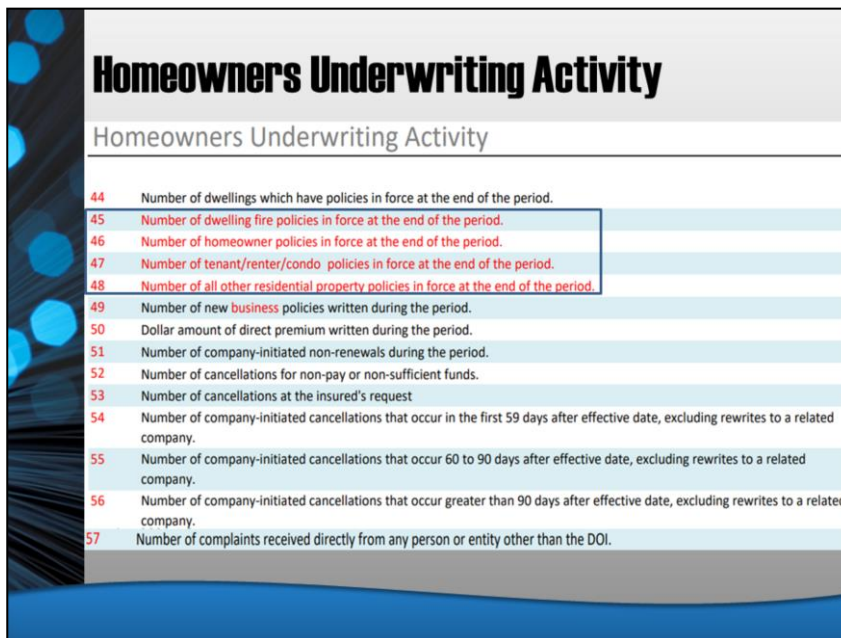
Now we'll review the Underwriting data elements.



Private Passenger Auto Underwriting Activity

Private Passenger Auto Underwriting Activity	
50	Number of autos which have policies in force at the end of the period.
51	Number of policies in force at the end of the period.
52	Number of new policies written during the period.
53	Dollar amount of direct written premium during the period.
54	Number of company-initiated non-renewals during the period.
55	Number of cancellations for non-pay or non-sufficient funds.
56	Number of cancellations at the insured's request
57	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
58	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
59	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.
60	Number of complaints received directly from any person or entity other than the DOI.

The Underwriting questions for Auto and Homeowners *combine* all the coverage parts, so you do not have to distinguish between coverage parts when answering the underwriting questions. Many of the underwriting questions are 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 questions. As you will see in the next slide, there are more underwriting questions for the homeowners line of business.

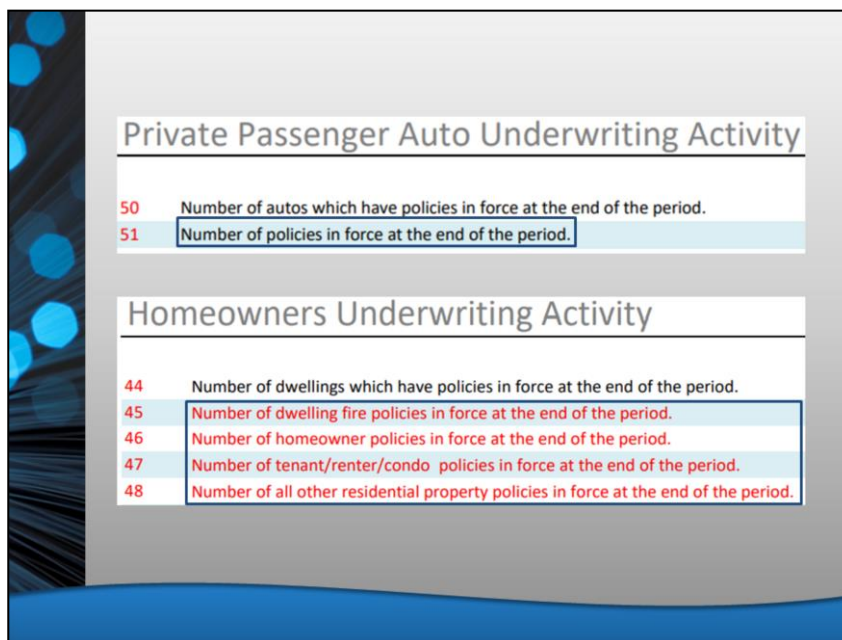


Homeowners Underwriting Activity

Homeowners Underwriting Activity

44	Number of dwellings which have policies in force at the end of the period.
45	Number of dwelling fire policies in force at the end of the period.
46	Number of homeowner policies in force at the end of the period.
47	Number of tenant/renter/condo policies in force at the end of the period.
48	Number of all other residential property policies in force at the end of the period.
49	Number of new business policies written during the period.
50	Dollar amount of direct premium written during the period.
51	Number of company-initiated non-renewals during the period.
52	Number of cancellations for non-pay or non-sufficient funds.
53	Number of cancellations at the insured's request
54	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
55	Number of company-initiated cancellations that occur 60 to 90 days after effective date, excluding rewrites to a related company.
56	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.
57	Number of complaints received directly from any person or entity other than the DOI.

One of the main differences between the Private Passenger Auto and Homeowners underwriting questions, are that the policies in force are separated out by type for the Homeowners line of business when you are asked for the policies in force at the end of the period.



Private Passenger Auto Underwriting Activity	
50	Number of autos which have policies in force at the end of the period.
51	Number of policies in force at the end of the period.

Homeowners Underwriting Activity	
44	Number of dwellings which have policies in force at the end of the period.
45	Number of dwelling fire policies in force at the end of the period.
46	Number of homeowner policies in force at the end of the period.
47	Number of tenant/renter/condo policies in force at the end of the period.
48	Number of all other residential property policies in force at the end of the period.

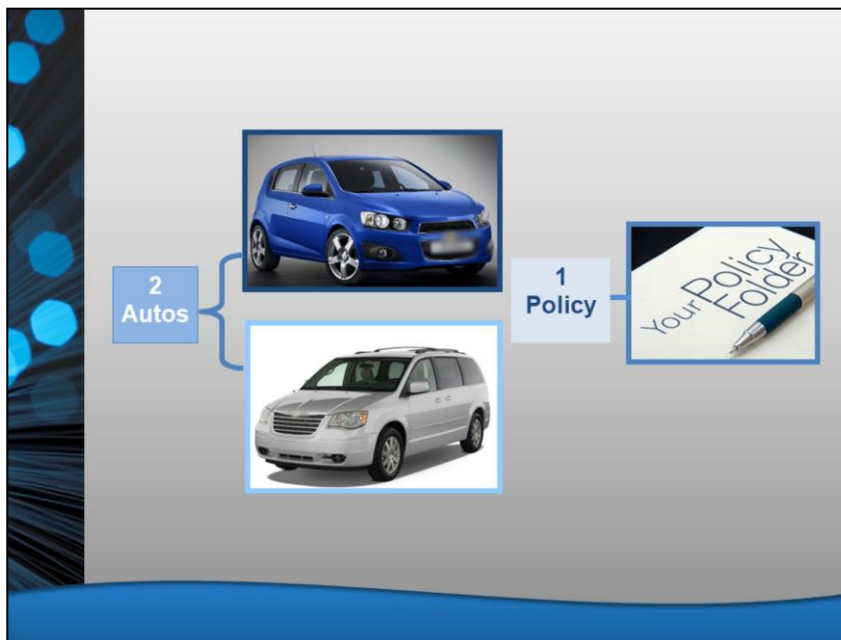
The first two underwriting questions for Private Passenger Auto and the first five questions for Homeowners, ask you to provide the total number of policies in force at the end of the period AND the total number of autos or dwellings being insured under those policies. The definitions for dwelling fire policies, homeowners policies, and tenant/renters/condo policies are outlined in the homeowners data call and definitions, but we'll review some of this information more closely on the next slide.

Homeowners Underwriting Activity

44	Number of dwellings which have policies in force at the end of the period.
45	Number of dwelling fire policies in force at the end of the period.
46	Number of homeowner policies in force at the end of the period.
47	Number of tenant/renter/condo policies in force at the end of the period.
48	Number of all other residential property policies in force at the end of the period.

- **Dwelling Fire** policies includes policies that meet the definition of a dwelling policy as defined in the data call and definitions. Typically includes policies written on forms DP-1, DP-2 and DP-3.
- **Homeowner** policies includes policies that meet the definition of a homeowner policy as defined in the data call and definitions. Typically includes policies written on forms HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8.
- **Tenant/renter/condo** policies includes policies that meet the definition of a tenant/renter/condo as defined in the data call and definitions. Typically includes policies written on forms HO-4 and HO-6.
- **All other residential property** policies includes policies that meet the specifics of MCAS reporting, but do not fall into one of the other categories requested in questions 45-47.
 - Note: if your company only writes policies that fall into the forms specified in questions 45-47, this number will be zero.

- **Dwelling Fire** policies includes those policies that meet the definition of a dwelling policy as defined in the data call and definitions. This would typically include policies written on forms DP-1, DP-2 and DP-3.
- **Homeowner** policies includes policies that meet the definition of a homeowner policy as defined in the data call and definitions, and typically includes policies written on forms HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8.
- **Tenant/renter/condo** policies includes policies that meet the definition of a tenant/renter/condo policy, which is policies that provide coverage for the personal property of tenants, renters, condominium and cooperative unit owners. Typically this includes policies written on forms HO-4 and HO-6, and finally,
- **All other residential property** policies includes policies that meet the specifics of MCAS reporting, but do not fall into one of the other categories requested in the preceding questions. Please note that if your company only writes policies that fall into the forms specified in the preceding questions, that this number will be zero.




To follow up with an example, if 2 autos are insured under 1 policy, you would report 2 autos for the 1st Private Passenger Auto Underwriting question, and 1 policy for the next underwriting question.

Private Passenger Auto Underwriting Activity	
50	Number of autos which have policies in force at the end of the period.
51	Number of policies in force at the end of the period.
52	Number of new policies written during the period.
53	Dollar amount of direct written premium during the period.
54	Number of company-initiated non-renewals during the period.
Homeowners Underwriting Activity	
44	Number of dwellings which have policies in force at the end of the period.
45	Number of dwelling fire policies in force at the end of the period.
46	Number of homeowner policies in force at the end of the period.
47	Number of tenant/renter/condo policies in force at the end of the period.
48	Number of all other residential property policies in force at the end of the period.
49	Number of new business policies written during the period.
50	Dollar amount of direct premium written during the period.
51	Number of company-initiated non-renewals during the period.

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.

Private Passenger Auto Underwriting Activity	
50	Number of autos which have policies in force at the end of the period.
51	Number of policies in force at the end of the period.
52	Number of new policies written during the period.
53	Dollar amount of direct written premium during the period.
54	Number of company-initiated non-renewals during the period.
Homeowners Underwriting Activity	
44	Number of dwellings which have policies in force at the end of the period.
45	Number of dwelling fire policies in force at the end of the period.
46	Number of homeowner policies in force at the end of the period.
47	Number of tenant/renter/condo policies in force at the end of the period.
48	Number of all other residential property policies in force at the end of the period.
49	Number of new business policies written during the period.
50	Dollar amount of direct premium written during the period.
51	Number of company-initiated non-renewals during the period.
January 1, 2021 – December 31, 2021	

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



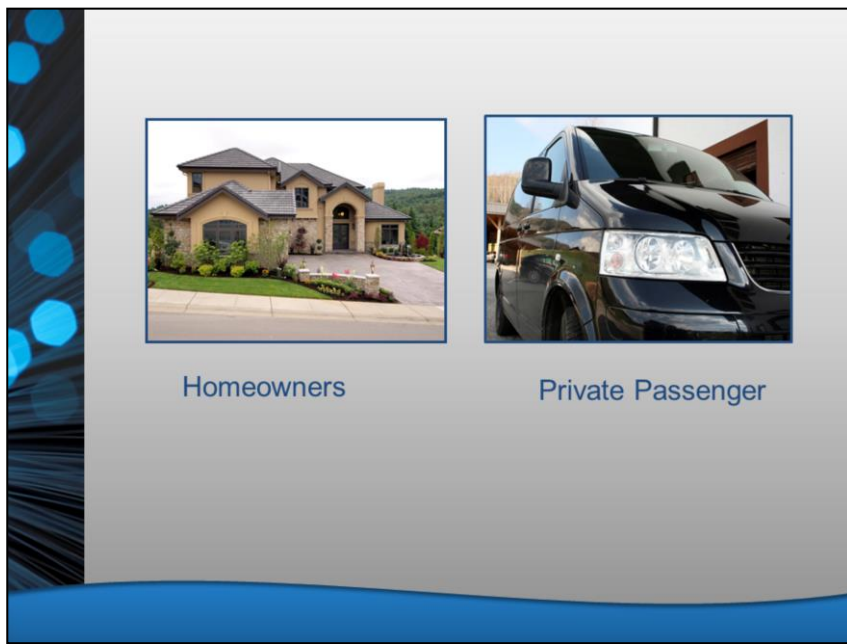
Auto/Homeowners Data Call & Definitions

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

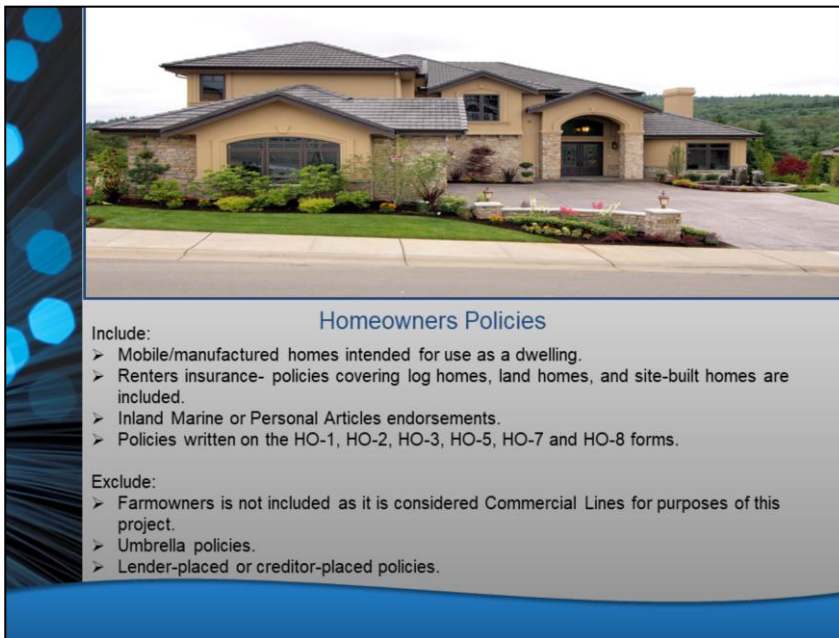
Exclude:

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

“New policies written” puts 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.



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 Policies

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.
- Policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 forms.

Exclude:

- Farmowners is not included as it is considered Commercial Lines for purposes of this project.
- Umbrella policies.
- Lender-placed or creditor-placed 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.

Mobile or manufactured homes intended for use as a dwelling are included, in addition to renters insurance, inland marine or personal articles endorsements, and policies written on the HO-1, HO-2, HO-3, HO-5, HO-7 and HO-8 forms.

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.



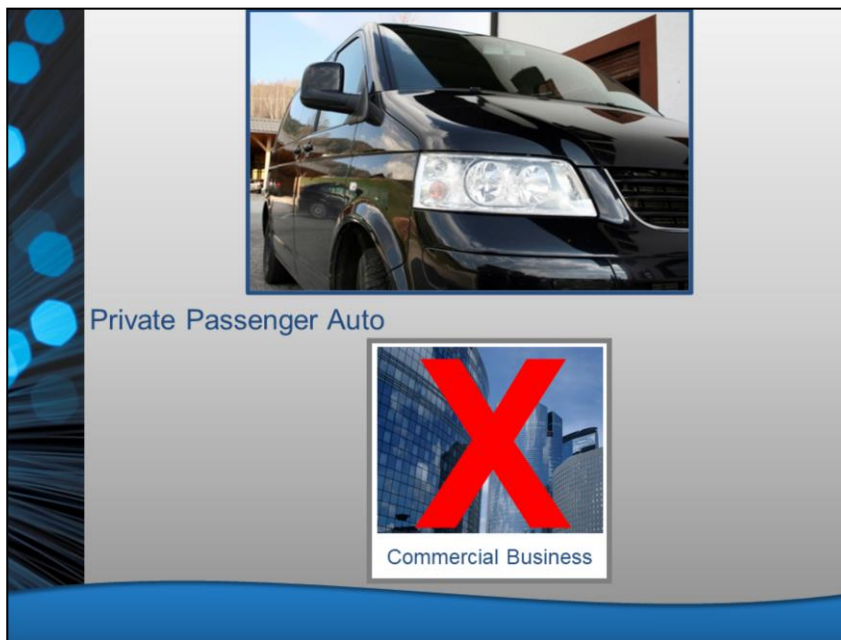
Private Passenger Auto

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.

Note: if lender-placed policies are included in the financial annual statement reporting on lines 19.1, 19.2 and 21.1, they should not be included, as lender-placed auto policies are to be reported separately on the lender-placed insurance MCAS.

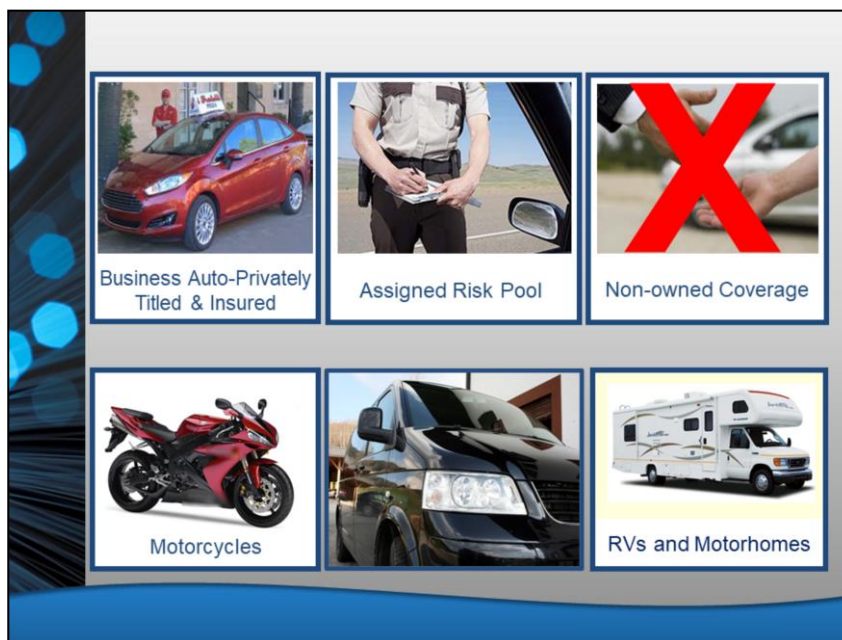
For the Private Passenger Auto MCAS, any policies that are reported on the Financial Annual Statement state page lines 19.1, 19.2 and 21.1 should also be reported in MCAS. These lines are for personal auto physical damage and liability coverages.

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.

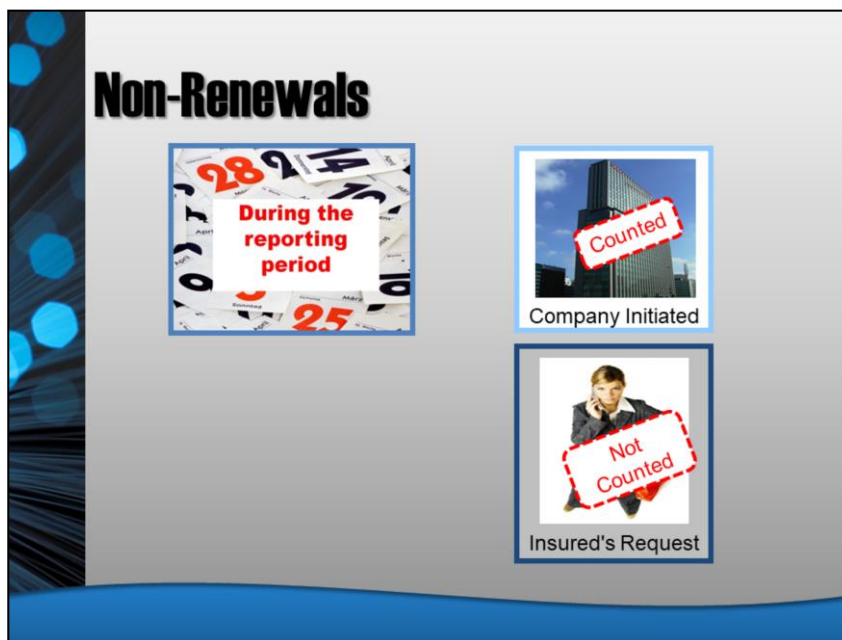


Non-Renewed and Cancelled Policies

Private Passenger Auto Underwriting Activity

50	Number of autos which have policies in force at the end of the period.
51	Number of policies in force at the end of the period.
52	Number of new policies written during the period.
53	Dollar amount of direct written premium during the period.
54	Number of company-initiated non-renewals during the period.
55	Number of cancellations for non-pay or non-sufficient funds.
56	Number of cancellations at the insured's request
57	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
58	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
59	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.
60	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.



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



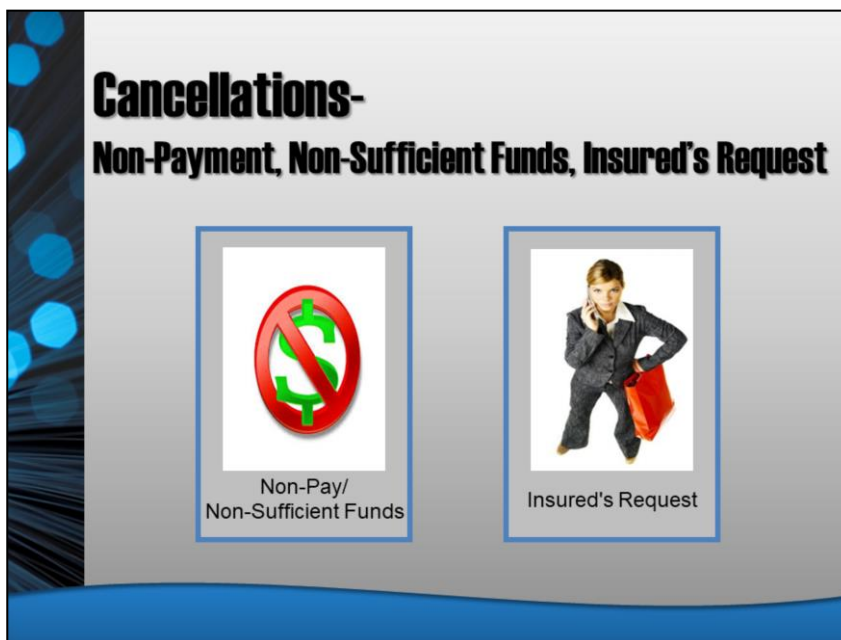
Be sure to only count policies, not the number of dwellings or autos. So, if an auto policy with 2 cars is non-renewed, this counts as just 1 non-renewal.

Cancellations

Private Passenger Auto Underwriting Activity

- 50 Number of autos which have policies in force at the end of the period.
- 51 Number of policies in force at the end of the period.
- 52 Number of new policies written during the period.
- 53 Dollar amount of direct written premium during the period.
- 54 Number of company-initiated non-renewals during the period.
- 55 Number of cancellations for non-pay or non-sufficient funds.
- 56 Number of cancellations at the insured's request.
- 57 Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
- 58 Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
- 59 Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.
- 60 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.



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



**1 policy cancelled
3 separate times
during the
reporting period**
(January - non-pay
April - non-pay
November - non-pay)
= 3 cancellations

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



Do not
report in
MCAS



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



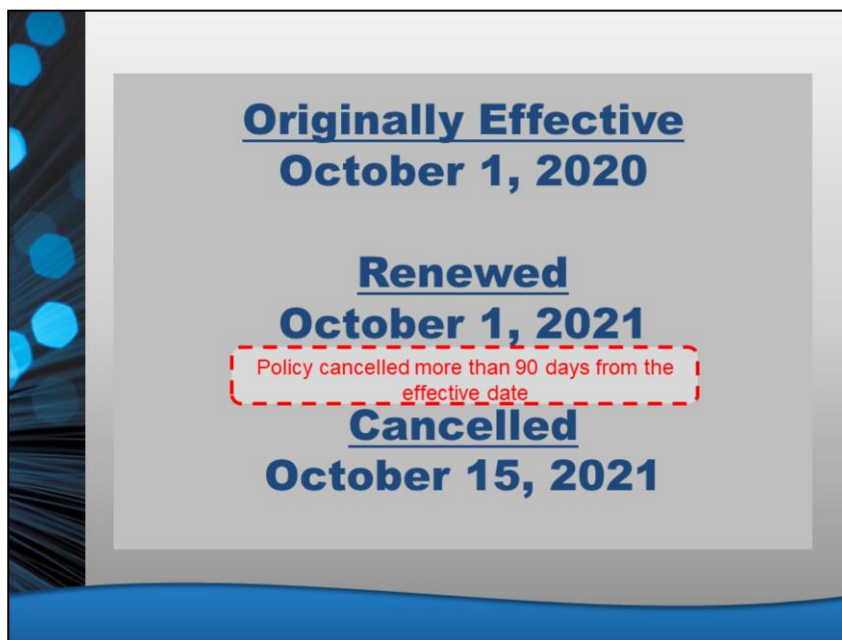
Company Initiated



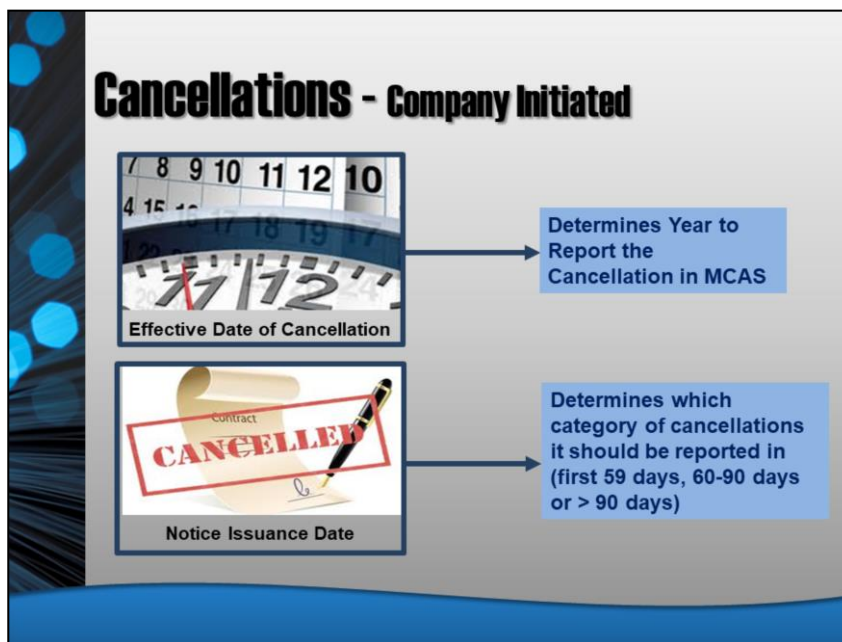
Cancelled:
< 60 days
60 – 90 Days
> 90 days



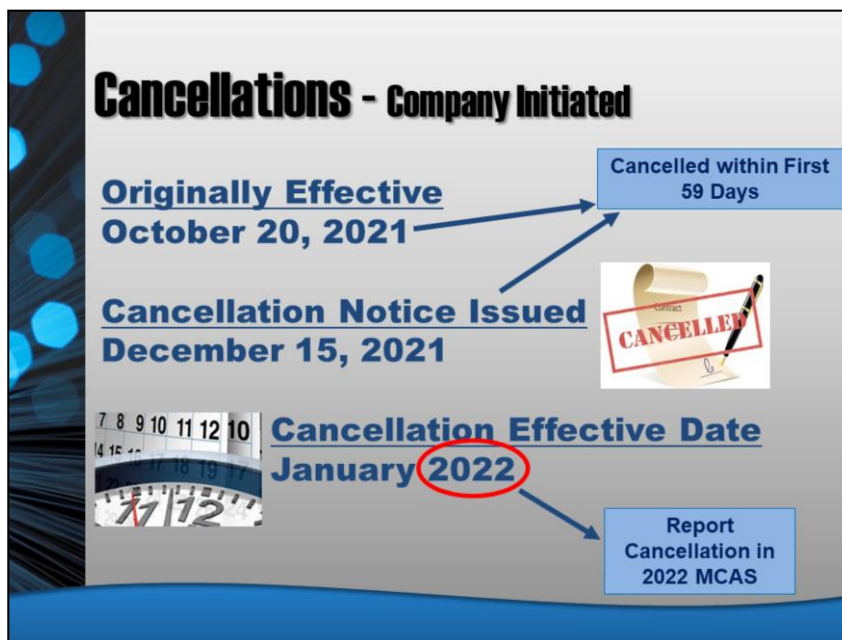
Additionally, cancellations are reported by those cancelled within 59 days of the effective date, those reported 60-90 days from the effective date and those reported more than 90 days from the effective date.



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.



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

50	Number of autos which have policies in force at the end of the period.
51	Number of policies in force at the end of the period.
52	Number of new policies written during the period.
53	Dollar amount of direct written premium during the period.
54	Number of company-initiated non-renewals during the period.
55	Number of cancellations for non-pay or non-sufficient funds.
56	Number of cancellations at the insured's request.
57	Number of company-initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to a related company.
58	Number of company-initiated cancellations that occur 60-90 days after effective date, excluding rewrites to a related company.
59	Number of company-initiated cancellations that occur greater than 90 days after effective date, excluding rewrites to a related company.
60	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.



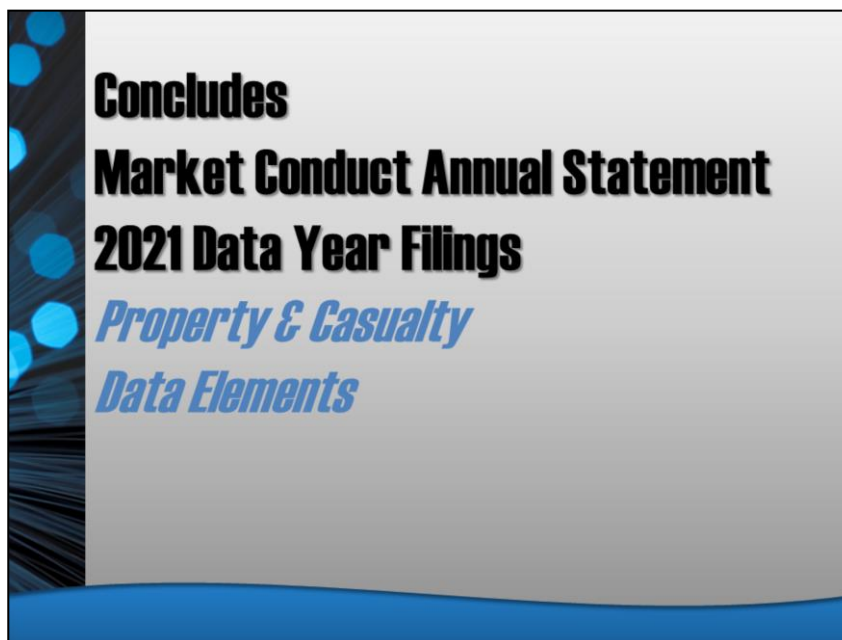
Auto/Homeowners Data Call & Definitions

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.

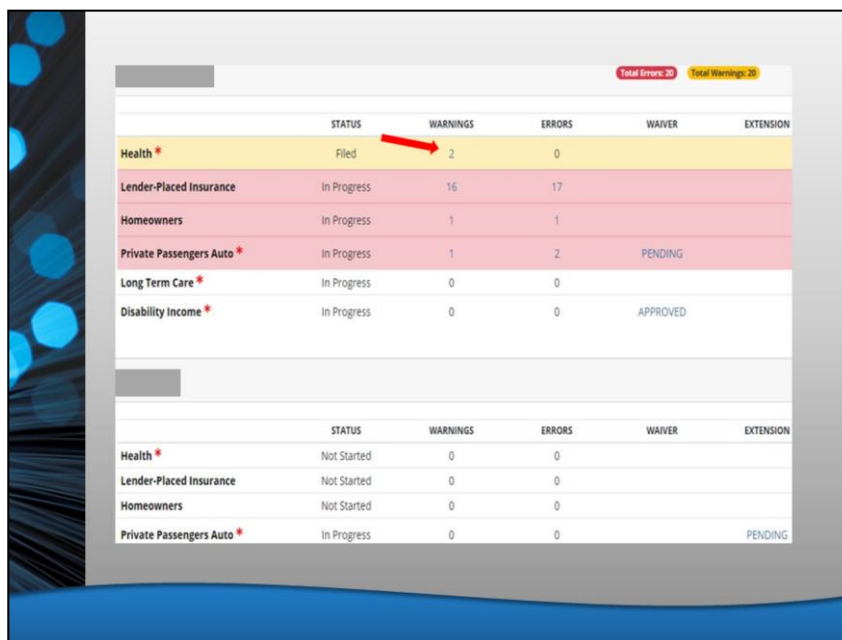
- They assist insurers in the review of their data within the MCAS application to ensure their data is accurate and entered as intended. For example: the validations can point out data issues that are a result of data entry errors or coding errors,
- And they assist state insurance regulators and NAIC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



The screenshot displays the MCAS system filing matrix. At the top right, there are two summary boxes: 'Total Errors: 20' in a red box and 'Total Warnings: 20' in a yellow box. The main table is divided into two sections. The top section shows filings with a 'STATUS' of 'Filed' (highlighted in yellow) and a red arrow pointing to the 'WARNINGS' column. The bottom section shows filings with a 'STATUS' of 'Not Started' or 'In Progress'.

	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	
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.

		Total Errors: 20		Total Warnings: 20	
	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

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.

Homeowners Interrogatories

		Yes No Response	Explanation
01	Were there policies in-force during the reporting period that provided Dwelling coverage?	----	----
02	Were there policies in-force during the reporting period that provided Personal Property coverage?	----	----
03	Were there policies in-force during the reporting period that provided Liability coverage?	----	----
04	Were there policies in-force during the reporting period that provided Medical Payments coverage?	----	----
05	Were there policies in-force during the reporting period that provided Loss of Use coverage?	----	----
06	Was the company still actively writing policies in the state at year end?	----	----
07	Does the company write in the non-standard market?	----	----
08	If Yes, what percentage of your business is non-standard?	----	Comments
09	If Yes, how is non-standard defined?	----	
10	Has the company had a significant event/business strategy that would affect data for this reporting period?	----	
11	If yes, add additional comments.	----	
12	Has all or part of this block of business been sold, closed or moved to another company during the reporting period?	----	
13	If yes, add additional comments.	----	----
14	How does the company treat subsequent supplemental or additional payments on previously closed claims?	----	----
15	Does the company use Managing General Agents (MGAs)?	----	----
16	If yes, list the names of the MGAs.	----	----
17	Does the company use Third Party Administrators (TPAs)?	----	----
18	If yes, list the names of the TPAs.	----	----
19	Additional state specific Claims comments (optional):	----	----
20	Additional state specific Underwriting comments (optional):	----	----

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

ATTESTATION						
	First Name	Middle Name	Last Name	Suffix	Title	Comments
165 First Attestor information	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
166 Second Attestor information	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
167 Overall Comments for the Filing Period	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

Attestation – New location

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are 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. They are 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 their 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. They are 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. They 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.

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 attestors 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.

ID	Description
10-89	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
10-90	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
10-91	Overall Comments for the Period

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.

Lender Placed Insurance (Auto and Home)	
Both Single Interest and Dual Interest	
Claims	
Ratio 1.	$\frac{\text{Number of claims closed without payment to total number of claims closed}}{(\# \text{ of claims closed with payment}) + (\# \text{ of claims closed without payment})}$
Ratio 2.	$\frac{\text{Claims open at the end of the period to total claims during the period}}{(\# \text{ of claims open at the beginning of period} + \# \text{ of claims opened during period} - \# \text{ of claims closed with payment} - \# \text{ of claims closed without payment})}$
Ratio 3.	$\frac{\text{Claims paid beyond 60 days to total claims closed with payment}}{(\# \text{ of claims settled 61} - 90 \text{ days} + \# \text{ of claims settled 91} - 180 \text{ days} + \# \text{ of claims settled 181} - 365 \text{ days} + \# \text{ of claims settled beyond 365 days})}$
Ratio 4.	$\frac{\text{Loss Ratio - Incurred claims to earned premium}}{(\text{dollars of claims incurred during the period})}$
Cancellations	
Ratio 5.	$\frac{\text{Master policy cancellations to master policies in force at beginning of the period}}{(\text{total \# of master policy cancellations})}$

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.

MCAS Market Conduct Annual Statement

2022 | 2021 (Current Data Year) | 2020 | 2019 | Contacts and Scorecards

RESOURCES

Data Collection Worksheets (Blanks)

- Annuity v. 2021.1.0
- Disability Income v. 2021.1.0
- Health v. 2021.1.0
- Homeowners v. 2021.1.0
- Lender-Placed Home and Auto v. 2021.1.1
- Life v. 2021.1.0
- Long-Term Care v. 2021.1.0
- Private Flood v. 2021.1.1
- Private Passenger Auto v. 2021.1.0

Data Call and Definitions (Instructions)

- Disability Income v. 2021.0.2
- Health v. 2021.1.0
- Homeowners v. 2021.1.0
- Lender-Placed Home and Auto v. 2021.1.0
- Life & Annuity v. 2021.0.2
- Long-Term Care v. 2021.1.0
- Private Flood v. 2021.1.0
- Private Passenger Auto v. 2021.1.0

Summary of 2021 Changes

- 2021 MCAS User Guide
- Scorecard Ratio Formulas

NEW FOR 2021 DATA YEAR

No new MCAS lines of business are being introduced for the 2021 data year. However, there are updates to the Life, Annuity, Homeowner, Private Passenger Auto, and Lender-Placed Auto and Home lines of business. A summary of these changes can be found in the [Summary of 2021 Changes](#) document.

WHAT DO DOCUMENTS 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

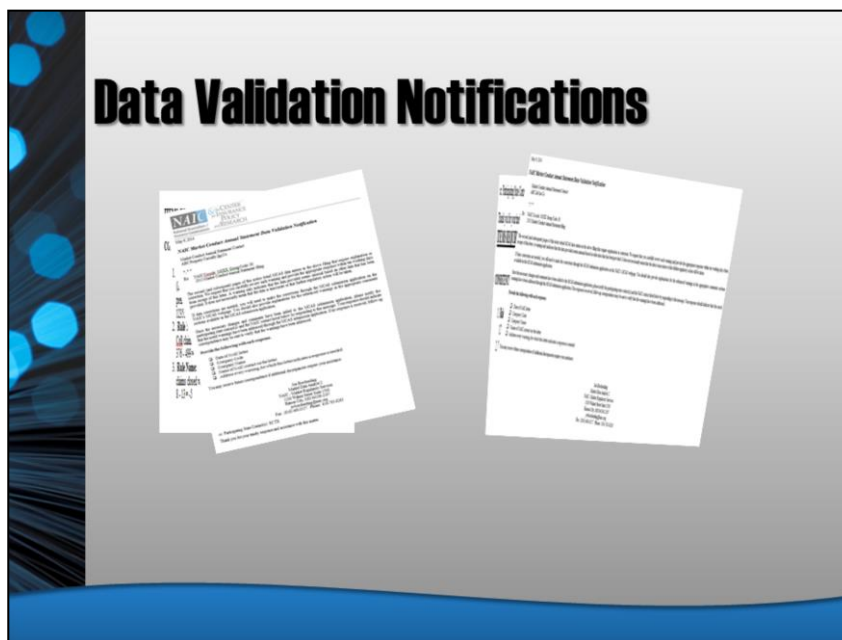
- Data Collection Worksheets (Blanks) – Table layout representation of the required data elements
- Data Call and Definitions (Instructions) – Listing of MCAS data elements and definitions to follow when preparing data for submission
- MCAS User Guide – Information about how to use the MCAS application 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 application (The use of a CSV file is not required)
- CSV Assistant Instructions – Guidance for using the CSV Assistance Files
- CSV Assistant Files – Templates to assist in the creation of CSV data files
- Scorecard Ratio Formulas – Listing of standard scorecard ratios calculated for each MCAS lines of business

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.

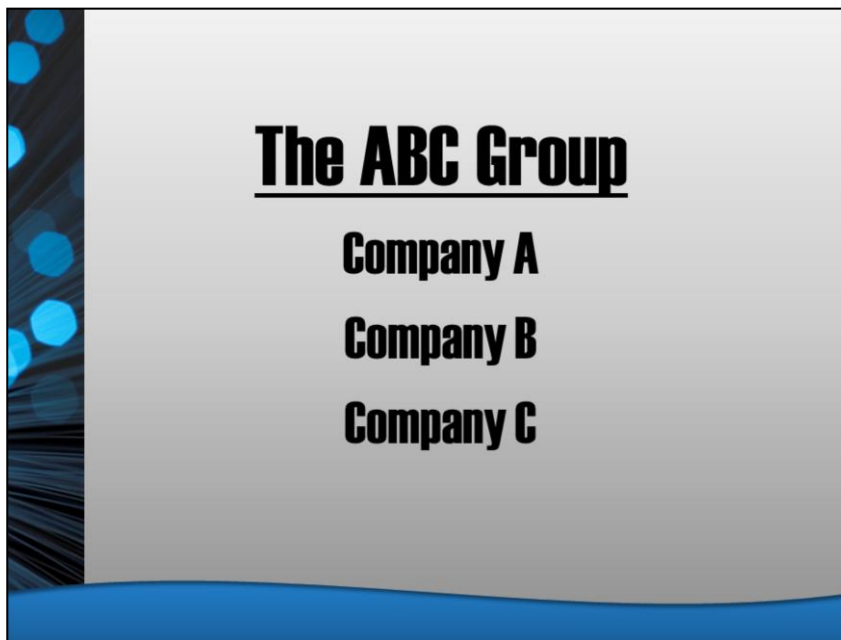
State Regulators have Oversight



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.



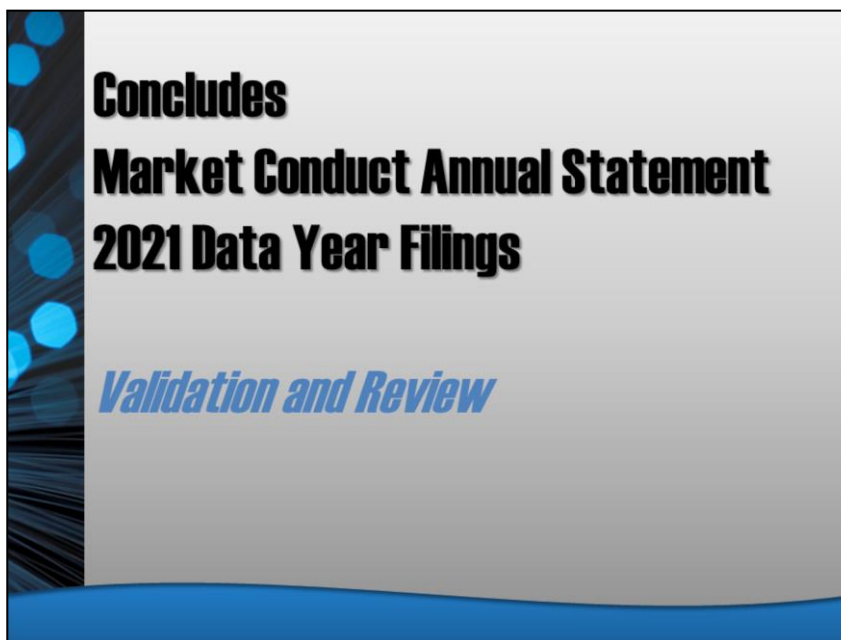
If there is reported data that appears to be mis-reported or inaccurate based on a review of data for states where data was submitted, NAIC will send an email letter to the Market Conduct Annual Statement Contact. When contact is made with individual companies, state regulators are notified of this correspondence.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