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

In this section of the Market Conduct Annual Statement training we will be reviewing the data elements that must be provided for the Life MCAS and the Annuity MCAS.
Many MCAS related resources are available to you on the MCAS web page. I encourage you to visit the page frequently to find the latest reporting information.

The available resources include:
• A Listing of Important Dates
• Participation Requirements
• Frequently Asked Questions
• Reporting Blanks
• Data Call and Definitions
• Copy of the Call Letter
• MCAS User Guide
• And CSV Data Upload Instructions
Before we begin, please be sure to remember the current year MCAS filing deadline is April 30th.
Also remember, the Life and Annuity threshold for all jurisdictions is $50,000 in individual life premium or $50,000 in individual annuity considerations.
Let’s jump right in…The first section of questions that you will see in the data entry screen is the interrogatories. The interrogatories provide one location for all comments and questions that require a text response.
You will notice on your data entry screen within the MCAS submission tool, that there are two separate pages to enter information.

The first page is for the Interrogatory questions, and the second page is for the data questions for the different policy types.
The first interrogatories ask insurers to indicate if they will be reporting data for each of the policy types for the line of business selected.
If you answer “YES” you must provide data to each of the data questions in the schedule.
If you respond “NO”, you must leave all of the response boxes blank. You should only provide data for schedules that you are required to report on.
If you indicate that you will be reporting data for a policy type, you are asked to provide any reasons that the reported information may identify the company as an outlier or be substantially different from previously reported data. These reasons may include such things as assuming, selling or closing blocks of business, shifting market strategies, or underwriting changes. This is your opportunity to explain any of your data that you anticipate may generate an inquiry from the state regulators. It is important that these questions be answered fully to allow for regulators to have an understanding of your company’s MCAS filing results.
The interrogatories also provide space where you may enter any state specific comments for the policy types. Any areas of your data that may raise questions or generated a warning when your data was validated should be explained fully in these comment areas. At the end of this tutorial, we will discuss the MCAS validations in more detail along with the importance of using the comments sections.
Most of the MCAS data elements are the same for both the Life and Annuity MCAS filings, but there are a few areas where there are differences. For this reason, we will first discuss the data elements contained in the Life MCAS filing, then later in the session we will go through the data elements that are different in the Annuity MCAS filing.
The Life MCAS requests market conduct data on two types of life policies. Life is split into individual life policies with a cash value component (which includes term life policies with a cash value), and life policies without a cash value component (or non-cash value Life policies). You should not report any data for Accidental Death and Dismemberment policies.
Before we move on to the main data elements, it’s important to point out that if there is any question regarding data reporting methodology, you should follow the same methodology used to report on the Financial Annual Statement.
Now we’re ready to discuss the individual life and individual annuity MCAS questions. The first series of questions addresses “replacement” activity during the reporting period. The reporting period for the current data year is January 1st through December 31st. So, you would provide the number of replacements **issued** between those dates, as indicated on the slide.

For both Individual Cash Value and Individual Non-Cash Value Life business you are asked to provide:

- The number of replacement policies issued during the period,
- Number of internal replacements issued during the period, and the
- Number of external replacements issued during the period.
In addition, for just the Individual Life Cash Value products you are asked to provide:

- The number of policies replaced where the age of insured at replacement was < 65 years old, and the
- Number of policies replaced where the age of insured at replacement was >= 65 years old.

Please note that if more than one person is insured on the policy, use the age of the oldest insured.
The definition of a replacement policy as stated in the Life and Annuity Data Call & Definitions is: a policy and/or annuity contract application received by your company that is intended to replace an existing policy and/or annuity contract according to each state's definition of a replacement. This may include both external and internal replacements according to each state's replacement law.
Included in the definition of a replacement policy are:

- Loan purchases, if the original policy is surrendered

- Surrenders, if a replacement policy is issued in conjunction with the surrender

- and 1035 exchanges.
Policy conversions and exchanges of a group policy for an individual policy should not be considered replacements.
If a person replaces two policies with one policy,
this should be counted as two replacements.
An internal replacement is when the policy to be replaced was also issued by your company.
And an external replacement is when the policy to be replaced was issued by another company. The replacements reported *do not* include policies written by your company that are replaced by policies issued by another company.
The next series of questions to be discussed are regarding surrenders. Of course, these only apply to the Life cash value policies. They do **not** apply to Life Non-Cash value business.
Surrenders are policies or contracts that are terminated at the request of the policy or annuity owner.
It does not include policies not taken or cancelled during the free look period. It also does not include loans against the cash value of a policy, or systematic withdrawals and partial withdrawals from an annuity.
For surrenders, you are asked to provide:

- The number of policies or contracts surrendered under 2 years from issuance,

- Number of policies or contracts surrendered between 2 years through 5 years from issuance,

- Number of policies or contracts surrendered between 6 years through 10 years from issuance, and the

- Total number of policies or contracts surrendered during the period.
The next questions are about policies issued during the period.

Both the Individual Life Cash Value and Non Cash Value schedules ask for the total number of policies issued by the company during the period.
However, the Individual Life Cash Value schedule also requires a breakout of policies issued by the age of the insured at issuance. You are asked for:

- The number of new policies issued during the period where age of the insured at issue was <65 years old, and the

- Number of new policies issued during the period where age of the insured at issue was >= 65 years old.
As mentioned before, the reporting period only includes those policies issued between January 1 and December 31. If a policy was applied for on December 31 of the reporting period, but not finally issued until the middle of January, do not count it. The sum of the number of policies issued during the period by age group should equal the total number of new policies issued.
A couple of additional points regarding policies or contracts issued:

If a joint policy is issued, use the age of the oldest insured when reporting policies issued broken out by the age of the insured or annuitant.

Also, internal and external replacements should be reported as new policies or contracts issued during the reporting period as well as reported in the numbers of internal and external replacements.
The next data element asks that you report the number of policies applied for during the period.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Number of new policies issued during the period.</td>
</tr>
<tr>
<td>21</td>
<td>Number of policies applied for during the period.</td>
</tr>
<tr>
<td>22</td>
<td>Number of free looks during the period.</td>
</tr>
<tr>
<td>23</td>
<td>Number of policies in force at the end of the period.</td>
</tr>
<tr>
<td>24</td>
<td>Dollar amount of direct written premium during the period.</td>
</tr>
<tr>
<td>25</td>
<td>Face amount of insurance issued during the period.</td>
</tr>
<tr>
<td>26</td>
<td>Face amount of insurance in force at the end of the period.</td>
</tr>
<tr>
<td>27</td>
<td>Number of complaints received directly from any person or entity other than the DOI.</td>
</tr>
</tbody>
</table>
Policies/Contracts Applied For are those applications for life insurance or annuities that are submitted to the company which have or will result in a formal offer of an insurance or annuity contract or a formal declination of the application by the company. Applications that are declined by a broker-dealer or producer and never reviewed by the company are not included in this count.
Then you are asked to report the number of free looks during the period.
A Free Look is a set number of days provided in an insurance or annuity contract that allows time for the purchaser to review the contract provisions with the right to return the contract for a full refund of all monies paid. Report the number of policies or contracts that were returned by the owner under the free look provision during the period, regardless of the original issuance date.
MCAS is **not** asking for the number of policies that have a Free Look provision; you are expected to provide the number of times the free look provision was exercised during the reporting period.
If an alternative policy is offered and the originally offered policy is returned during the free look period in order to accept the alternative policy, this would be reported as a free look for the returned policy and as a policy issued for the alternative policy which was issued.
Also, regardless of when the policy was issued, you should include only those free looks that occurred during the reporting period.
Next, you are asked to report the number of policies in-force at the end of the period.

The number of policies in-force, is simply the number of in-force policies and contracts on the last day of the reporting period.
The next question in MCAS asks for the dollar amount of direct premium during the period. This is the dollar amount of premium written by the company during the reporting period. How you report this premium (whether by residency or state of issuance, for example) must be consistent with how you report the premium on your financial annual statement state page.
Only report the Life insurance premium received for individual life products – remember that group life insurance is excluded.
Following the premium question, there are two questions that ask for the face amounts of insurance issued and face amount of insurance in force.
By face amount, MCAS is looking for the amounts that would be payable to the beneficiary upon the death of the insured. As with premium, this amount should be reported in MCAS according to the same methodology that your company used when it reported face amounts on the financial annual statement.
There is one question concerning complaints. The data element asks that you report the number of complaints received directly from any entity other than the Department of Insurance.

The change in wording does not change the intended reporting for complaints, but instead clarifies complaints that are expected to be reported.
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.

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.
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. Remember that the complaints should be reported separately for Life Cash Value and Life Non-Cash Value products.
There are ten questions remaining to be answered, all concerning claims.
The first three claims questions ask for the number of death claims that were closed with payment during the period. The reporting is broken out by those paid within 30 days from the date the claim was received, those paid within 31 to 60 days from the date the claim was received and those paid beyond 60 days from the date the claim was received.
Claims questions 31 through 33 are similar to questions 28 through 30. They ask for the number of death claims that were closed with payment during the period, and the reporting for these questions is broken out by those paid within 30 days from the date of due proof of loss, those paid within 31 to 60 days from the date of due proof of loss and those paid beyond 60 days from the date of due proof of loss.
So, for these six questions, you are concentrating only on those claims that were *paid* between January 1 and December 31 (regardless of when they were presented or when you received the proof of loss).
If the Proof of Loss was received on December 15 of the prior reporting period, and paid on Jan 12 of this reporting period,
you would count it as paid within 60 days.
If, however, the proof of loss was received on December 15 of THIS reporting period, and not paid until January 12 of the NEXT reporting period,
do NOT include it in your count.
What if you have a claim with multiple beneficiaries or an insured covered under multiple policies? You will count the claims per life policy.
So, if the insured owned one policy that had two beneficiaries, it is counted as 1 claim.
If the insured was covered on two separate policies, that would be 2 claims (1 claim per policy, regardless of the number of beneficiaries). Remember also to report the claim under the correct schedule.
If the insured was covered under a term life policy (without cash value) and a whole life policy (with cash value),
you would report 1 claim on the non-cash value life schedule and 1 claim on the cash value life schedule.
Remember when you are measuring the number of days from the due proof of loss, that this date of due proof of loss is defined in MCAS as the date the company received the necessary proof of loss on which to base a claim determination.
You will use a similar method as that just outlined for the questions regarding how long it was between the date a claim was received and the date it was paid. Instead of the “beginning date” being the date the due proof of loss was received, it will be the date the claim was received. As defined in MCAS, the date the claim was received is the first date the claim is opened on the company system.
For the next MCAS question, you are asked to provide the number of claims that were denied, compromised or resisted.
A denied claim is, of course, a claim where a demand for payment was made but payment was not made. If an event was reported “for information only” or if there was just an inquiry regarding coverage, do not consider it as a claim, since no formal claim has actually been presented.
A compromised claim is a claim for which there was a settlement that was less than the face value of the policy or anything less than 100% of what was owed under the policy.
A claim is considered resisted when it is in dispute and not resolved on the financial statement date for the reporting period. Where the company is holding up payment for sufficient evidence or where a beneficiary has made a claim and then withdraws it, such items should be considered as in the course of settlement—that is, you would not count as paid or resisted.
In counting the total number of claims denied, compromised or resisted, you will count those claims that were denied or compromised during the period, and then add to that the number of claims being resisted at the end of the reporting period.
The next two questions deal with the contestability period.
The contestability period is the period of time before a policy’s incontestability clause becomes effective. During this period, a company may contest a claim based upon material misrepresentation or concealment during the policy application process. The contestability period is usually 2 years.
Do not report claims on guaranteed issue life policies and do not report claims that are contested after the incontestability clause is in effect.
One question asks for claims closed with payment during the period that occurred within the contestability period and the other asks for claims denied during the period that occurred within the contestability period.
Finally, MCAS asks for the total number of claims that were received during the reporting period. As mentioned before, do not count events that were only reported for information or that were simply inquiries about coverage. Count only those claims for which a claim was opened within your company’s system. And for purposes of determining whether or not the claim was reported during the period, use the date that it was opened on your system.

We are finished reviewing the Life MCAS data elements,
and we will move on to the Annuity MCAS data element differences.
The first data elements that are reported for Annuities that differ from the Life lines of business are the number of contracts replaced. For Annuities, the age breakouts are different.

The breakouts are:

The number of contracts replaced where the age of annuitant at replacement was <65 years old,

The number of contracts replaced where the age of annuitant at replacement was 65 to 80 years old, and the

Number of contracts replaced where the age of annuitant at replacement was >80 years old.
The next difference is that for Annuity lines you are asked for information regarding immediate and deferred contracts by the age of the annuitant at the time of issuance of the annuity.

The immediate and deferred questions for Annuities are:

- The number of new immediate contracts issued during the period

- The Number of new deferred contracts issued during the period where the age of the annuitant was < 65 years old,

- The Number of new deferred contracts issued during the period where the age of the annuitant was 65-80 years old,

- The Number of new deferred contracts issued during the period where the age of the annuitant was >80 years old, and the

- Total number of new deferred contracts issued by the company during the period.
The remaining area that requires some clarification for Annuities is related to the reporting of the dollar amount of annuity considerations during the period. For Annuity, report only considerations on specifically allocated business that has insurance risk.
For example, you would not report considerations received on deposit-type contracts, nor would you report considerations received toward a pension plan where the funds are not allocated prior to retirement.
This concludes the data elements review portion of the tutorial. Now we'll discuss the MCAS data validations.
MCAS Validation and Review
MCAS Validations are data checks programmed within the MCAS data submission application.

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

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

If a filing contains “warning messages,” and there are no comments entered by the company, it is more likely that the company will be contacted for an explanation by NAIC staff.
The company’s standard ratio results are also reviewed. A listing of the scorecard ratios can be found on the MCAS web page.

During review of a company’s ratio results, values that are significantly different than the expected value are identified, along with any significant changes in a company’s ratio values year to year. Companies will be notified of these anomalies to allow verification of the submitted data.
In addition to warnings and ratios, data relationships within the submission are reviewed. An example would be a comparison of policies in-force to the number of claims. Another example would be the comparison of 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.
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.