

Market Regulation Handbook

VOLUME II

2019

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Market Regulation Handbook

2019 Edition

Volume II

What is Market Analysis

This guidance is as adopted by the NAIC as of December 2018. Please note that there are modifications to the chapters that are included in this handbook during each calendar year, as such guidance is subject to the maintenance process. To address this, the NAIC has a web page dedicated to providing the holder of this manual with the latest information/interim adoptions which impact the content of this handbook.

State regulators may access updates adopted after December 2018 and *Market Regulation Handbook* Reference Documents via myNAIC on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents.

Non-regulator purchasers of the 2019 *Market Regulation Handbook* may access updates adopted after December 2018 and *Market Regulation Handbook* Reference Documents via their Account Manager login at www.naic.org/account_manager.htm.

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(Pages 1-88)**

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
Introduction	Chapter 1	Chapter 1
Continuum of Market Actions	Chapter 2	Chapter 2
Market Regulation Investigation Guidelines	Chapter 7	Chapter 3
Collaborative Actions	Chapter 6	Chapter 4
Core Competencies	Appendix D	Chapter 5

**Volume II-What is Market Analysis
(Pages 89-174)**

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
Basic Analytical Tools	Chapter 3	Chapter 6
Putting it all Together: Market Analysis	Chapter 4	Chapter 7
Enhancing State Market Analysis	Chapter 5	Chapter 8
iSite+ Reports	Appendix A	Chapter 9
Market Analysis Level 1 Questions	Appendix B	Chapter 10
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**Volume III-How to Conduct Market Conduct Examination
(Pages 175-276)**

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
Examination Introduction	Chapter 8	Chapter 12
Types of Examinations	Chapter 10	Chapter 13
Examiner Classifications, Qualifications and Compensation (was previously titled Examiner Qualifications and Compensation)	Chapter 9	Chapter 14
Standardized Data Requests	Chapter 13	Chapter 15
Scheduling, Coordinating and Communicating	Chapter 12	Chapter 16
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Writing the Examination Report	Chapter 15	Chapter 19

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**Volume IV-Review/Examination Criteria for Specific Types of Insurance and Regulated Entities
(Pages 277-1117)**

Chapter/Section Title	Location in Handbooks Published 2006-2017	Location in 2018 Handbook and Subsequent Years' Handbooks
General Examination Standards	Chapter 16	Chapter 20
Conducting the Property and Casualty Examination	Chapter 17	Chapter 21
Conducting the Title Insurance Company and Title Insurance Agent Examination	Chapter 18	Chapter 22
Conducting the Life and Annuity Examination	Chapter 19	Chapter 23
Conducting the Health Examination	Chapter 20	Chapter 24
Conducting the Affordable Care Act (ACA) Related Examination	Chapter 20A	Chapter 24A
Conducting the Medicare Supplement Examination	Chapter 21	Chapter 25
Conducting the Long-Term Care Examination	Chapter 22	Chapter 26
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Conducting the Examination of a Viatical Settlement Provider	Chapter 27	Chapter 31
Conducting the Premium Finance Company Examination	Chapter 28	Chapter 32

VOLUME II—FORWARD

What is Market Analysis

A market analysis program is a system of collection and analysis of data and other information.

This handbook provides the fundamental elements of a system for market analysis for all companies and all lines of business. The indicators that result from the analysis suggested in this handbook provide a basis for regulators to initially screen and follow-up with insurers whose results are outside of normal parameters and help focus resources on insurers with potential market conduct problems.

Market analysis can enable a regulator to do the following:

- Provide the fundamental elements of a system for market analysis for all companies and all lines of business;
- Screen and follow-up with insurers whose results are out of the norm and help focus resources on insurers with potential market conduct problems;
- Provide a good approach for monitoring the performance of a newly formed or newly licensed company;
- Identify general market disruptions and important market conduct problems as early as possible and, if possible, eliminate, or at least limit, the harm to consumers;
- Better prioritize and coordinate the various market regulation functions of the insurance department and establish an integrated system of proportional responses to market problems; and
- Provide a framework for collaboration among the states and with federal regulators regarding identification of market conduct issues and market regulation.

As the General Accounting Office explained in its September 2003 report on state market regulation:²

Among other things, market analysis can provide information on insurance companies' compliance with applicable laws and regulations, highlight practices that could have a negative effect on consumers and help identify problem companies for examination. The NAIC and some states recognize that market analysis can be a significant regulatory tool and all of the states we visited performed some type of market analysis, but in most cases these efforts were fragmented and lacked a systematic organization and framework. We found that in many states, market analysis consisted largely of monitoring complaints and complaint trends and reacting to significant market issues. Analyzing complaints and complaint trends does provide regulators with useful and important information and should be part of any market analysis program. However, other types of information can also help regulators identify and deal with market conduct issues, including data from financial reports, rate and form filings and other company filings, routine and special requests for company data and information from other federal and state regulators. All this information, consistently and routinely evaluated by well-trained analysts, can help regulators identify companies that examiners need to look at more closely or that merit regulatory actions.

² *Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation*. No. GAO-03-433, September 30, 2003.

Market analysis will assist a state in its review of existing data. As more techniques are developed and refined by the states, and as more states participate in market analysis and other market oversight activities, this handbook will be updated so that states are constantly learning from each other and relying upon the resources of all of the states. For example, as states become consistent in their consumer complaint reporting as suggested in this handbook, the more useful and meaningful market analysis will become on a countrywide basis. As explained earlier, analysis of existing data is only one component of an effective market regulation program and all of the components must work together. Insights gained from data analysis must be shared and used to improve both the examination and data reporting processes and, likewise, the sharing of insights from market conduct examinations and reports will improve states' understanding of the significance of complaint data, financial data and other external information for market analysis.

Intended Use of the *Market Regulation Handbook*

This handbook is only a guide and should be used by each jurisdiction as a tool for developing jurisdiction-specific procedures and guidelines. To effectively use this handbook, it is recommended that each jurisdiction closely review the handbook to determine those standards that reflect the statutes and regulations of the given jurisdiction and those that do not. This handbook is designed solely to provide assistance to each jurisdiction in developing effective and consistent methodology. It does not reflect policies or procedures that are required to be implemented by any jurisdiction. It is not intended that market regulators apply any requirements to the market regulation process beyond the laws of their respective jurisdictions. To the extent possible, jurisdictions are encouraged to follow the standards established in this handbook. The text of this handbook becomes the procedure or policy of a given jurisdiction only after it has been adopted by that agency. Deviations from this handbook by an agency to accommodate the specific requirements of its own jurisdiction should not be construed as a failure of that agency to implement adequate examination or other market regulation procedures.

It is also important that each jurisdiction communicate to its market regulators the intent and scope of its market regulatory efforts. This includes direction regarding in which areas a jurisdiction's market analysis, market conduct initiatives and regulatory responses are to be concentrated, and what standards and criteria are to be considered within any particular subject area. For example, a jurisdiction may wish to concentrate on market analysis of complaint data and trends in a specific line of business or a jurisdiction may wish to focus upon a regulated entity's compliance with a limited number of key components of a particular state regulation. Specific direction provided by a jurisdiction to its market regulators will serve to sharpen the jurisdiction's focus on its market regulatory activities and will also conserve jurisdiction and company staff resources.

Structure of the *Market Regulation Handbook*

Beginning with the 2018 edition of the *Market Regulation Handbook*, the subject matter of the handbook is restructured and divided into four volumes:

- Overview of market regulation oversight;
- What is market analysis;
- How to conduct market conduct examinations; and
- Review/Examination criteria for specific types of insurance and regulated entities.

The *Market Regulation Handbook* table of contents outlines the subject areas contained within each volume. The purpose of the restructuring of the handbook is to combine interrelated chapters into the broad categories outlined above and to provide regulators with functional guidance to support state insurance department market surveillance activities.

Updating the *Market Regulation Handbook*

This handbook is updated and revised on an annual basis. Updates to the *Market Regulation Handbook* that are adopted periodically during the year by the Market Regulation and Consumer Affairs (D) Committee will be posted on the NAIC website. Instructions for accessing the updates on the NAIC website are located at the front of the most recently published *Market Regulation Handbook*.

Chapter 6—Basic Analytical Tools

A. Market Conduct Indicators and Priorities

The common denominator of this handbook is change. When there are changes in laws or regulations or in the marketplace, they affect processes and procedures within insurance companies and can increase the risk of market conduct or compliance problems during a period of adjustment. Similar problems can result from internal changes in a company, such as where, how and what lines of business it writes. Conversely, disruptions in a market sector or stresses or irregularities in a particular company's operations will also leave their mark in the statistics.

Many changes are positive and a market with no signs of change would be troubling. Nevertheless, significant signs of change deserve careful regulatory attention, at least until their causes and effects are better understood. Even when a change is undeniably for the better, changes may, however, highlight areas where some companies have not adapted as well as others to the evolving marketplace.

In order to assess the nature and extent of changes, it is essential to have meaningful data. This section of the handbook explains the use of the NAIC iSite+ system, an essential information resource for state insurance regulators, and then discusses a few key items of information that are most likely to be indicators of market conduct problems; consumer complaint data and state-by-state data from insurers' financial statements. Other significant sources of available data are also discussed briefly.

The importance of data begins at the very earliest stages of the process. Because state resources are finite, one of the most critical market analysis functions is setting priorities for review. Almost all states have over 1,000 insurers licensed to do business, so without a good sense of priorities, it can be daunting for a state insurance department to identify which companies to look at and what to look for. Because companies with a larger market share will impact the greatest number of consumers, an effective regulatory review program must include the companies with the largest market shares, while at the same time being careful not to overlook concerns that may arise with smaller companies.

Market share reports are among the wealth of data compilations that the NAIC makes available to state regulators on iSite+. For example, if a single company writes 25 percent of a significant line of insurance in a regulator's state, this company is a market leader to which regulators should pay attention. For that reason alone. However, the same companies are likely to be targeted in other states, which makes multistate coordination imperative, not only to avoid imposing unnecessary regulatory burdens upon insurers, but also to facilitate a deeper and more coherent analysis by the various regulators so as to address as efficiently and consistently as possible the company's activities in all states where it does business.

Other factors for state regulators to consider when setting priorities include consumer complaint activity and the lines of insurance transacted. Some lines of insurance are more prone than others to particular types of market conduct problems. A more proactive market regulation program is generally better suited to personal lines than to commercial lines and generally better suited to small business markets than to other commercial lines markets. However, none of these criteria should be applied too rigidly. There is no foolproof way to predict which market issues will rise to the forefront, as demonstrated, for example, by the impact on the health care market of the problems many states have been experiencing with the medical malpractice insurance markets and by the broad-ranging consequences of the property insurance market's response to Sept. 11, 2001.

B. NAIC iSite+

The iSite+ suite of applications are used to report financial, market regulation and producer information housed in the NAIC databases. Regulators should familiarize themselves with iSite+, a secure regulator-only area within the NAIC website which provides access to NAIC databases and a wide variety of reports prepared from those databases. Of particular importance to market analysis are consumer complaint data and annual statement information.

iSite+ provides state insurance department regulators with access to applications used by regulators. Regulators may access iSite+ via the myNAIC link on the NAIC website. In order to log into myNAIC, regulators must have an active NAIC Oracle account and password login. Regulators who do not have myNAIC login credentials or do not remember their user ID and password should contact their insurance department IT Liaison.

iSite+ reports are standardized reports that provide regulators with a variety of financial and market regulation information. Most of these reports provide information related to a group of entities with similar attributes (e.g. companies that write business in a particular state) rather than individual entities. A comprehensive listing and description of available iSite+ reports are located in the Help file on iSite+.

C. Use of Complaint Data in Market Analysis

One of the primary missions of state insurance departments is to serve and protect the insurance consumer. To fulfill that mission, state insurance departments provide the valuable service of working with consumers and insurers to address consumer complaints. For lines of business where the insurance department has an active complaint resolution program, such as automobile, homeowners and health, consumer complaints should be a key starting point both to identify emerging issues and to screen insurers for potential market conduct or compliance problems. Of all the types of information that departments initially collect for other purposes, consumer complaints have the most obvious relevance to market conduct. The goal here is to take the information we learn when doing complaint resolution and put it to work for complaint prevention.

The efficient use of a complaint analysis system allows an insurance department to create an effective and immediate surveillance program by detecting potential problems on both individual company and industry-wide levels. This complaint information is used by the states as an early warning system to detect problems and to provide a basis for further market conduct review. However, despite the obvious correlations between consumer complaints and market conduct concerns, regulators must be careful not to jump to conclusions purely on the basis of complaint data, nor should they conclude that the absence of complaints means an absence of market problems. There are a number of reasons why an exclusive focus on consumer complaints cannot be used as a substitute for a more thorough inquiry into the company's activities, including:

- Complaints are to some degree anecdotal and often are not documented in sufficient numbers to be statistically credible. Although this deficiency can be mitigated to some degree by using multistate data, inconsistencies between different state approaches raise other concerns.
- One reason for the small sample size is that not every problem gives rise to a documented complaint. States need to gauge how informed state consumers are about voicing concerns or complaints regarding insurance;
- Conversely, the customer might not always be right. The presence of a complaint points to the existence of a conflict, but not the nature or the cause. A complaint could be the result of an insurer failing to live up to its obligations or the result of a breakdown in communications, but it could also be the result of unrealistic expectations on the part of the consumer. To address this concern, "confirmed" complaints should be distinguished from other consumer complaints;
- There are some lines of insurance for which there are no useful complaint records, because the nature of the business makes it unlikely that consumers will file complaints or the insurance department does not have an active complaint resolution program. For example, violations of disclosure requirements might never generate complaints because, in the absence of disclosure, consumers do not know their rights have been violated. Similar problems also arise when premiums or benefits involve complex calculations because of the nature of the product; and

- Some markets are inherently more prone to complaints than others. For example, this is likely to be true for the high-risk sector within any line of insurance. Such differences must be taken into account before trying to compare the performance of different companies serving different markets. When problems appear with life insurance, they are less likely to become visible through the consumer complaint process. Similarly, complaints are more likely in lines of business where consumers have more frequent interactions with their insurer, such as health or personal auto, regardless of how serious the potential problems might be.

Nevertheless, complaint information is still the single most useful source of currently available data for market analysis. Complaints provide a great deal of information about the industry, individual insurers and real-time consumer concerns, including emerging issues in the marketplace.

Complaint information is one factor that should be considered in the selection of companies for further review and in the determination of the nature and scope of that review. Identifying companies with consistently high levels of complaint activity can be a first step toward corrective action. Once an insurance department has determined that a problematic complaint trend is occurring, complaint data may be helpful in resolving issues for consumers in a number of different ways. Insurance department staff may want to meet with the company to review adverse trends and require the company to establish a compliance plan, which may include self-audits and refunds to consumers.

Even in cases where a company turns out to have done nothing wrong, complaints serve as a compass pointing toward those issues where consumers need enhanced knowledge and awareness, allowing regulators to target efforts such as publishing brochures, speaking engagements at schools and community groups and placing public service announcements in the media.

Whatever system of recording and classifying complaints is used, complaint analysis must relate the raw complaint data to a meaningful analysis. Therefore, the centerpiece of a basic market analysis program should be the development and use of reports compiling, summarizing and comparing complaint information about the companies in a regulator's state marketplace.

The efficient use of a complaint analysis system as part of an insurance department's market conduct surveillance system allows an insurance department to create an effective and immediate surveillance program in detecting problem areas on an industry-wide level and in isolating potential problems for an individual company. Any complaint system used by the complaint division of an insurance department, in order to be efficient and meaningful, must be tabulated at least quarterly and preferably on a monthly basis. If a longer period is used, trends will not be spotted in a timely manner and the statistics that are generated will only show proof of an existing problem. From the tabulations, the complaint division can readily detect problems by using comparisons of past performance from past statistical information on the industry-wide level, by line or from individual companies.

The NAIC recommends the use of the *Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act* (#884). The purpose of the regulation is to prescribe the minimum information required to be maintained in a record of complaints in order to comply with the statute, and to set forth a format for a complaint record that may be used by any entity subject to the regulation. A complaints register should be available at the offices of the insurer. Information from this register can be obtained during field examinations of the company or on request from the home office of the company. The register is primarily a management tool for insurance companies, but may help alert insurance regulators to problem areas within entities subject to the regulation.

In October 1991, the NAIC released the Complaints Database System (CDS). The CDS provides regulators with online access to a database, which consists of the complaints data collected from NAIC members. The database enables insurance departments in all jurisdictions to inquire about and analyze closed complaints filed against insurance firms and individuals within and/or across state boundaries. Additionally, the system provides summary reports and complaint ratios for NAIC members. States submit closed consumer complaints information to CDS on a monthly or quarterly basis. The complaint records are then aggregated on a regional and national basis, providing total complaint counts, trend analysis and complaint index rankings to state regulators.

Supplemental information regarding the Complaints Database System (CDS), such as complaint data fields and user guides, is available on StateNet. The most current version of the NAIC standard complaint data form is also available on StateNet on the Market Data Team (MIS) web page.

Although the focus of analysis is on patterns and trends, some individual complaints by their nature will raise serious questions about an insurer's conduct, which call for follow-up even if the company's complaint index and complaint trends are otherwise unremarkable. This underscores the need for effective communication between divisions. Insurance departments should establish criteria for their complaint analysts to use in identifying complaints, which should be called to the attention of their market conduct and/or enforcement staff for further review. Inquiries from producers, consumers or health care providers about particular business practices may also warrant the attention of market regulators.

D. Use of Annual Statement Data in Market Analysis

Market Conduct Annual Statement

The first Market Conduct Annual Statement (MCAS) was adopted by the NAIC in 1991. Its original design was an aid in targeting examinations, as well as an alternative to examinations. The MCAS was initially designed to capture private passenger automobile claim payment information. On an annual basis, companies writing private passenger automobile coverage submitted a diskette containing a Microsoft Access® database populated with specified claim information. Included in the report were the number of claims opened and closed with and without payment during the period; the median number of days to pay first-party and third-party liability and property damage claims; the median number of days from the date of loss to the date a claim is reported and the number of first- and third-party suits filed during the reporting period. This reporting was intended to assist in the detection of insurers that exhibited results outside the industry normal ranges.

During 2003, the Market Regulation and Consumer Affairs (D) Committee took a proactive approach to market regulation and began implementing various market reform initiatives. As a result, an MCAS pilot program for life and property/casualty companies was implemented to assess the long-term viability of an annual statement approach to identifying market problems. Following a successful pilot, the project was adopted as an additional market analysis tool. Data collected through MCAS can be used to review the market activity of the entire insurance marketplace in a consistent manner and identify companies whose practices are outside normal ranges.

At the 2008 Fall National Meeting, the NAIC Executive (EX) Committee adopted a proposal to determine the best possible way to collect MCAS data according to a two-part plan:

Short-Term:

The first part of the plan provided for the transfer of MCAS data collected in 2009 by the 29 participating states to the NAIC for storage, aggregation and analysis in the existing Microsoft Access® database format. The proposal also provided direction for NAIC staff to analyze the aggregated data and identify strengths and weaknesses in the data currently being collected.

Long-Term:

The second part of the plan focused on the long-term commitment of the NAIC to centralize collection of market conduct data. As a result, the 2010 MCAS data was collected and stored centrally by the NAIC through an online submission tool.

For the 2010 and 2011 data years, sixteen new states collected MCAS data using the new centralized collection process. This brought the total number of states participating in the MCAS to 45. Currently, there are 49 participating jurisdictions. An overview of the participating jurisdictions is available on the NAIC MCAS web page.

Currently, MCAS data is collected on individual life cash and non-cash value products, individual fixed and variable annuities, individual stand-alone and hybrid long-term care policies, private passenger automobile policies, homeowners policies, in-exchange and out-of-exchange health plans and lender placed home and automobile policies. In addition, the collection of disability income MCAS data will begin for the 2019 data year reported in 2020.

By using common data and analysis, states have a uniform method of comparing the performance of companies. Data is collected regarding claims, premiums, policies in force, new policies written, nonrenewals, cancellations, replacement-related activity, suits and consumer complaints on an industry-wide basis. If a company's performance appears to be unusual as compared to the industry, the state may undertake further review of that company. The additional review may be as simple as calling the company for further information or clarification or conducting further analysis.

Additional information regarding the Market Conduct Annual Statement program may be found at https://www.naic.org/mcas_main.htm or by contacting NAIC Market Regulation Department staff.

Financial Annual Statements

The most comprehensive source of data on the financial aspects of insurers' activity in the marketplace are the annual (and quarterly) financial statements, which an insurer is required to file with its state of domicile, the NAIC and, in most instances, all jurisdictions in which the insurer is authorized to transact business. These statements include specific schedules and interrogatories that provide detailed information, such as premium volume, losses and changes in business. The NAIC compiles a wide variety of reports from the filed financial statements and makes them available to state insurance departments at iSite+. Financial statement data has value for market analysis on several levels and sometimes will allow regulators to identify companies with an increased risk of future compliance problems, allowing regulators to respond proactively before serious problems occur.

Most directly, financial information is meaningful to market regulators because market activity takes place through financial transactions. Although the dollars and cents, especially when aggregated at the statewide or nationwide level, do not by any means tell the whole story of a company's underwriting, sales, rating, risk classification and claims-handling practices, the underlying financial information is systematically collected and quantified in a consistent manner and suitable for use as a starting point for further analysis.

Certain types of consumer problems tend to be accompanied by characteristic patterns in company-specific or aggregate financial data. Indicators of financial stress should be of concern to market analysts, because financial problems are often accompanied by market conduct problems, such as delayed claims payments and neglect of customer service. Furthermore, the failure, retrenchment or reorganization of a major market presence will have a disruptive effect on the market as a whole.

Every insurer, as part of its annual statement, files a State Page in each state in which it is licensed. The financial data of greatest general interest to market analysts can be found there, with the caveat that State Pages do not capture potentially significant information on geographic units within the state. The content of the State Page varies by product line, but generally, it is an exhibit of premiums and losses.

For property/casualty insurers (which file on the yellow statement Blank), this page is, for historical reasons, referred to as “Statutory Page 14.” This page is officially called “Exhibit of Premiums and Losses—Statutory Page 14.” The page no longer appears on the actual page 14 of the property/casualty Blank. On the life and accident and health (blue) statement, the State Page is commonly referred to as “Page 15.” The actual location of the page changes from year to year. In the health (orange) statement, the State Page is officially titled “Exhibit of Premiums, Enrollment and Utilization.” And, as with the other Blanks, its actual location varies. On the health State Page, the company reports statewide earned and written premiums, incurred and paid losses and other key information, broken down by line of business. The reporting format will vary depending on the type of annual statement the company files, as will the additional information requested. For example, the property/casualty Blank includes entries for direct defense and cost containment expense, commission and brokerage expenses and taxes, licenses and fees, while the health Blank reports total members, ambulatory patient encounters, inpatient admissions and hospital inpatient days incurred.

Claims-related information is of particular relevance to market performance, so one of the key items of financial data for market analysts is claim reserves, which is itemized on the property/casualty Blank as “Direct Losses Unpaid” and “Direct Defense and Cost Containment Expense Unpaid.”³ A spike in reserves can occur for a number of reasons, some of which might signal market conduct problems. If losses and reserves are both moving in the same direction, there is less concern. A spike in reserves without a corresponding change in losses paid should be investigated. Perhaps a major lawsuit was filed against one of the company’s insureds, or there may be a correction of reserves on pending claims. The insurance regulator should investigate the reason and also check the complaints made against the insurer, trends over time and reserve activity for comparable companies in the market.

For liability insurers, significant changes in defense costs may be an indicator of market conduct problems if it shows that a disproportionate share of claims are going into litigation. This information, like changes in reserves, must be looked at in its proper context in order for it to be used effectively as a market indicator. If the increase in defense costs correlates with increases in premium volume and losses, there is less concern. An inquiry should be made when defense costs are rising disproportionately to direct losses. Although less common, similar concerns may also be raised by unusual loss adjustment expense activity in other lines of business.

The premium information enables the calculation of the company’s market share for each line of business or for the market as a whole, by dividing the company’s premium by the market aggregate. Market share information allows regulators to quickly identify the companies with the most impact in the market—bearing in mind that these companies are by no means the entire market and smaller companies and their consumers cannot be ignored. In addition, comparing market share information over time allows regulators to identify companies whose operations in the state are expanding or contracting and to inquire further into the reasons for the change and whether the company has the resources to deal effectively with rapid growth or with lost business. States should analyze at least three to five years of historical data to place the information most recently reported in its proper context. For example, California provides a market share history on its website for insurers actively writing property/casualty, life/annuity and title business there.

Financial statement data also allows the calculation of “reverse market share” information—since companies report premium written by state, it is apparent how a state fits into the company’s overall operations, what the rest of its market looks like and how that pattern compares to other companies doing business in a regulator’s state marketplace.

³ Although this information may also be of value when studying accident and health insurers, particularly in lines like long-term disability and long-term care, there is no analogous line item on the health or life and health state pages. Because calendar year paid loss data aggregates layers of the losses incurred in many different years, unpaid losses cannot be backed out by comparing calendar year paid and incurred loss data.

For property/casualty companies, market share information is readily available on iSite+ in the NAIC's financial market share summary report titled, "Market Share—By Line of Business," which can be calculated for any line of business as reported on the annual statement Blank or for any combination of up to 10 lines of business. This report indicates the market share by company, by line of business, as well as relative loss ratio.⁴ This report is based on three columns from the State Page: Direct Premiums Written, Direct Premiums Earned and Direct Losses Incurred. Market share for each company is calculated by dividing Direct Premiums Written for that company by total Direct Premiums Written. Data for Property and Health companies is included in this report.

The loss ratio information will help identify companies with greater contact with consumers through the claims settlement process and significant deviations from the norm could indicate financial stress if the loss ratio is too high—or the potential for concerns about claim handling or underwriting practices if the loss ratio is unusually low. It must be kept in mind, however, that what might be considered a "normal" loss ratio—consistent with profitable operations—may vary significantly, depending upon the line of business and (especially for "long-tail" lines of business) upon changes in general economic conditions.

For life and health companies, there are four market share reports on iSite+: "Market Share—Life & Annuities," "Market Share—Credit Life," "Market Share—A&H" and "Market Share—Credit A&H." For the Market Share—A&H report, data can be included for one business type or for all Property, Life and Health companies. For the Market Share—Credit A&H report, data can be included for Property companies only or for both Property and Life companies.

The Insurance Regulatory Information System (IRIS) tool, based on financial statement data, should also be noted. Although the IRIS ratios were developed to assist solvency regulators, they also capture some information that can be useful to market analysts.

E. Issues Specific to Particular Types of Companies

As we have seen in the discussion of financial information, different types of insurers engage in different activities that make different types of information relevant. The most pronounced differences are reflected in the distinctions between the two major annual statement formats—property/casualty and life/accident/health—but there are also issues specific to particular lines of business that regulators need to take into consideration.

Health Insurance

In many insurance departments, there are consumer assistance resources dedicated specifically to health insurance. These areas may have more extensive complaint information and the complaint information in most states will be supplemented by external review information. At the same time, however, the relevant financial statement information will be more fragmented, because this market uniquely comprises companies filing on all three types of annual statement Blanks. In addition, self-insured employers (which are exempt from state regulation) provide a substantial proportion of health coverage and consumers are not always aware that this coverage is not insurance. The Health Insurance Portability and Accountability Act (HIPAA) and Employee Retirement Income Security Act (ERISA) play a unique role in this area of coverage and there are also significant state-to-state variations in laws regulating access to individual coverage, mandated benefits and individual and small group rating practices.

⁴ The paid loss ratio—paid losses to written premiums—is another loss ratio measure in common usage. Each has its advantages and disadvantages. The incurred loss ratio is a more meaningful measure of profitability as long as the underlying data are accurate, but incurred loss estimates are inherently subjective. Paid loss information is precise and objective, but the paid loss and written premium reports for a given year reflect different blocks of policies.

Property/Casualty Insurance

Personal lines property/casualty coverage is another key focus of consumer assistance and complaint resolution programs. Because a high proportion of consumer concerns in these lines of business relate to claims and to policy termination; often the two go together. This is a dynamic market with many emerging issues, such as the use of credit scoring in underwriting and rating. Other issues include concerns raised by consumer advocates that some companies may be using underwriting guidelines that have the effect of limiting the availability or quality of insurance to certain groups. There are significant state-to-state variations in property/casualty lines of business. Many of the variations in the liability insurance markets reflect variations in the underlying substantive laws giving rise to the liability exposure. This is especially true for automobile insurance, where several states have modified the traditional tort law for automobile collisions with some form of “no-fault” coverage.

Life Insurance

The coverage structure and company finances for life insurers are notably different from other types of insurance. Proportionately, market conduct problems with life companies are more likely to arise on the sales side and less likely to arise on the claims side than in other lines of insurance. In life insurance, there is significantly less interaction between the company and the consumer over the course of a customer relationship than with other lines of insurance. Market conduct problems are often less likely to surface promptly in the form of a consumer complaint.

Workers’ Compensation Insurance

In this line, market conduct issues may involve either the insured (the employer) or the claimant (the employee). This is true to a lesser degree for other third-party coverage, particularly auto insurance in tort states, but workers’ compensation insurers in most states have statutory obligations to claimants that liability insurers do not have. The experience rating system gives the employer a more direct interest in claims practices and there are unique jurisdictional issues in states where workers’ compensation claim handling is the primary or exclusive responsibility of the state workers’ compensation agency rather than the insurance department.

F. Other Useful Information

While complaint records and financial statements may be the most comprehensive and concentrated sources of data on market activity, there are many additional sources that should be reviewed in order to obtain the rest of the story. For example, a high proportion of the activity in the insurance marketplace involves licensed insurance producers. Records of disciplinary actions or appointment termination may reveal patterns of questionable practices in certain market sectors or implicating certain companies. Even routine activities, such as increases or decreases in new licenses or appointments or changes in lines of authority, can be indicative of market trends which might warrant further inquiry to evaluate whether the effects are positive, negative or mixed. The information contained in this handbook provides additional resources for assisting with the analysis of a company. This handbook contains information about matched pair testing, rating territories and underwriting guidelines, which may be helpful if the initial analysis has indicated a potential area of concern.

Financial Reporting (Public and Private Sector)

Statutory annual and quarterly statements are the principal source of financial information on insurers, but they are not the only source. If the insurer is publicly traded, it will also be filing with the U.S. Securities and Exchange Commission (SEC). There are a variety of private-sector sources that compile and evaluate financial information, such as rating agencies, statistical and ratemaking advisory organizations, trade associations, securities analysts and academic and nonprofit research institutions. Some of these data compilations are directed towards specialized information, such as claims activity, that is also of particular interest to market regulators. Surveys and reports on particular topics by research institutions, consumer groups and trade organizations may also yield valuable data.

Rating Agencies

There are five principal rating firms that measure insurance companies' financial strength: A.M. Best Company, Moody's Investor Service, Fitch Ratings, Standard & Poor's and Weiss Ratings. It is common for a company's compliance or marketing strategies to change when there is a rating decrease by one or more of these rating agencies. Market analysts should review a company's financial rating from each of the main financial rating firms to determine if there is a possible correlation between a downgraded rating and market regulatory practices. It is important to note that ratings should be reviewed independently for each rating organization. For instance, a company may receive a high rating from Standard & Poor's or Fitch Ratings, but fail to receive a high rating from A.M. Best. There are also variances in the areas rated by each rating firm and analysts should consider the areas of review and the methodology of the rating organizations. Market analysts are encouraged to review rating changes over a period of five years for substantive changes.

Informational Filings

All insurers are subject to state licensing and holding company regulations. Under these laws, state insurance departments will receive notice of changes in corporate officers and directors, changes in the domicile of insurers in the holding company group and reports on significant transactions among an insurer and its affiliates. These changes are rarely, if ever, indicators of market conduct problems by themselves, and material transactions in most cases have already been subject to regulatory review. However, when other indicators show warning signs, it is often useful to take a second look at holding company regulation statements and company licensing information, such as updates of director and officer information, to see if certain information that did not seem noteworthy at the time takes on a new meaning in hindsight. If a state insurance department collects or reviews them, companies' underwriting and claims manuals may contain useful information, though it must be kept in mind that such manuals are generally regarded as proprietary and, as such, should be protected from public disclosure. Attention should be paid to changes in underwriting guidelines since this provides real-time information on market practices the companies themselves have identified as important.

Communication Between Work Units

As mentioned above in the discussion of complaint information, anecdotal information of various kinds can also be valuable even when it cannot be measured and reduced to numbers. The rewards of quantitative analysis can bring with them the risk of "not seeing the forest for the trees." Thus, a continuous dialogue with regulators in other areas with a department of insurance is essential, as issues arising in other areas may be mirrored by related problems consumers are having with the same companies or markets. For lines of business that are subject to form or rate review or certification, incidents where a company has been observed using unapproved or improperly certified rates or forms should trigger further inquiry, since such incidents often are part of a wider pattern.

Enforcement Actions

In particular, significant enforcement actions against a licensed insurer or examination reports with findings of violations (keeping in mind that these could be from financial examinations, not just from market conduct examinations), are clearly of major interest from a market analyst's perspective, whether they arise in a regulator's state marketplace or in another state where the company does business. A consumer complaint or even a pending regulatory proceeding is of interest, especially on a cumulative basis, but in and of itself does not necessarily mean the company has done anything wrong. However, a disciplinary order or a finding of violations is a more serious matter, even though it may be based on different laws or market conditions. Likewise, a record that a company has been or is being investigated by several different states for similar reasons raises questions every bit as serious as the questions raised by a high complaint index.

Regulatory Information Retrieval System

The NAIC Regulatory Information Retrieval System (RIRS) tracks adjudicated regulatory actions for companies, producers and agencies. The origin, reason and disposition of the regulatory action are recorded in the RIRS database. RIRS is an essential resource for market regulators and states should ensure its high quality by taking care to report all adjudicated regulatory actions to RIRS. It should be kept in mind, however, that because enforcement actions are considerably less frequent than consumer complaints, they do not lend themselves well to ratios or other quantitative techniques. For most companies in most years, the percentage of premiums paid out as fines or restitution will be zero—and simply tracking the number of enforcement actions may give too much weight to minor violations, such as isolated cases of late reporting. The most recent version of the RIRS submission form is available on StateNet on the Market Data Team (MIS) web page.

Market Action Tracking System (MATS)

Information regarding market conduct examinations and other market conduct initiatives may be quickly obtained on iSite+ through the Market Action Tracking System (MATS) Detailed Report, which provides a history of market actions matching specified criteria. A report may be generated displaying all market conduct actions originating in a specified state for a specified date range. MATS includes not only actions related to market conduct examinations, but also non-examination regulatory interventions or inquiries.

Self-Audits and “Best Practices” Reviews

Reports from voluntary examinations of companies provide another potential source of useful market analysis information at any stage of the analysis process. In addition to self-audits conducted by companies, evaluations are also prepared when insurers apply for membership or accreditation to “best practices organizations” or independent standard-setting organizations and when those organizations conduct periodic reviews.⁵

It must be kept in mind, however, that such evaluations are a supplement to regulatory analysis and not a substitute, and that an organization might not set comprehensive standards for “best practices” across the entire field of operations, focusing instead on particular areas such as marketing and advertising. Market conduct analysts and examiners should be conversant with the standards required to qualify for membership in organizations such as the National Council on Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) (for health insurers). State insurance departments should review these standards to evaluate the extent to which compliance with the standards can be considered as a relevant indicator of compliance with related state statutes and regulations, to refine the market analysis. States are encouraged to direct analysts and examiners to request information associated with these organizations’ assessment activities to determine how such information might be used to gauge the appropriate nature and scope of further market conduct review that may be indicated.

Some best practices organizations have developed standardized reporting formats, which are designed to provide market conduct analysts and examiners with a comprehensive summary of the testing and review activities that take place during a company’s self-audit and/or independent review process. Market conduct analysts and examiners are encouraged to become conversant with the specific review standards applicable to the independent analysis. Work papers retained by the company or its independent reviewer may provide additional useful information for market analysis purposes. Regulators must be sensitive, however, to the confidentiality concerns raised by these materials, as discussed in the NAIC white paper, *Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege*. Personnel who work with confidential material should be specifically trained in the applicable laws and in the agency procedures for protecting confidential or privileged information from public disclosure, whether it is maintained in paper or electronic form.

In some states, self-evaluative privilege statutes provide specific guidance on the regulators’ access rights and confidentiality obligations, whereas regulators in other states must consider a variety of issues related to the protection of proprietary information, attorney work product, trade secrets and other privileged information.

⁵ Market analysts should refer to the NAIC white paper *Best Practices Organizations* for additional guidance related to the application of such evaluations and standards.

Addressing these concerns and working with companies' voluntary review activities is important, because a full understanding of a company's market activities encompasses the company's policies and the practices that implement the company's policies. An active compliance program at a company often reflects a corporate culture that places a high value on compliance. Since "bottom-up" information on a company's market practices is more accessible to regulators, the "top-down" policy focus often found in insurer peer reviews can be a useful complement to the information that is otherwise available.

Consumer Dispute Resolution Processes

For some lines of insurance, statutory dispute resolution processes provide another useful source of market information. In particular, most states now have some sort of external review framework for health insurance claims disputes; regulators should review the records of external review requests, disposition and companies' responses over time. Similarly, records of administrative hearings on cancellations or nonrenewals of property insurance and automobile insurance policies (in states where these activities are subject to regulatory review) may shed some light on market practices in these lines of insurance.

Matched Pair Testing

For homeowners insurance, market conduct analysts should consider the use of matched pair testing to evaluate whether geographic areas with a relatively high percentage of persons in protected classes are receiving the same level of service and availability and quality of product as residents of nearby geographic areas which have different racial or ethnic characteristics. The number of matched pair tests conducted for this purpose does not need to be statistically significant, as the tests are designed to be a snapshot of the way in which a specific company is operating at a specific moment, and not an evaluation of the marketplace as a whole. In matched pair testing for homeowners' insurance purposes, two houses of similar age, construction type, style and maintenance level, but in different racially identifiable neighborhoods, are used as the basis for the test. Trained testers, whose race matches that of each neighborhood, call an insurance agent just as a bona fide homeowner would, and identify themselves as a homeowner or buyer. They request information and quotes about homeowners insurance, track the responses and fill out a report which is submitted to the person coordinating the test, along with any written materials subsequently received from the insurer. The test coordinator reviews the results of both contacts and compares the treatment in each case to determine whether both callers were treated equally. (The same general concept of comparative treatment applies to auto insurance, and can be executed using testers with similar driving records calling about similar cars). While the concept is simple and straightforward, quality of execution is important, and market conduct analysts should consider contracting with an entity experienced in the conduct of insurance testing, such as the National Fair Housing Alliance (NFHA). They may also use their own staff or contract testers. Training in how to conduct such tests should be sought from NFHA or other qualified organizations.

Rating Territories

An evaluation of the way in which the market is being served for homeowners and auto insurance should include overlaying rating territories with census maps, to determine whether the rating territories have been designed in such a way that makes it likely that persons in protected classes will pay higher prices than residents of predominately Caucasian or higher-income areas. If that appears to be the case, information on loss data should be gathered to determine whether the higher costs are justified.

Miscellaneous

Anecdotal information of useful interest may even be found in such unexpected sources as a state insurance department human resources division, which might have useful information, since an influx of resumes from a particular company could be a sign of stress. At the same time, regulators in various divisions of a state insurance department need to communicate relevant issues. For example, claim delays or disputes could be a symptom of financial stress and repeated consumer complaints relating to particular policy language may suggest that an insurance department reconsider the approval of such clauses.

Other information collected by some regulators, though not necessarily available in all states, includes underwriting guidelines, detailed geographic market performance data, surveys of market participants and marketplace testing. Detailed geographic data—such as ZIP code data by company and type coverage—has been

used by some regulators to identify underserved markets and investigate redlining allegations. Surveys of market participants—including agents, realtors and consumers—are another source of real-time market performance information. Testing—sending people to purchase insurance who have similar risk characteristics but different races or other characteristics that may make them targets of unfair discrimination—adapts a tool that has long been used in the fields of housing, lending and employment to verify compliance with fair practices. In addition, a review of recent insurance-related lawsuits can provide insight into consumer perceptions of market abuses, and this information is publicly available.

Market regulators should keep their eyes and ears open outside the office, as well. Valuable information can arrive in structured formats—such as regulatory meetings, continuing education programs, email discussion groups and clipping digests—and also in less structured environments, ranging from stories about lawsuits to interesting names in the news and chance remarks by acquaintances. The more one knows, the better equipped one is to ask the next question.

Chapter 7—Putting It All Together: Market Analysis

State insurance departments already have at their disposal the information needed to develop some key baseline indicators of market conduct concerns. This section of the handbook will provide a step-by-step outline for establishing a market analysis program, identifying companies for analysis, how to perform baseline analysis and guidelines for conducting basic market analysis in three core areas: consumer complaint data, State Page data and market share data, as well as a section regarding coordination with the Market Actions (D) Working Group.

Excerpts from the NAIC Framework for Market Analysis document, which provides an overview of the basic principles and structure of market analysis, have been reproduced in Section A. The Framework for Market Analysis document was adopted by the Market Analysis Priorities (D) Working Group at the NAIC 2006 Winter National Meeting.

A. Framework for Market Analysis

The *A Reinforced Commitment: Insurance Regulatory Modernization Action Plan* (NAIC Modernization Plan) established the following principles and goals for Market Regulation. "...to assess the quality of every insurer's conduct in the marketplace, uniformity, and interstate collaboration...the goal of the market regulatory enhancements is to create a common set of standards for a uniform market regulatory oversight program that will include all states." To implement these principles and goals, the NAIC established an action plan. The three pillars of this action plan include market analysis, market conduct and interstate collaboration. With respect to the market analysis pillar, the NAIC set a goal that each state will "produce a standardized market regulatory profile for each 'nationally significant' domestic company," and each state should "adopt uniform market analysis standards and procedures" and use its market analysis in other market regulatory functions, including market conduct and interstate collaboration.

Market analysis is designed to (a) provide tools for each state to review its entire market, (b) identify companies operating in each state's market that are potentially harming consumers because they are not complying with the state's laws and regulations designed to protect consumers, and (c) assist in narrowing the scope of any regulatory action that a state determines it must use to address those companies that appear to be experiencing compliance problems. One of the goals of the market analysis process is to focus a state's resources on regulatory problems that cause harm to its consumers. In conjunction with interstate collaboration and targeted regulatory actions in market conduct efforts, market analysis creates efficiencies for both the states and the companies.

Market analysis should be conducted on a regular basis, but no less frequently than annually. The data analyzed for a given market analysis year includes the prior calendar year financial and market conduct annual statement data. Companies must report all of their financial and market conduct annual statement data for a given calendar year by April 30.

To accomplish its purposes, market analysis has an array of tools for states to use. The first of these is the Market Analysis Prioritization Tool (MAPT) available from the NAIC. This tool is designed to provide states a quick overall look at their marketplace for a particular line of business. The Market Analysis Prioritization Tool (MAPT), released in 2006, creates a weighting system to assist analysts in prioritizing companies. The Market Analysis Prioritization Tool will provide the analyst a high level comparison of companies for a particular line of business based on financial, complaint and regulatory activity information available from NAIC databases. States should use this tool to identify companies that need further, more detailed analysis and elevate these companies to a Level 1 Review. The information obtained from this tool is merely an indicator of a potential regulatory problem. Normally, additional research and investigation is required to draw a final conclusion about actual behaviors than what is available at this level of analysis.

The Level 1 Review is a second tool available to the states in their market analysis process. This tool involves looking at much of the same data in the Market Analysis Prioritization Tool (MAPT) but on a more detailed and thoughtful basis. Whereas the Market Analysis Prioritization Tool identifies companies based on certain formulas

and overall company performance, the Level 1 Review requires a more detailed and thoughtful analysis, where the analyst looks at company-specific information to determine if the anomalies can be explained. A Level 1 review is a more detailed review of certain information contained in NAIC databases, and is available to the analyst through the Market Analysis Review System (MARS). It is critical for the state to do this review to eliminate companies that do not warrant further analysis and to begin the process of identifying the cause of the anomaly for those that do warrant additional analysis.

A third tool that states have available is the Market Conduct Annual Statement (MCAS). This tool provides a more detailed look at companies' market activity on an annual basis. Information such as the number of policies written, the number of claims reported, or the number of claims that the company has denied is included in the MCAS. Analysis of the information provided in the MCAS will assist the analyst in narrowing the focus of any regulatory action undertaken by the state.

A fourth tool that states have to further refine the analysis is the Level 2 Review. This process assists the states in confirming that there is a market regulatory issue or in determining to a much greater degree the cause and extent of the problem. The Level 2 Review process requires the states to delve deeply into a company's complaints, its website, other regulatory agencies, and other areas that provide information about the company's market practices.

If the Level 2 Review tool indicates that there is a specific regulatory problem(s), the state should then proceed with the continuum of market actions, always using the least intrusive, most efficient method to identify the cause and extent of the problem. States should keep in mind that at any point in this process, the analysis might determine that no further analysis/action is warranted. Generally, states should proceed through a Level 2 Review before moving into the continuum of market actions. By proceeding in this manner, the analyst is able to target those areas where irregularities have been noted in discussions with the company, and is able to choose the appropriate action from the continuum.

By collecting data over multiple years, states will be able to include trending analysis as part of the overall market analysis process. Reliable trending analysis will provide a proactive approach to market analysis "reflecting our commitment to continuing to modernize insurance regulation." This tool can provide greater consumer protections in that problems can potentially be identified much earlier and before they cause harm.

The approach to market regulation described above assumes a level of trust between the regulator and the regulated entity. It also assumes that companies want to comply with insurance law and regulations. Most companies do want to comply. However, in a small number of instances, such a level of trust may not be warranted. If not, the state would use the regulatory action most appropriate to protect the consumer. This may mean skipping some or all of the steps in the market analysis process and moving quickly to the regulatory response that is most appropriate to avoid harm to consumers. In such a scenario, while the state may not move methodically through all the market analysis steps, the use of some of those steps may prove helpful. For example, reviewing the MCAS data for the company, the complaints, or the information in the NAIC's databases may be very valuable to the state in addressing its concerns.

One of the goals of the NAIC Modernization Plan is the integration of market analysis, market conduct, and interstate collaboration into a cohesive, uniform oversight program for states to use to regulate their markets. By using market analysis in the market conduct actions and interstate collaboration, states achieve efficiencies and uniformity in their approach to regulating their markets. The market analysis process should not be static. States should work together to test the results of the market analysis process against their findings to refine the process. By doing this, the states can develop a more efficient market analysis process that will provide more useful information about companies' market activities. By working together in this manner, states will achieve the goal of uniform market analysis standards and procedures that provide specific information about the companies that operate in their markets.

B. Developing a Market Analysis Program

Effective market regulation and consumer education requires an organized market analysis program. Insurance departments should, at a minimum, take the following steps:

Step 1—Appoint a Market Analysis Chief (MAC)

Unlike financial information, market conduct information can come into the insurance department at different times to different staff persons or functions and for a variety of reasons. For example, State Page information is submitted with the annual statement in March. Holding company and licensing changes are reported as they occur. Consumer complaints can flow in all the time, while complaint ratios are generally calculated at specific times. Each insurance department needs a clearly identified person as a Market Analysis Chief (MAC) to whom all other department staff should report indicators of market conduct problems. The MAC should oversee the department's analysis and ensure that appropriate Level 1 Analysis and Level 2 Analysis reviews are completed. Each department also needs a Collaborative Action Designee (CAD), who will also coordinate information sharing with other insurance departments through the Market Actions (D) Working Group. The CAD may be the same person as the MAC. If the same person does not hold these positions, regular communication between the two persons is essential.

Organizing these processes is a crucial administrative function. How the market analysis function will be organized within the department will depend on the size of the department and its broader organizational framework, but it is essential to have some method of clearly delineating market analysis responsibilities. It is essential, of course, to have open lines of communication among all areas of the insurance department, flowing in both directions. Staff personnel responsible for market analysis must have access to the information and must be able to share their knowledge with other areas as needed. The MAC is also responsible for communicating with other insurance departments via the NAIC Market Analysis Bulletin Board.

Step 2—Establish a Systematic Procedure for Interdivisional Communication

Market conduct problems do not occur in a vacuum. Complaint activity, legal issues, financial concerns or irregularities in rate and form filings often accompany them. At the same time, market conduct problems may be an early warning sign of other problems with a company, so it is essential for information to be shared and discussed between the MAC and other department staff. This should be done on a systematic basis, including, at a minimum, a quarterly questionnaire requesting other work areas within the department to report unusual activity that may be of interest to the MAC, such as patterns of adverse financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates.

Step 3—Identify Warning Signs that All Staff Should Share with the MAC

In particular, all insurance department staff should report any of these indicators to the MAC when the information is received in the department (e.g., annual statements, holding company reports, license transactions):

- Significant changes in the ratio of consumer complaints against the insurer or significant numbers of complaints in a relatively short period of time;
- Dramatic growth (> +33 percent) or decline (< -10 percent) in one or more lines of business;
- Significant changes in the company's book of business;
- Rapid expansion into new states and significant premium volume in new states;
- Significant concentrations of risk—geographically, by line of business or exposure—or significant changes in the concentrations of risk;
- Significant changes in expense levels (such as defense costs or commissions);
- Recent change of the state of domicile of a major writer in an insurer group;
- Recent changes in ownership or senior management;
- A high degree of reliance on third parties to perform company functions, such as managing general agents (MGAs) or third-party administrators (TPAs);

- Significant problems with electronic data processing systems such that the integrity of data underlying claims, underwriting and financial systems is questionable;
- Reports listed in the Regulatory Information Retrieval System (RIRS);
- Reports listed in the Market Action Tracking System (MATS); and
- Reports listed in the Market Analysis Review System (MARS).

Note: The presence of one or more of the above does not necessarily indicate that a problem exists, but rather, that further analysis or investigation may be warranted.

Step 4—Develop and Instruct Complaint Analysts in Key Indicators in Complaint Data

Complaint analysts in the insurance department should report the following types of information to the MAC at the time the insurance department receives this information:

- Specific complaints so critical that one complaint merits reporting (e.g., antitrust, flagrant or willful disregard of the law, or matters of serious consumer harm);
- Spikes in complaints against the same company on the same product/practice during a specific time interval (e.g., 10 new complaints in a week); and
- Any of the other indicators listed above in Step 3.

Step 5—Identify Potential Problems from Complaint Ratios

Complaint ratios should be reviewed annually at a regular time and the MAC should use information generated on insurers with ratios outside of the norms, along with other information about those companies available in the department, to determine whether any further review is necessary. Through the use of complaint ratios, regulators are able to properly gauge not only long-term trends, but more importantly, to monitor frequent problems or developing areas of concern to determine whether an inquiry should be generated or if prompt regulatory action is required. After compiling complaint ratios for the individual insurers, the department can compare the ratios to determine which companies lie outside the average in a given year and to compare an individual insurer's ratio with the previous year. For example, an increase in the number of complaints can indicate a change in claims practices.

Step 6—Annual Statement State Page and Other Financial Indicators Should Routinely Be Shared with the MAC

Every insurer—foreign as well as domestic—is required to file a State Page with each state in which it is licensed, to show changes in the company's business in the state. In most insurance departments, a significant amount of staff resources are devoted to the review and analysis of financial statements. While such financial analysis should be primary, at some point after the Blanks are received, the MAC should be routinely advised of:

- Significant increases or decreases in premium volume;
- Significant increases in reserves without corresponding change in direct losses paid;
- Significant changes in loss ratio or significant deviations from market norms; and
- Significant increases in defense costs without corresponding changes in direct losses (for liability insurers).

Step 7—Market Conduct Annual Statement

If a state participates in the Market Conduct Annual Statement (MCAS) project, that data should be reviewed as part of market analysis.

Step 8—Establish a Market Analysis Program on a Coordinated Schedule and Conduct Baseline Analysis

On a coordinated basis, states should conduct baseline analysis as outlined in the Framework for Market Analysis document, reproduced in Section 3 of this chapter. All states should analyze the various data elements and indicators within the same general time frame to assist in the coordination of possible collaborative actions. Results should be compiled and reviewed quarterly. If state Market Analysis Chiefs (MACs) find an issue with a particular company, they can share information with their state Collaborative Action Designees (CADs). CADs can then contact other state CADs to compare the most current information, and determine if a collaborative action or a Request for Review (RFR) to the Market Actions (D) Working Group is in order.

Step 9—Conduct Level 1 Analysis via the Market Analysis Review System (MARS)

The Market Analysis Procedures (D) Working Group is responsible for the MARS Level 1 areas of review and questions. Level 1 Analysis questions have been reproduced in Appendix B of this handbook. Level 1 Analysis questions are subject to annual review by the Market Analysis Procedures (D) Working Group and state insurance regulators.

Step 10—Conduct Level 2 Analysis via the Market Analysis Review System (MARS)

A Level 2 Analysis allows market analysts to further investigate and review a company, without the need to contact the company. Unlike the initial analysis or Level 1 Analysis, a Level 2 Analysis requires the market analyst to seek input and gather information from sources outside of the NAIC databases and the company's financial and market conduct annual statements. By its very nature, a Level 2 Analysis is much more labor intensive than a Level 1 Analysis. To assist market analysts in completing a Level 2 Analysis of a company, the Level 2 Analysis Guide has been developed. The guide consists of six core areas of review and an additional 15 potential areas that the market analyst may review when performing a Level 2 Analysis. For each area of review, the guide includes information about the area to be reviewed and, where applicable, potential resources to aid in the review of that area. The guide also provides the user with specific items to consider during the review of a particular area. The Level 2 Analysis Guide is contained in Appendix C.

Of the six core areas of a Level 2 Analysis review, only the Complaints section is required to be completed. The number of core and additional areas reviewed during a Level 2 Analysis of a specific company will be dependent on many different factors, such as the line of business under review, the areas of concern identified during earlier analysis, the rules and regulations of the jurisdiction performing the analysis and the company itself. During the course of completing a Level 2 Analysis, the market analyst may find information that requires the review of one or more areas not initially selected for review. If this happens, the market analyst should expand the scope of the Level 2 Analysis to include those areas of review not initially identified. The market analyst should also consider whether a Level 2 Analysis is necessary on related companies (companies under the same management or ownership); if the areas of concern for the company under review have the potential to be present in a related company.

Step 11—Coordinate Regulatory Actions through the Market Actions (D) Working Group

Concerns resulting from market analysis that appear to focus on a small number of states should be brought to those states' attention by communication through state Collaborative Action Designees (CADs). Plans for regulatory actions, including examinations and investigations, that focus on companies of national significance should be referred by CADs to the Market Actions (D) Working Group through a Request for Review (RFR).

C. Identifying Markets and Companies for Analysis

An insurance department's periodic review of companies should begin by identifying which lines of business will be surveyed. These should include all of the major lines: group health (including HMOs), individual health (including HMOs), homeowners, personal auto and individual life (including annuities). This list should be supplemented as resources permit, with highest priority given to any other lines identified as being of significant consumer or regulatory concern in a given state. These may include, for example, medical malpractice, credit life and health, workers' compensation, disability or long-term care.

Once the lines of business have been selected, the next step is to identify companies with any appreciable market activity in each of these lines—at a minimum, those with either one percent or greater market share; \$100,000 or more in premium; or five or more complaints. The relevant market share information should be readily available in the insurance department or from the NAIC. If it is not currently maintained in the insurance department in a form conducive to market analysis, the department should update its data management procedures. This screening process does not mean that a regulator should neglect market conduct problems with companies that have negligible activity in their state, only that the numerical indicators (quantitative analysis) are unlikely to be meaningful in cases where, for example, a single complaint can move a company from the top of the complaint index chart to the bottom. Therefore, problems with such companies, if they arise, can usually only be identified through other case-by-case (qualitative) methods, such as discussions with other potentially impacted states, and may result in a Market Actions (D) Working Group Request for Review (RFR).

Additional Uses for Market Share Information

While an insurer's market share is not an indicator of its conduct in the marketplace, state regulators need information on changes and trends in the composition of the state marketplace in order to have a meaningful picture of market activity. In addition to its use in the initial screening process, market share data has three principal uses in market analysis:

- Providing a lineup of the current market participants and their relative impact;
- Identifying changes and trends in market participation; and
- Evaluating the degree of competition in the marketplace.

To put this information in its proper context, it is necessary to view it from a historical perspective. For example, in looking at current increases in premium volume from State Page data, one may see a different picture, if at least three to five years of historical data are used as the overlay for the review of current data. For example, does historical state data show an increase or decrease in concentration of insurers writing a particular line of business in the state? Which companies have undergone a significant change in their market position?

States implementing a market analysis program for the first time may not have the benefit of market share data initially. In implementing a historical review approach, states need to give consideration to what historical data they want to track and in what format. For example, the California Department of Insurance website contains market share information for various lines of business, which can be found at <http://www.insurance.ca.gov/01-consumers/120-company/04-mrktshare/>. Another example is the Missouri Department of Insurance, Financial Institutions & Professional Registration website at <http://insurance.mo.gov>, which also provides market share reports for various lines of business.

Market share information can be used to evaluate the degree of competition in a market sector. For example, the NAIC annually publishes the Competition Database Report that contains data regarding thirteen commercial lines: commercial auto liability, commercial auto physical damage, commercial auto total, commercial multiple peril, fire, allied lines, inland marine, mortgage guaranty, financial guaranty, medical professional liability, other liability, workers' compensation and products liability, and six personal lines: private passenger auto liability, private passenger auto physical damage, private passenger auto total, homeowners multiple peril, farmowners, multiple peril and earthquake. Aggregated nationwide as well as in each state, for each of the commercial and personal lines and for the aggregate statewide market, the report shows the total premiums written; the combined market share of the four largest groups; the Herfindahl-Hirschman Index (HHI) for the market (the HHI is a formula used to measure market concentration, which is widely used in antitrust analysis); the number of insurance groups that have affiliate insurers writing premium in the market; the number of insurance groups that have affiliate insurers writing premium in the market that have either entered or exited the market at any time over the past five years; the market growth, measured by premiums written, in the past three years and ten years; the percent of premiums written in the market by risk retention groups in the past year and averaged over the past five years for commercial lines of business only; the surplus lines market share in the past year and averaged over the past five years; and the ten-year mean return on net worth.

D. Baseline Analysis

In general, baseline analysis utilizes data as a benchmark from which deviations and comparisons are measured. Baseline analysis within market analysis is a systematic process whereby basic parameters are used to evaluate the entire marketplace in order to identify those companies that may require more detailed and thorough analysis. Baseline analysis was developed by regulators to provide a uniform starting point for analyzing a state's insurance market. Baseline analysis is often the first step in the market analysis process, and except in certain circumstances, should be conducted as a prerequisite to Level 1 Analysis reviews, or to identify those companies needing further, more detailed review in the form of a Level 1 Analysis review.

Tools Available for Conducting Baseline Analysis

The Market Analysis Research and Development Subgroup developed the Market Analysis Prioritization Tool (MAPT), released in 2006, which allows regulators to narrow down the number of companies under review to a manageable list by creating a scoring system so companies can be prioritized more easily. MAPT provides regulators with a web-based tool that serves as a starting point in the analysis process by prioritizing companies for further analysis. This prioritization of companies allows state insurance regulators to better focus their resources and to develop more efficient regulatory policies and practices.

MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. MAPT can provide reports against market and financial data of Market Conduct Annual Statement (MCAS) data. Market and financial MAPT reports provide an overall prioritization ranking, a national prioritization ranking and a state prioritization ranking for companies by line of business, which allows market analysts to compare companies writing premiums in a specified line of business on a national and state basis using a uniform data set.

In 2009, the data elements and functionality contained within the NAIC Market Analysis Company Listings report were incorporated into MAPT and as of December 2009, the Market Analysis Company Listings report was no longer available. Key market regulation components used in MAPT vary by line of business. They include, but are not limited to: losses, expenses and premiums, enrollments, regulatory actions, complaints, examinations and demographics.

The available lines of business for the market and financial MAPT report are homeowners, private passenger auto, credit, group accident and health, individual accident and health, group major medical, individual major medical, Medicare supplement, long-term care, group life, individual life, group annuity and individual annuity. The available lines of business for the MCAS MAPT report are homeowners, private passenger, long-term care, individual life, individual annuity, health and lender placed home and auto.

MAPT does not produce scores to be viewed in absolute terms, where one score is seen as “better” or “worse” than another. Instead, MAPT provides a system that gives guidance to a market analyst in prioritizing companies for further analysis. Each insurance department will have its own triggers based on criteria unique to that state's marketplace. It is important to note that the underlying data in MAPT should be analyzed—market analysts should not rely solely on the prioritization ranking of individual companies to identify companies which may require further analysis. The information obtained from MAPT is merely an indicator that one or more potential issues may exist that could have an adverse impact on consumers. Normally, no conclusions about actual company marketplace behaviors can be drawn at this level of analysis. Therefore, insurance departments should use MAPT as a starting point to identify companies that may need further regulator attention, such as a more detailed analysis via a Level 1 Analysis review.

MAPT is accessible from the Summary Reports section of iSite+. Since it is a regulator-only system containing confidential information, access to MAPT requires users to have a special security role assignment in order to view information. Each state's Market Analysis Chief (MAC) has access to MAPT. If individuals other than the MAC need access, the MAC can grant access to other regulators via the NAIC Help Desk at help@naic.org.

Regulators initially established the factors and weights used in generating the prioritization ranking in the MAPT. Regulators continue to monitor the effectiveness of MAPT and consider revisions to the components and weights used through participation in the Market Information Systems (D) Task Force. The Market Information Systems (D) Task Force is responsible for monitoring the effectiveness of MAPT and determining the components and weights used. Baseline analysis is still very much an evolving process that is continually undergoing change to make it more effective.

How to Conduct Baseline Analysis

States can easily begin conducting a baseline analysis by utilizing the Market Analysis Prioritization Tool (MAPT). Numerous factors can be focused on during a baseline analysis such as prioritization rankings, percent rankings, premium dollars, etc. Remember that baseline analysis is a very subjective process; each analyst, based on his or her experience may choose different criteria on which to focus.

- Log into iSite+ and download the Market Analysis Prioritization Tool (MAPT) report for the line of business to be analyzed; and
- Save the report to the desired location as a Microsoft Excel file, then apply desired formatting: e.g., wrap text, borders, select font (for readability purposes).

After the reports are downloaded, an analyst may:

- Rearrange the columns so that areas of focus are more prominently displayed;
- Sort on any column, such as:
 1. National confirmed complaint index;
 2. Premium volume;
 3. Number of Regulatory Information Retrieval System (RIRS) actions; or
 4. Number of examinations.
- Add columns to obtain additional information, such as the percentage of increase in complaint indices from the prior year to the current year. If the formula is known, the column can be added to obtain the information that will be most useful to the state; and
- Select companies that appear to be potential outliers based on the insurance department's priorities.

Once a list of potential outliers has been obtained, a Level 1 Analysis can be conducted on each of the companies or a search can be performed for additional information about the company to narrow the list even farther by looking at items such as:

- The “complete profile” pages for the companies;
- The complete financial profile to determine if there may be a reason for the outlying data—e.g., ceded premium, few writings in that line of business, etc.; and/or
- Use the remaining CoCodes to compile a list for Level 1 Analyses.

Other Methods Used to Conduct Baseline

Some insurance departments use additional tools to conduct and/or enhance their baseline analysis. In a 2008 survey, state insurance departments identified other criteria and tools which they utilize as part of their baseline process. With the exception of state-specific prioritization methods, these tools and sources are generally used in addition to MAPT. These various criteria and tools include:

- Utilizing the MAPT to focus on the companies with the highest score for each line, then applying the below-listed criteria to the companies chosen:
 1. Does the applicable state have an open exam;
 2. Is the last exam the applicable state performed less than one year old;
 3. Does the company have less than \$100,000 in written premium; and
 4. Has the company notified the insurance department that it is ceasing to write business in the state.

If any of the companies meet any of the criteria above, they are removed from the list and Level 1 Analysis reviews are conducted on the remaining companies:

- Utilizing state Market Conduct Annual Statement (MCAS) data to identify outliers;
- Developing and utilizing an internal state system in which data is culled and combined from MAPT, MCAS, financial information, complaint indices and other information that the state feels is valuable in order to develop another score(s), specific to that state;
- Utilizing internal referrals from other work units/divisions, such as the consumer complaint department and the provider grievance department;
- Utilizing internal resources, such as health care claims survey results, market monitoring reports, standardized data requests and annual prompt pay reports;
- Utilizing market share reports that include premium data, market share and loss information that can be analyzed in conjunction with MAPT;
- Utilizing the Complaints Database System (CDS), the Market Action Tracking System (MATS), the Regulatory Information Retrieval System (RIRS), company websites, the various rating entities, news articles, internal complaints and various online search engines;
- Running line reports from the Schedule T to obtain written premium for the previous two-year period to determine if there has been a large swing in premium from one year to the next; and
- Conducting follow-up Level 1 Analyses on companies previously identified in a Level 2 Analysis to have no current market problem, but a potential market problem that requires monitoring.

E. How to Analyze Consumer Complaint Data

In order to conduct a systematic and focused analysis, it is necessary to develop meaningful numerical indicators which will allow regulators to make comparisons between companies and track the activities over time of each company and of market averages. Outliers—companies whose complaint activity significantly exceed industry norms, historical conditions or established best practice guidelines—can be singled out for individualized attention.⁶

The total number and frequency of complaints should be used as the basic indicator. Insurance departments should also look at numbers of complaints by line of business, so that potential problems in one area are not lost in total numbers and that reasonable comparisons are made between insurers selling like kinds of policies. Complaints should also be reviewed by company and not merely by insurer group, as companies in the same holding company group may write different types of business and even when they write the same type of business, they may represent different market tiers and different approaches to consumer relations. Finally, an insurer's complaint numbers should be compared to their overall premium volume and also, where appropriate, to the number of policies or policyholders.

Basic Complaint Ratio Analysis

Having selected the relevant markets and companies in accordance with the procedures outlined above, each state should then, at a minimum, conduct a basic complaint ratio analysis on the selected companies:

- Identify confirmed complaints; and
- Calculate complaint indices (complaint rate relative to market average).

⁶ Of course, the identification of a company as an outlier may be the result of factors entirely unrelated to the company's actual performance in the market. For example, a report once identified a company as having a complaint index of 2,189,763.36730—that is, a complaint frequency more than two million times higher than “expected,” based on the company's premium volume. However, this statistic was based on \$1 in reported premium and a single consumer complaint.

Definition of “Complaint”

The definition of a complaint, as adopted by NAIC membership, is:

“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, would meet the definition of a complaint for this purpose.”

Definition of “Confirmed Complaint”

The NAIC definition of a confirmed complaint, as adopted by NAIC membership, is:

“A complaint in which the state department of insurance determines:

- a) The insurer, licensee, producer, or other regulated entity committed any violation of:
 - 1) An applicable state insurance law or regulation;
 - 2) A federal requirement that the state department of insurance has the authority to enforce; or
 - 3) The term/condition of an insurance policy or certificate; or
- b) The complaint and entity’s response, considered together, indicate that the entity was in error.”

The definition of “confirmed complaint” was adopted by the Market Regulation and Consumer Affairs (MRCA) Committee in December 2008.

Revisions to Complaints Database System (CDS) Complaint Coding and Complaint Mapping

In December 2008, the NAIC membership adopted a new coding plan for the Complaints Database System (CDS) and a recommended implementation plan. The primary objective of creating a new CDS coding plan was to improve complaint data quality through uniform complaint handling and reporting by all state insurance departments.

Key revisions to CDS complaint coding and mapping included:

- Changes to existing reason and disposition codes;
- Creation of new coverage, reason, disposition and subject codes;
- Modifications to the mapping of some reason codes and disposition codes to new or existing codes;
- Revisions to the CDS standard complaint data form (creation of a new subject field and confirmed field); and
- Revisions to the CDS Definitions and Basics Manual.

Implementation called for each state to convert to the new coding plan, with the assistance of NAIC staff, over a five-year conversion period (2011-2015). Following conversion, states reported complaints to CDS using the new coding plan. Prior to converting to the new coding plan, states reported complaints to CDS using the previous coding plan. The NAIC converted these complaints, upon receipt, to the new coding plan. As of December 13, 2010, all historical complaint data in CDS was converted to the new coding plan.

All reports created in iSite+ and the Consumer Information System (CIS) reflect the new coding plan, and as of April 2016, all states have converted to the new coding plan. Additional detail and guidance regarding the revised CDS complaint coding and mapping—as well as the revised CDS standard complaint data form and the CDS Definitions and Basics Manual, are available to regulators via myNAIC on StateNet, at the link to the Market Data Team (MIS).

Although total complaints are useful for many purposes, the baseline complaint index should be based on confirmed complaints, both because these are a more meaningful indicator of company-specific shortcomings and because this enables consistent comparisons from state to state and between states and the Consumer Information Source (CIS). States should be tracking consumer complaints in a format consistent with the Complaints Database System (CDS) format and reporting complaints to the CDS. Confirmed complaints are complaints in which one of the complaint resolution codes used by the state, also known as “complaint disposition,” upheld the consumer’s complaint position. Complaint disposition codes in which a consumer’s complaint position was upheld include the following:*

- 1208 Compromise Settlement/Resolution;
- 1225 Claim Reopened;
- 1230 Claim Settled;
- 1257 Fine Assessed;
- 1280 Referred to Other Division for Possible Disciplinary Action; and
- 1311 Company Position Overturned.

*Note: Once a state has implemented the new complaint coding plan, the state no longer uses the above-referenced complaint disposition codes to determine if a complaint is confirmed; upon implementation of the new coding plan, states submit a “confirmed” status, indicating if a complaint is confirmed or not, based upon the state’s analysis of the consumer complaint.

Complaint Ratios

A company’s complaint ratio is defined as:

$$\frac{(\text{number of confirmed complaints})}{(\text{gross premium written [in thousands of dollars]})}$$

It is important, of course, that these figures be comparable—for the same line of business, for the same period of time and for the same state or geographic region. Gross premium is used, rather than net premium, because what is important is the company’s level of activity in the market in question. The use of complaints per \$1,000 is recommended for consistency with other states and because the numbers that result are easier to follow and to work with than complaints per \$1, which usually results in multiple leading zeros.

Example: Consider three hypothetical companies. Insurer A wrote \$50 million in annual premium volume in an individual state, while Insurer B wrote \$10 million and Insurer C wrote \$1 million. Insurer A had 500 confirmed complaints in a given state last year, Insurer B had 150 confirmed complaints and Insurer C had 10 confirmed complaints. Their ratios of complaints per \$1,000 of premium are:

Insurer A	500 complaints/\$50 million in premium	500/50000	= 0.010
Insurer B	150 complaints/\$10 million in premium	150/10000	= 0.015
Insurer C	20 complaints/\$1 million in premium	20/1000	= 0.020

Complaint Indices

It is important to distinguish between the complaint ratio and the complaint index. A company’s complaint ratio is based entirely on company-specific information, while a company’s complaint index measures the performance relative to other companies in the same market. The purpose of the complaint index is to make the complaint information more meaningful by expressing it in comparative terms. As discussed above, it is also important to use an appropriate basis of comparison, which generally means companies in the same line of business.

Complaint Index

A complaint index is defined as:

$$\frac{(\text{complaint ratio for the company})}{(\text{complaint ratio for the aggregate market})}$$

Thus, a company with a complaint index of 2.35 has a complaint ratio that is more than twice as high as the market average, while a company with a complaint index of 0.48 has a complaint ratio slightly less than half the average. Some states multiply this complaint index by 100 to express it as a percentage, in which case the above indices would be 235 percent and 48 percent, respectively. However, this is not recommended, because it can be confusing to try to compare figures based on different scales. When looking at complaint indices published by other sources, it is essential to be aware whether the source used 1 or 100 to describe the performance of the “average company.”

When calculating a complaint index, the complaint ratio for the aggregate market is calculated in the same manner as for individual companies: divide the aggregate number of confirmed complaints for all companies (in the relevant time period, state(s) and line(s) of business) by the comparable aggregate premium volume.

It should be noted that the formula above is mathematically equivalent to defining the complaint index as:

$$\frac{(\text{company's complaint share})}{(\text{company's market share})}$$

The “complaint share” is defined in the same manner as a company’s market share; i.e., by dividing the company’s complaints by the aggregate number of complaints in the relevant market.⁷ This is the format in which the NAIC CDS compilations are presented on iSite+.⁸ When doing the actual numerical calculations, in order to minimize rounding errors, the relevant data should be input directly, so that the complaint ratio is calculated as:

$$\frac{(\text{number of complaints against company}) \times (\text{market aggregate written premium})}{(\text{market aggregate complaints}) \times (\text{company written premium})}$$

Note that a “typical” complaint ratio will depend on the line of business involved and on a number of other factors, including prices in the relevant market at the relevant time. By contrast, the average complaint index will always be 1.00, regardless of the scale used for the underlying complaint ratios.

Example: Supposing for simplicity that Insurers A, B and C from the previous example represented the entire market for that line of insurance in the state, the aggregate complaint ratio for the entire market (rounded to two significant figures) would then be:

$$670 \text{ confirmed complaints} / \$61 \text{ million in premium: } 670 / 61000 = 0.011$$

This corresponds to complaint indices for the three insurers (rounded to two decimal places) of:⁹

Insurer A	0.010/0.011	0.91
Insurer B	0.015/0.011	1.37 ¹⁰
Insurer C	0.020/0.011	1.82

⁷ This formula demonstrates why the complaint index will be the same whether the original complaint ratios are expressed in terms of complaints per dollar, complaints per thousand dollars or complaints per million dollars.

⁸ However, at this writing, those reports are based on raw complaint data, not confirmed complaints. The NAIC is developing a report framework based on confirmed complaints.

⁹ Additional precision, although readily available, is inappropriate because it would not reflect any meaningful distinction between companies. Indeed, even the two decimal place calculation will generally overstate the significance of the underlying data.

¹⁰ The careful reader might note that the approximation 15/11 actually rounds to 1.36. *See supra* note 9.

Complaint indices may be calculated relative to both state and national markets and perhaps also for a multistate region, giving the insurance department both a local and a global view of potential consumer issues. The CDS, as discussed in more detail below, provides complaint index reports for 10 different lines of insurance: by state, nationally, by NAIC zone or for any selected list of states.

Although the complaint index is one of the most valuable tools for evaluating market performance, regulators need to note its limitations, which include:

- Although complaint indices should be calculated by line of business if possible, their accuracy depends on the availability (and the use) of accurate confirmed complaint counts by line of business. Complaint ratios and complaint indices draw a misleading picture if the complaint count and the gross premium figure are based on different sets of policies;
- Premium volume may not be the best measure of market activity in many lines of business, particularly annuities and life insurance. States should give strong consideration to supplementing their basic complaint analysis with an alternative complaint index calculation based on policy count, when that information is available. For life insurers, the number of policies and group certificates in force is reported on the State Page, itemized by the type of coverage;
- Complaint indices can be misleading for companies with small market presence. In particular, it is not appropriate for published tables or rankings to include (at least without a conspicuous disclaimer) companies whose complaint indices would be significantly different with one or two more or fewer confirmed complaints;¹¹
- Using more states and/or more years provides a larger sample size, but this will only give more accurate results if the information from other states or earlier years is comparable. Inaccuracies may result from changes in company behavior over time, different company practices or market conditions in other states or inconsistencies in the ways different states gather or report complaint data. For example, all other things being equal, if the average policy in a given state is half as expensive as in a neighboring state, then complaint ratios, calculated by premium volume, will be twice as high in that state as the same level of complaint activity would generate in a neighboring state; and
- A CDS Closed Complaint Summary Index Report can be run, using complaint information from one year and premium information from a different year, allowing multiple complaint years to be compared to a common baseline. This corrects for the effects of general economic conditions, such as inflation on premium growth, but will create other distortions when premium volume changes for other reasons.

Reports from the NAIC Complaints Database System

Complaint index reports are among the most important market analysis resources that the NAIC makes available to the states on iSite+. These reports are compiled from the NAIC Complaints Database System (CDS), which collects complaint information from participating states in standardized form. The CDS also assists the states in complying with the provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA), requiring states to report Medicare supplement complaint information to the Centers for Medicare & Medicaid Services (CMS, formerly known as Health Care Finance Administration—HCFA). The NAIC submits quarterly reports to CMS on behalf of all states that submit data to the CDS. The remaining states are required to comply with the OBRA requirements on their own.

¹¹ A company which returned more premium than it wrote will actually appear in computer-generated tables with a negative complaint ratio, which in its face is absurd and should be seen as a clear indication that the company had too little activity in that market to generate a credible report. On the other hand, if several complaints were filed against such a company, regulatory follow-up is clearly warranted.

The following CDS reports are currently available on iSite+. A comprehensive listing and description of all available iSite+ CDS reports is located in the Help file on iSite+.

- **CDS Closed Complaint Summary Index Report**—Displays the 1) market share (total business line premiums for the company in a specified state or zone/total business line premiums for all CDS companies in the specified state or zone) and 2) complaint share (total CDS complaints for the company writing the designated line of business in a specified state or zone/total CDS complaints for all companies writing that line of business in the selected state or zone) for the selected company based on specific lines of business. An index of 1.0 indicates that the company had a percentage of complaints equal to its percentage of premium written for the coverage type and state(s) selected. The report is available only for those firms that have both closed consumer complaints and premiums reported through submission of their annual financial data to the NAIC. Current complaint year data is available on July 1st of the current year.
- **CDS Summary Closed Complaint Counts by Code Report**—Displays the number of complaints selected for an entity based on various complaint codes (type, reason and disposition) based on the criteria selected.
- **CDS Summary Closed Complaint Counts by State Report**—Displays an alphabetical list of all NAIC member jurisdictions with a count of the number of complaint records in the database for an entity based on the criteria selected.
- **CDS Summary Closed Complaint Trend Report**—Displays the number and percent of change in closed complaints for an entity, based on the criteria selected. The information is displayed for the current year and the previous five years, as well as monthly detail for the past 36 months.
- **CDS Closed Complaint Participating State Report**—Lists by state/territory the number of closed complaints entered in CDS, the earliest record closed date, the most recent record closed date and the most recent entry date. This report is useful in determining which states/territories are actively participating in submitting complaint records to CDS.

The NAIC also publishes complaint index information for the general public through its Consumer Information Source (CIS). These reports calculate complaint indices on a nationwide basis, based only on confirmed complaints, and rebalanced so that a score of 1.00 represents the median company for a particular line of business¹²—half the companies in that line of business had better complaint ratios for that year, while the other half had worse, rather than the mean complaint ratio overall. To illustrate the difference, the median complaint index for group health insurers in 2002 was 1.28. This indicates that most companies in this line of business had complaint indices noticeably greater than 1.00—the most likely explanation for such a result is that those companies with high complaint indices tended to be smaller companies (or companies for which group health was not a major line of business), while the larger group health writers tended, on average, to have fewer complaints relative to premium volume.¹³ This brings down the average, so that a company could have a better complaint record than most of its competitors, but still have a complaint index of 1.1.

Therefore, the CIS would report such a company's complaint score as $1.1/1.28 = 0.86$, highlighting its performance relative to other companies rather than its proportionate share of the nationwide complaint total.¹⁴

¹² The CIS report refers to the rebalanced complaint index as a “complaint ratio,” but that is different from the way that term is used in this guide.

¹³ Another possibility would be a bimodal (“camel hump”) distribution curve in which there are really two distinct market sectors being compared here, the larger of which (on average) has measurably higher complaint ratios.

¹⁴ The underlying question is which figure can most fairly be called “normal” market behavior. The use of the median is based on the premise that the market-wide complaint ratio (i.e., the mean complaint ratio) is disproportionately influenced by the behavior of a few large companies. Conversely, however, it can be argued that the median complaint ratio is disproportionately influenced by very small companies whose behavior affects relatively few consumers.

F. Market Conduct Annual Statement Data

The Market Conduct Annual Statement (MCAS) is a uniform method for states to collect key data elements. Currently, MCAS data is collected on individual life cash and non-cash value products, individual fixed and variable annuities, individual stand-alone and hybrid long-term care policies, private passenger automobile policies, homeowners policies, in-exchange and out-of-exchange health plans and lender placed home and automobile policies. In addition, the collection of disability income MCAS data will begin for the 2019 data year reported in 2020.

The collection of MCAS data allows state regulators to compare and contrast entity-specific results with the results for the remainder of the industry regarding such issues as claims, premiums, policies in force, new policies written, nonrenewals, cancellations, replacement-related activity, suits and consumer complaints. The MAC should review the results of this analysis and consult with the state's Collaborative Action Designee (CAD) regarding a potential need for an action from the continuum of market actions.

G. How to Analyze State Page Data

Insurers file a State Page in each state in which they are licensed as part of the annual statement, which is available in electronic form from the NAIC and which is also filed in print form with the insurance department. The company reports the following information by line of business for the state:

- **Property/Casualty (Yellow)**—Includes premiums written and earned; losses paid, incurred and unpaid (reserves); defense costs paid, incurred and unpaid; dividends; unearned premium reserves; taxes and fees; and commissions.
- **Life/Health (Blue)**—Includes detailed information on premiums (and annuity considerations), benefits; dividends; benefits paid and incurred; and policies (and annuity contracts) in force.
- **Health (Orange)**—Includes premiums collected and earned; claims paid and incurred; membership by calendar quarter; current year member-months; ambulatory encounters (itemized between physician and non-physician); hospital patient days; and inpatient admissions.

This state-specific information can be used to track the company's movement in the state and changes in key class of company operations from year to year. There are four key State Page indicators that should be used to screen insurers for market analysis purposes: premium volume, changes in reserves (relative to losses), loss ratio and defense costs.

The market analysis unit in every insurance department should obtain this information annually, to the extent applicable to the insurer's lines of business, for every insurer that is subject to baseline review. The MAC should ensure that this information is available as soon as possible after the annual statement is filed each March, so that the necessary market analysis can proceed in tandem with the company's financial analysis.

Review Data for Significant Changes in Premium Volume

The list of licensed companies and changes in premium volume needs to be examined to find the companies with significant fluctuations in premium volume since the prior year. The initial analysis of premium volume should aim at focusing state insurance department resources on companies with the most significant changes. Every insurer's premium volume changes every year, so the analyst should be looking for dramatic growth (33 percent or more) or decline (10 percent or more) on one or more lines of business in the state. Since most changes are increases, the normal range for increases is broader than the normal range for decreases.¹⁵ Schedule T, on all three types of statement blanks, provides a state-by-state breakdown of premium activity; and it may be useful to check this schedule to compare activity in other states and identify regional or national trends.

¹⁵ It should also be noted that when a company is one of the dominant insurers in the market, there is less room to grow in the normal course of business, so a lower threshold for "significant" premium growth should be considered for those companies.

Market analysis of the State Page data when it is filed in March provides a good opportunity to double-check whether all state insurance department staff are aware of and are alerting the department's MAC of the warning signs noted above. The March annual statement filings should rarely be the first notice that the department receives if an insurer has had significant premium fluctuations or other unusual financial results in the prior year. Usually, some preliminary indication was already present in the quarterly reports or some other source of current information.

When an insurer with unusual premium activity has been identified, the next step is to determine the cause of the increase or decrease:

- Does the change correlate with complaints filed against the insurer?
- How many rate, rule and form filings has the company made? Does the number, compared to the change in the company's writings, suggest that the company is using a rate structure that is not filed or not approved, if required for that line of business?
- Is the increase in premium volume due largely to an increase in the number of risks assumed or due largely to rate increases?¹⁶
- If there are significant rate increases, do they reflect trends in the overall market or is the company an outlier?
- If the company's writings have changed, have the numbers of agents changed accordingly?
- How many agent appointments and terminations has the company made?
- For what lines are they licensed?
- If the company's writings have changed, have the number of adjusters changed? (If relevant to the line of business in question and the state requires a license for adjusters or this information is otherwise available.)

Did the premium volume increase primarily because of large rate increases? If this appears to be the case, then the market analyst needs to work with other insurance department staff to determine whether there is a potential market conduct problem that would warrant further follow-up with the insurer. Even premium decreases may signal market conduct problems. Decreases often reflect increased competition in the marketplace, and some companies may respond to the pressure by cutting services or by aggressive claims practices. If a significant change in premium volume is due to expansion and new business, then the market analyst needs to work with others in the insurance department who can provide assistance in determining the following:

- How much experience does the company have in the line of business in which there is a significant increase?
- Does the company have the resources to deal effectively with rapid growth? (Or with lost business, in the case of a decrease in volume?)
- Is the company relying extensively on managing general agents and/or fronting arrangements?
- Have there been any recent management changes in the company?
- Has the company entered a new line of business?
- Is it a new licensee in the state?
- Has it made a quick entrance and exit from the state? If so, why?

Rapid expansion into new states, coupled with significant premium volume in the new states, is an indicator of material change in market position, as are significant changes in a company's book of business. To complete the analysis in this area, the analyst should look at the insurer's complaint data to determine if the changes in the company have been the source of complaints filed against the insurer and whether those were confirmed complaints.

Review Data for Changes in Reserves

State Page data must also be reviewed to focus on the companies that have had a recent spike in reserves. Once such a company is identified, the market analyst must determine the reason for change.

¹⁶ In lines of business where rates are not filed, this will be more difficult to ascertain.

The basic analysis should compare changes in losses and changes in reserves. If both are moving in the same direction at a similar rate, this is less likely to indicate a market conduct issue; if there is a problem, it is more likely financial. When the market analyst finds that a spike in reserves occurs without a corresponding increase in losses paid, however, the market analyst should work with the financial analysis unit to determine the cause. It may well be that a major lawsuit was filed against the insurer at year's end. If so, what is the nature of that lawsuit? Does it relate to the company's marketplace behavior? Or was the spike simply due to a correction of reserves on pending claims? If so, this is likely a financial matter and not necessarily an indication of a market conduct problem.

It should be noted, however, that adverse loss experience may trigger changes in a company's claims practices. Again, this would be a good time to cross check complaints filed against the insurer.

Review Loss Ratio Data

Relative loss ratios are readily available for property/casualty insurers on iSite+ using the financial market share summary report titled "Market Share—By Line of Business." There is no "one-size-fits-all" numerical guideline that can be applied—"normal" loss ratios can vary significantly, not only between lines of business but also from year to year within the same line of business. Instead, analysts should identify companies with loss ratios that are significantly higher or lower than those of comparable companies and also companies with unusual trends or year-to-year variations. Companies with unusually high loss ratios compared to their competitors might be financially stressed. Conversely, if the loss ratio is unusually low, regulators should verify that this is the result of successful business operations, and not irregularities in reporting or in underwriting or claims practices.

Variations affecting an entire line of business, rather than particular companies may reflect the impact of a specific catastrophic event or the effects of the business cycle. Although these types of variations cannot be used to identify specific problem companies, regulators do need to be aware when a market is experiencing extreme "hard market" or "soft market" conditions, since either extreme can have an adverse impact on consumers.

Review Data on Defense Costs

For casualty insurers, State Page data needs to be reviewed to identify insurers with significant changes in defense costs. Significant changes in expenses have been identified as one of the primary indicators of potential problems. Defense costs should be a particular focus for market analysis purposes. Once the companies with significant changes in their defense costs from the previous year have been identified, the market analyst should determine the cause for this change. Changes in defense costs can be an indicator of problems if a disproportionate share of claims is going into litigation. If defense costs are rising relative to increases in premium volume and losses, the change in defense costs does not itself indicate potential market conduct problems, but follow-up with the company is called for when defense costs are rising disproportionately to direct losses. This should include a cross check on consumer complaints, particularly complaints about claims practices.

Not for Distribution

Chapter 8—Enhancing State Market Analysis

As states proceed with implementing market analysis programs and evaluating their effectiveness, the next phase is to figure out how these programs can be improved, both internally and through enhanced coordination with other states. A wide range of enhancements can be considered, depending on which goals the insurance department sees as its most immediate priorities. There are many directions in which states can look and then share their insights with other states that have followed different paths, such as:

- Improving the quality of the techniques already in use;
- Adding a new range of issues to consider;
- Coordinating better with other states;
- More efficiently focusing on just the problem companies or markets;
- Monitoring more companies; and
- Improving the follow-up after companies are identified.

Below are some examples of possible approaches.

A. Improving Consumer Complaint Analysis

Over the last two decades, the NAIC has analyzed the insurance consumer complaint process and the value the process affords regulators in understanding the insurance marketplace in each state. In 2000, the NAIC adopted the *Consumer Complaints White Paper*, which outlines best practices for handling consumer complaints, recognizing the need to maintain uniform complaint information and the critical value of accurate complaint information to insurance consumers, as well as to regulators. All market analysts and coordinators should review this white paper.

As we have seen in the chapter on basic analytical tools, the NAIC Complaints Database System (CDS) is one of the key resources for market analysts, but it can only be as good as the information it receives from participating states. Meaningful comparison of complaint data from state to state requires nationwide uniformity in state insurance departments' treatment of complaints. If an insurance department fails to code complaints properly or if departments use conflicting coding systems, other states will receive an inaccurate picture of general business practices, emerging issues and changes in the marketplace. In particular, the distinction between "complaints" and "inquiries" must be drawn in a consistent manner. States that call on insurers to self-report complaints and other consumer actions should be particularly vigilant in this regard, to ensure that companies that give themselves the benefit of the doubt do not have an unfair advantage over companies that bend over backwards to provide full disclosure.

Having uniform definitions and standards applicable in all states results in an accurate exchange of information, allows for the systematic analysis of that information, allows complaint information to be used effectively in the market surveillance process and allows accurate complaint summaries to be compiled for public distribution. As noted in Chapter 7—Putting It All Together: Market Analysis, readers do not have to switch gears unnecessarily; there is value in standardization even for nonsubstantive formatting conventions, such as whether complaint indices are expressed as percentages, with 100 as the norm, or as ratios, with 1.00 as the norm.

1. Key Elements of Best Practices

The basic goals of complaint analysis are to obtain (1) a complaint ratio to evaluate the relative activity of each insurer in the marketplace; and (2) data on emerging marketplace issues and activities of individual insurers or of the industry at large.

To that end, each state insurance department needs to adopt, in conjunction with the other states, a uniform system for measuring consumer complaints and complaint ratios for each company by state. This should begin with a uniform definition of a “complaint” (as distinguished from an inquiry):

A complaint is “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, would meet the definition of a complaint for this purpose.”¹⁷

At the NAIC 2009 Summer National Meeting, the NAIC membership adopted the following definition of an “inquiry”:

An inquiry is “any oral or written communication that is not a complaint, as defined above, such as a request for general information or an expression of opinion regarding an insurance-related issue that may or may not require a response by the department of insurance.”

States should not track only those expressions of dissatisfaction that are received in writing, but should also monitor and report complaints received by fax, through electronic transmissions, by phone or in person. Written complaints (hardcopy or electronic) should be signed in some manner that identifies the complainant. Oral complaints should eventually be recorded in hardcopy and signed. There needs to be standards for determining when there is enough specificity to warrant follow-up with the insurer. For example, although a consumer expressing dissatisfaction regarding a state’s mandatory auto insurance law is expressing a grievance that the insurance department should record and track, such a grievance is not a complaint against a specific insurance entity and cannot be included in insurer complaint data. However, a consumer need not allege a violation of insurance laws in order for his or her expression of dissatisfaction to qualify as a complaint.

Since the same complaint can be reviewed by different personnel in different formats, care must be taken to prevent duplication of complaint records. Whether or not a complaint is “confirmed,” it should still be recorded, properly coded and reported to the Complaints Database System (CDS), because the broad universe of all types of complaints is the foundation on which more detailed analyses rest and because even complaints in which the company is found to be acting within its rights highlight areas of concern to regulators. On the other hand, care must also be taken to ensure that meritorious complaints are not lost due to improper coding. For example, a complaint may be coded as “1240: Refer to Outside Agency/Department” and thus tracked as “unconfirmed,” even though the referral was to another section of the same department which found that the company was in violation. Or, a complaint may raise two separate issues, but on one issue, the company is found to be in violation, but the entire complaint is tracked as “unconfirmed” because the other issue resulted in a secondary code of “1295: Company Position Substantiated.”

Complaints should be tallied on an aggregate basis, regardless of who filed the complaint. However, the nature of the complaint and the nature of the complainant are important factors both for the eventual resolution of the complaint and for further market analysis. Therefore, the insurance department should track who generated the complaint, according to the following categories:

- Insured;
- Service provider; and
- Other.

¹⁷ Similarly, the *Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act* (#884) provides that “complaint” shall mean a written communication primarily expressing a grievance. This definition was adopted by the Market Regulation and Consumer Affairs (D) Committee in 2006 after a review of the complaint definition recommended in the NAIC *Consumer Complaints* White Paper adopted June 2000.

In addition, the following three categories are recommended for state complaints databases, even though the NAIC does not currently use these categories for the closed complaint database:

- Third-party claimant;
- Counsel; and
- Public adjuster.

As noted, “the expression of dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws” is what distinguishes inquiries from complaints, but insurance departments should track both types of communication. For example, a consumer inquiring about rates or coverage for a specific line of business should not be classified as a consumer complaint. However, separately monitoring and tracking the types of inquiries made by consumers offer valuable information in making a professional determination if further insurance department action is needed or if common issues of inquiry might suggest a need for better consumer education and outreach programs.

2. More Detailed Information on Complaints and Regulatory Actions

The number of complaints does not tell the whole story. It is also important to know, both for specific companies and for market sectors in the aggregate, what consumers are complaining about: e.g. rates, claim payments or sales practices. The Complaints Database System (CDS) captures the following complaint data elements:

- Entity complained against;
- Date complaint opened and closed;
- Subject codes;
- Confirmed complaint indicator;
- Respondent/firm/agency and respondent individual information;
- Respondent function codes (in relation to respondent type: firm/agency or individual);
- Complainant/Insured information;
- Type of coverage (auto, life/annuity, fire, allied lines and commercial multiperil, accident/health, homeowners, liability and miscellaneous lines);
- Reason for complaint (underwriting, policyholder service, claim handling, marketing and sales); and
- Disposition.

States may also collect additional information, such as the geographic region within the state or subcategories within the broader lines of business. If several years of systematic complaint information are available, it is possible to complement snapshots of current complaint data with a dynamic view of complaint trends over time.

However, in order for complaint data to be useful, states need to be diligent about ensuring that there is consistency from state to state in how complaints are defined and characterized. For example, a state may decide to break down a category in the Complaints Database System (CDS) into more detailed subcategories, but should not be replaced with a framework that draws the lines between categories in a totally different way.

3. Calculating Complaint Ratios by Number of Policies

Another refinement states may consider for complaint analysis is to compare complaint ratios calculated in the standard manner, based on premium volume, to some alternative baseline, such as the number of transactions. Premium data is more easily obtained and, within a particular product line, is often a reasonable surrogate for policy count, but if an appropriate measure is available of the number of policies, policyholders or covered lives (or some other measure specific to a particular line of business such as car-years), it may provide a more meaningful measurement, depending on whether the level of activity on a policy is likely to increase as the premium increases. Annuity business, in particular, is a line of business where the dollars involved can vary so much from transaction to transaction that “premium” volume is a poor measure of the level of market activity. Similar concerns apply to life insurance as well—the race-based premium scandal, for example, affected many more consumers than their share of the overall life insurance premium volume would indicate. Although mishandling a single “large case” policy has a significant impact and should not be taken lightly, the complaint analysis system should not encourage giving disproportionate attention to accounts with tens of thousands of dollars or more in annual premium at the expense of all other consumers.

Example (complaint ratio by number of policies): The complaint data for three hypothetical insurers illustrates that the definition of “complaint ratio” takes on a different cast when complaint ratios are calculated on the basis of policy count rather than premium volume. Hypothetical Insurers A, B and C had 500, 150 and 10 complaints, respectively, on premium volumes of \$50 million, \$10 million and \$1 million, for complaint ratios (based on premium volume) of 0.010 for Insurer A, 0.015 for Insurer B and 0.020 for Insurer C. However, assume that Insurers A and B write individual health coverage with an average premium of \$10,000, so that Insurer A’s \$50 million in premium represents 5,000 policies and Insurer B’s \$10 million represents 1,000 policies, while Insurer C specializes in high-deductible policies and writes 500 policies with average premium of \$2,000. Their ratios of complaints per policy are:

Insurer A	500 complaints/5000 policies	0.10
Insurer B	150 complaints/1000 policies	0.15
Insurer C	20 complaints/500 policies	0.04

Example (complaint index by number of policies): Any alternative basis for calculating complaint ratios can also be used to develop complaint indices. In the prior example, the aggregate complaint ratio is 600 complaints/6,500 policies: 0.103 and the complaint indices for the three insurers are, therefore:

Insurer A	0.100/0.103	0.97
Insurer B	0.15/0.103	1.46
Insurer C	0.04/0.103	0.39

This example also highlights why it may be useful, when feasible, to distinguish between market sectors within a line of business. The differences between high-deductible indemnity coverage and HMO coverage or the differences between preferred and substandard or urban and rural automobile coverage may be more significant than a simple conversion between premium volume and policy count would be able to capture.

4. Improving Complaint Analysis through Use of the Complaints Database System (CDS)

Complaint trending is currently the most prevalent technique the states employ to identify potential market problems. The CDS makes it possible to analyze complaint trends at the state, regional and national levels. The value of CDS is enhanced as all states move to full participation, definitions are uniform and standard coding protocols are adopted. A complaint tracking system should be able to compile and measure complaints by type, reason and company, so that an index can be established for each company.

It is important for insurance departments to establish a database to track key elements of the complaint process. The analysis of complaint data can identify potential company or industry trends or concerns including non-complying general business practices or acts that may adversely affect consumers. For instance, a large influx of complaints about premiums within a specific geographic area may be reflective of a rate increase by carriers, or possibly indicate a lack of affordable coverage in the area. The trends identified from analysis of the database can be used to trigger a simple inquiry or generate a referral to the examination or enforcement area. The database might track the number of complaints against particular companies or producers for the improper cancellation or denial of coverage. When the number of such complaints reaches a certain level, other divisions of the insurance department should be notified.

The CDS provides a central repository for complaint information in a standardized format that is electronically retrievable. This format is based on a uniform complaint recording form with data fields that identify and categorize the complainant, the entity against whom the complaint is filed, the type of coverage, the reason for the complaint and the final disposition of the complaint. The computerized data collection system and the compilation of standardized reports provide states with a resource for in-depth analysis of complaint information. Data can be analyzed by geographical area, by line of business, by company or by any other standardized data element. Therefore, it is imperative that states adopt the uniform data standards used for the CDS when establishing internal complaint tracking systems.

5. Publishing Complaint Information

Most state insurance departments publish aggregate data in some format, either in an annual report, consumer brochure or on an insurance department website. While not all states affirmatively disseminate aggregate complaint information, many states now publish complaint index ratios, at least for personal lines in the property/casualty industry.

Because complaint ratios can have an impact on the general public's perception of the company and on an insurance department's decision whether to pursue regulatory action, it is vitally important that complaint indices be based on reliable data and that all categories and terms be adequately defined. Internal quality control measures to ensure data integrity should be implemented. Routine audits or studies should be conducted to determine that proper codes are in place and are being used consistently. States should also review state codes to determine if new or amended codes are necessary to address evolving market issues. However, states must be cognizant that any change in internal code structures will impact reporting to the Complaints Database System (CDS), so all code changes should be coordinated through the NAIC.

The complaint index should be adequately footnoted to clearly specify how it was calculated and how the relevant terminology is defined, including "complaint." There should also be an explanation of whether the index is based on unscreened complaints or confirmed complaints and, if it is based on confirmed complaints, what criteria and processes are used for identifying which complaints are considered "confirmed." Most complaint index ratios are based upon premium volume—information made available by all insurers in a common format. If some other measure of market activity is used as the baseline for comparison, this should be clearly indicated. Those alternative measures should be used only as a supplement to complaint ratios based on premium volume, not as a replacement, because premium volume is the only standard that is in consistent use within the states and by the NAIC.

Finally, it must be kept in mind that, as with all consumer outreach programs, the value and effectiveness of the insurance department's complaint index reports and any other market analysis publications the insurance department might make available, is measured by what the program does for consumers. To close the circle of communication, insurance departments must conduct ongoing assessments of consumer reactions and consumer awareness.

6. Confirmed Complaints

The definition of a confirmed complaint, as adopted by NAIC membership, is:

"A complaint in which the state department of insurance determines:

- a) The insurer, licensee, producer, or other regulated entity committed any violation of:
 - 1) An applicable state insurance law or regulation;
 - 2) A federal requirement that the state department of insurance has the authority to enforce; or
 - 3) The term/condition of an insurance policy or certificate; or
- b) The complaint and entity's response, considered together, indicate that the entity was in error."

The definition of "confirmed complaint" was adopted by the Market Regulation and Consumer Affairs (D) Committee in December 2008.

For this reason, many insurance departments consider it important to distinguish between "confirmed" and "unconfirmed" complaints, especially when compiling information for publication. Other terms in common use are "substantiated" and "justified." Since a high complaint index reflects adversely on a company, these insurance departments feel that it is fairer to base complaint indices purely on complaints where a screening process has led to a finding that the company was in the wrong—or at least to leave complaints out of the index when there has been a finding that the company was in the right. Criteria for confirmed complaint status vary from state to state and may include, for example, whether an insurer violated a law, whether the complaint was resolved in favor of the consumer or whether the complaint analyst determined that the complaint was valid.

Other insurance departments, however, continue to use unscreened complaints and some insurance departments have discontinued screening programs that were formerly in place. One reason is a view that what complaint data measures is consumer satisfaction, not regulatory compliance, and that accordingly, all expressions of dissatisfaction should be counted equally. Some insurance departments also believe that unscreened complaint indices track confirmed complaint indices closely enough that the costs of screening programs outweigh the perceived benefits. Those costs can be substantial, because if due process is perceived to require the regulator to determine whether a complaint is confirmed, then due process would also require the regulator to give the company an opportunity to contest the finding. This has the potential of turning every complaint into a mini-disciplinary proceeding. Another concern is that if a favorable resolution for the consumer results in a black mark against the insurer, the insurer is given a perverse incentive to be uncooperative. Paradoxically, it is even possible that unscreened complaint indices may in many cases actually produce a more accurate picture of company behavior than confirmed complaint indices, because restriction to confirmed complaints makes a relatively small sample even smaller and any inconsistencies in the screening process and insurers' responses can have a serious impact on the accuracy of the data.

Therefore, whether to screen complaints remains an open question. Some states have effective screening programs, which allow additional layers of analysis, while others rely on unscreened complaints. The two systems can work in harmony, as long as states with screening programs also continue to report all complaints to the Complaints Database System (CDS), whether or not they are confirmed, in the same manner as other participating states. "Confirmed complaint" states can assist other states by testing the degree of consistency between confirmed and unscreened complaint indices. They may also choose to develop collaborative programs to evaluate confirmed complaint data on a multistate basis, but should be cautious about whether they are really working with consistent data, since both the criteria for confirmation and how those criteria are applied vary significantly from state to state.

B. Use of myNAIC and iSite+ in Market Analysis

As part of the Framework for Market Analysis, market analysts identify companies of interest for analysis, monitoring or regulatory action. Monitoring companies occurs regardless of the analyst's decision to pursue any of the items within the continuum of market actions.

MyNAIC was created by the NAIC in June 2016 as a web page from which publicly available NAIC tools can be accessed, and also as a web page which allows regulators to have a single page from which to access regulator-only NAIC/NIPR/IIPRC tools. Regulators may access myNAIC by clicking on the myNAIC link on www.naic.org; regulators may then login to the regulator-only portion of myNAIC by clicking on "Login" in the upper right corner of the myNAIC public applications web page. The applications on the myNAIC regulator-only page are based upon the roles associated with a regulator's iSite+ password and ID. All of the functionality from the former myNAIC, such as "News and Resources" and "Tools" has been incorporated into iSite+.

The iSite+ suite of applications is used to report financial, market regulation and producer information housed in the NAIC databases. iSite+ provides access to NAIC databases and a wide variety of reports prepared from those databases. iSite+ reports are standardized reports that provide regulators with a variety of financial and market regulation information. Most of these reports provide information related to a group of entities with similar attributes (e.g. companies that write business in a particular state) rather than individual entities.

The market regulation tools on iSite+ can be used after a Level 1 Analysis or Level 2 Analysis, in which a regulator may want to monitor a company or when a regulator has a potential or on-going examination of a company. iSite+ users are able to personalize applications to assist with analyzing and monitoring specific companies. iSite+ provides a quick high-level snapshot of a company's overall activities, including market share, complaint indices, Level 1 Analysis reviews, state market regulation initiatives and market conduct examinations. Users are able to select a customized listing of insurers and lines of business to display in iSite+. While the default display is to show state level information, users can add national data once a company has been selected. National data is helpful information which can be used to monitor the activity of insurance companies when analysts believe there is potential for further regulatory analysis or action.

C. Use of IRIS Ratios in Market Analysis

As discussed more fully on the NAIC website, the Insurance Regulatory Information System (IRIS) is a tool designed to assist state insurance departments in monitoring the industry's financial condition. A key component of IRIS is a series of financial ratios based on annual statement information, developed for the purpose of identifying companies with potential financial difficulties. There is a separate series of IRIS ratios for property/casualty companies and for life/health companies.¹⁸ IRIS ratios are a preliminary screening tool and IRIS ratios outside the pre-established norm do not necessarily indicate an adverse financial condition, let alone constitute evidence of market conduct problems. The IRIS ratio merely provides a signal for the regulator to follow-up to determine the cause of the changes in the company measured by the ratio or ratios in question. Bearing in mind these limitations, the eight IRIS ratios that are most likely to be of value as market conduct indicators are:

- **Property/Casualty—Gross Premiums Written to Policyholders' Surplus (P/C Overall Ratio 1)**

This ratio tests the adequacy of the company's surplus, without the effects of reinsurance. The higher the ratio, the more risk the company bears in relation to the surplus available to absorb loss variations, without the benefit of reinsurance.

Guidelines: Normal results for this ratio may be as high as 900 percent, but what is "normal" will depend on the line of business, since lines with more variability in losses, such as liability and workers' compensation, will require more surplus, other factors being equal, to sustain the same premium volume.

- **Property/Casualty—Net Premiums Written to Policyholders' Surplus (P/C Overall Ratio 2)**

This ratio is similar to the Gross Premiums Written to Policyholders' Surplus ratio, but it considers the effects of reinsurance. The higher this ratio, the more risk the company retains in relation to available surplus.

Guidelines: Normal results for this ratio will vary by line of business, but the usual range for the ratio includes results up to 300 percent. It is important to compare this ratio to the Gross Premiums Written to Policyholders' Surplus ratio. If the disparity between the two ratios is large, the company may be relying heavily on reinsurance. To the extent that the reinsurers are financially sound and make prompt payments to the company, this may not be a problem. However, if analysis of the company's reinsurers finds deficiencies in this area, the percentage of gross premiums written to policyholders' surplus becomes more telling. Special consideration should be given to reinsurance transactions between affiliates that are not part of an established intercompany pooling arrangement.

¹⁸ There are 12 life/accident & health ratios, 13 property/casualty ratios and 11 fraternal ratios.

- **Property/Casualty—Change In Net Premiums Written (P/C Overall Ratio 3)**

Major increases or decreases in net premium written can indicate a lack of stability in the company's operations and/or management. A large increase in premium may signal an abrupt entry into new lines of business or new jurisdictions—this could have market conduct implications even if the new business is profitable financially. In addition, a company that is attempting to increase cash flow in order to make loss payments may do this by taking on risky or unprofitable business. A large decrease in premiums indicate the discontinuance of certain lines of business, scaled-back writings due to large losses in certain lines, loss of market share due to competition, or increased use of reinsurance.

Companies writing questionable business in aggressive pursuit of market share or cash flow may seek to disguise this by understating their incurred losses. The analyst should review the cash flow statement for significant increases in benefit payments and should consider whether there may be an existing operating problem, such as an inadequately priced product or poor underwriting results.

Guidelines—The usual range for this ratio is between -33 percent and +33 percent. Ratios that fall outside the norm frequently indicate a lack of stability in the company's operations and management. Other evidence of instability may include dramatic shifts in product mix, marketing areas, underwriting policy and similar factors. Further analysis, as always, will be required.

- **Property/Casualty—Adjusted Liabilities to Liquid Assets (P/C Liquidity Ratio 9)**

This ratio is a measure of the company's ability to meet the financial demands that may be placed upon it. If the company's ratio is out of the norm in this area, there may be problems with its ability to pay claims.

Guidelines—The usual range is below 100 percent. Past analysis has shown that many insurers that later became insolvent had reported increasing ratios of adjusted liabilities to liquid assets in their final years. Thus, when looking at this ratio, it is important to consider the trend, not just the current year.

- **Life/Health—Net Change in Capital and Surplus (Life/A&H Overall Ratio 1)**

This ratio compares the company's surplus in the current and immediately preceding years, adjusted to disregard capital and surplus paid-in to reflect the impact of operations on capital and surplus. It is considered the most general measure of improvement or deterioration in a company's financial condition during the year.

Guidelines—This ratio is usually less than 50 percent and greater than negative 10 percent. Any number that is significantly outside this range should be investigated further to determine the reason. The four life/health ratios discussed here are not calculated for a newly formed company because they are dependent on prior year data.

- **Life/Health—Gross Change in Capital and Surplus (Life/A&H Overall Ratio 2)**

This ratio is similar to the Net Change in Capital and Surplus ratio, but it takes into account capital and surplus, including surplus notes, paid-in during the year.

Guidelines—This ratio is usually less than 50 percent and greater than negative 10 percent. Any number that is significantly outside this range should be investigated further to determine the reason. If this ratio is higher than the Net Change in Capital and Surplus ratio, it may indicate that the company is relying on capital contributions or subordinated debt in order to maintain its financial position.

- **Life/Health—Change in Premium (Life/A&H Change in Operations Ratio 9)**

This ratio represents the percentage change in premium from the prior year to the current year. This ratio is not calculated for a newly formed company because of the lack of prior year data. The calculation is the change in total premiums, deposit-type contract fund considerations and other considerations from the prior year to the current year, divided by total premiums, deposit-type fund considerations and other considerations for the prior year.

Guidelines—The usual range for this ratio includes results less than 5 percent. Any number that is significantly outside this range should be investigated further to determine the reason. The issues presented are similar to those raised by sudden changes in property/casualty net premiums written, as discussed above.

- **Life/Health—Change in Product Mix (Life/A&H Change in Operations Ratio 10)**

This ratio represents the average change in the percentage of total premium from each product line during the year. The calculation of this ratio begins by determining the percentage of premium from each product line for the current and prior years. Next, the change in the percentage of premium between the two years is determined for each product line and expressed as a positive number, whether it is an increase or a decrease. Finally, these differences are averaged by adding them (without regard to sign) and dividing by the number of product lines. Lines for which total premiums for either year are zero or negative are excluded.

Guidelines—The usual range for this ratio includes results than 5 percent. Anything materially higher should be investigated further with the financial services section of the state insurance department. Does the company have a business plan? What is management's expertise in product pricing, underwriting, claims and reserving in new lines of business? Why is the company changing product lines? Are there changes in the marketplace that impact a company's decision to shift direction? Are there changes in company ownership or management that have resulted in shifts in product mix or entrance into new geographic areas?

Each state's financial analysis department should be identifying the companies doing business in each state with IRIS ratios outside the norm, should be sharing that information with market regulators and may have already completed an inquiry into the reasons for the result and whether there is any real cause for concern. In addition, the NAIC makes IRIS ratio information directly accessible to regulators through iSIR+.

Since IRIS ratios were originally developed for financial purposes, market analysts must keep in mind the similarities and differences between market analysis and financial analysis and how these affect the use of IRIS ratios. As noted before, unusual IRIS scores do not necessarily indicate financial problems; however, they could still be of interest to market analysts. For example, a company could have the capital to venture safely into a new, untested line of business, but might not have the customer service resources in place—or vice versa.

An IRIS score indicating a significant change in written premium calls for follow-up by both financial and market analysts; however, they could be following up in different ways. For example, one key market indicator tracked by IRIS is the change in net premiums written (Property/Casualty Ratio 3 or Life/A&H Ratio 9). A significant change in premium volume should suggest a series of inquiries for market analysts.

Ratios and trends, though often helpful in identifying companies likely to experience financial difficulties, are not in themselves indicative of adverse financial condition. The ratios and range comparisons are mechanically produced. True financial condition can only be determined by knowledgeable financial analysts. Furthermore, financial problems do not necessarily indicate market conduct problems; let alone what those problems might be for a particular company. Therefore, IRIS ratios should only be used in conjunction with other indicators, and any conclusions drawn from IRIS ratios should be validated through discussions with financial analysts.

D. The Use of Underwriting Guidelines in Market Analysis

Underwriting is the process by which an insurer determines whether it will accept or reject an application for coverage, or whether it will renew or nonrenew an existing policy. Underwriting also includes the process of assigning policyholders (and prospective policyholders) to different risk classifications or rating tiers for purposes of determining the premium level the insurer will charge.

Underwriting guidelines are the standards by which the insurer makes these underwriting decisions—to accept or reject a consumer and to determine which rating tier, base rate or “market” the insurer will assign the consumer if accepted. Insurers generally compile written underwriting guidelines to provide to insurance producers (or sales representatives for direct writers) or in-house underwriters. Underwriting guidelines range from very detailed and objective written rules (i.e., limitations on insuring homes under a specified value) to broad and subjective forms of guidance for the producer or underwriter. For some lines of insurance, underwriting has become an increasingly automated process over the past 10 years. For these lines, insurers provide producers with software that incorporates the underwriting guidelines and accesses third-party data, such as credit information and claims history, as the producer gathers information from the consumer.

Although underwriting judgment is at the heart of insurers’ business practices in almost every area of insurance, there are a variety of reasons why underwriting practices differ for different lines of insurance. The more complex the risk insured, the more underwriting practices may differ from company to company and from risk to risk. The primary focus of this discussion is personal lines property/casualty coverage and, therefore, regulators must keep in mind that when considering other lines of insurance, not all of the concepts discussed here will apply. For example, annuities typically are not underwritten at all; life insurance is often written as a whole life contract or as a term contract with guaranteed renewal at a set rate for an extended period of time; and many health insurance markets are subject to laws requiring guaranteed issue, guaranteed renewal and limits on rate variation.

1. The Significance of Underwriting Guidelines

An insurer’s underwriting guidelines are one source of significant information on the insurer’s market strategies and factors affecting coverage. Often, a regulator can gain a better understanding of the overall marketplace by reviewing and comparing different insurers’ underwriting guidelines. Underwriting guidelines can be used by regulators to determine which risks insurers are accepting and which risks are being rejected. With this knowledge, regulators can better understand and react to those insurer decisions. In addition, a review of underwriting guidelines can help focus investigation and examination efforts.

Historically, underwriting decisions have been considered matters of business judgment for the marketplace to decide (subject to a few narrowly drawn antidiscrimination laws, such as prohibitions against the use of race as a factor), while rates for many lines of insurance (particularly personal lines) have been subject to close regulatory oversight. Often, this freedom from regulation has applied to the criteria for tier placement, with those criteria being considered judgment calls, rather than integral parts of the underlying rating plans. This has provided one of the incentives for some companies to develop highly evolved tier structures, in at least one case with more than 100 rating tiers. In some states, the introduction of credit scoring for rating purposes drew little notice when it was initially introduced because it was done through underwriting guidelines rather than through filed rates. More recently, similar concerns have been surfacing over the use of claim history reports. A related issue is that the line between acceptance/rejection decisions and rating decisions is not always a bright line, since groups of affiliated companies under common management will often assign different tiers of policyholders to different companies within the group, with different rating plans.

A timely review of an insurer’s amendments to its underwriting guidelines may assist regulators in the early detection of practices that could be detrimental to insurance consumers. For example, in the case of homeowner’s insurance, a review of underwriting guidelines may provide information that will assist in determining whether or not certain market segments are undervalued. In particular, underwriting guidelines that limit the availability of insurance, or of replacement cost insurance, on the basis of the age or value of the house or the ratio of value to replacement cost, may disproportionately affect homeowners in minority or inner-city neighborhoods. Inner-city neighborhoods tend to be older than suburban neighborhoods and undervalued, and frequently have a higher ratio of minority residents. For these reasons, some insurers have modified or eliminated such criteria from their underwriting guidelines.

2. Reviewing Underwriting Guidelines

Since few, if any, states routinely require the filing of underwriting guidelines, in order to conduct this review, a state regulator will more than likely have to issue a special data request and request underwriting guidelines from insurers for specific lines of insurance. A request for insurer underwriting guidelines may include the following:

- A complete copy, either paper or electronic, of a company's current underwriting guidelines for any companies writing [specify the line of business] in [state]. If there are common underwriting guidelines for several companies, please submit only one copy of those common guidelines;
- A list of all changes to the underwriting guidelines for the last three years [or other specified time period]; and
- For the purpose of this request, underwriting guidelines are defined as the rules used to determine eligibility for coverage and the assignment of customers to specific rating tiers, risk classifications or "markets."

It should be noted that many underwriting guidelines are considered trade secrets and/or proprietary in nature. A state must review its confidentiality laws before issuing this data request and, where applicable, take appropriate measures to ensure that the information will be protected in accordance with those laws and nonpublic information will not be released to the public. One approach is to appoint a custodian for underwriting guidelines who has responsibility for maintaining the documents and tracking how the information is accessed within the insurance department.

After the initial submission and review of underwriting guidelines, a state may want to ask insurers to submit significant changes in underwriting guidelines for review shortly before the new underwriting guidelines become effective. This is relevant for several reasons: to ensure that the underwriting guidelines do not conflict with the insurer's approved rating plan or other filings; to ensure that the information regulators are relying on is current; and because changes in companies' underwriting guidelines could represent a market development of interest to regulators.

3. Use of Information Obtained from Underwriting Guidelines

Not all practices are either clearly discriminatory or non-discriminatory. For those practices that raise questions, a two-step analysis may be used:

- First, is the underwriting guideline prohibited by law or regulation? Are there any "red flags," such as a clear violation of broad public policy or a factor that is an obvious proxy for some prohibited characteristic?
- Second, does the underwriting guideline serve a necessary underwriting purpose by identifying a characteristic of the consumer, vehicle or property that is demonstrably related to risk of loss and does not duplicate some other factor that has already been taken into account?

The second test typically requires insurance data sufficiently detailed to enable the analyst to perform a statistical or actuarial analysis to ascertain that the underwriting or rating factor in question does correlate with the risk of loss and to identify its unique contribution to the risk analysis. Such an analysis assists the analyst in determining whether the practice might violate the law by unfairly discriminating against consumers who do not satisfy the underwriting guideline.

It is important to remember that underwriting guidelines should not be analyzed in a vacuum. A second type of analysis that can be performed is to review these guidelines in the context of actual policies issued or declined by the company. The following are examples of the types of questions that can be asked when reviewing a policy. Did the company:

- Refuse to sell a policy;
- Charge a higher premium for the same coverage;
- Offer different payment plans to different policyholders;
- Refuse to sell a replacement value policy;
- Require higher deductibles;
- Exclude specific coverages; and/or
- Offer different benefits for the same price.

In addition, different companies' underwriting guidelines may be compared to develop an overview of some of the significant features of the market as a whole. The following table shows one way that a state may compile the information in underwriting guidelines for initial analysis. The table allows the state to quickly see what guidelines are being used by which companies constituting what share of the market.

Example of Compilation of Underwriting Guidelines for Private Passenger Auto

Company			A	B	C	D	E
Group			AA	AA	AA	BB	BB
Market Share			4.30%	2.40%	0.70%	3.30%	1.10%
Claims History	No At-Fault Claims	3 Years				×	
		5 Years					
		7 Years	×				
	1 At-Fault Claim	3 Years					×
		5 Years		×			
		7 Years					
	2 At-Fault Claims	3 Years					
		5 Years					
		7 Years					
	No Not-At-Fault Claims	3 Years				×	
		5 Years	×				
	1 Not-At-Fault Claim	3 Years		×	×		×
Prior Insurance		5 Years					
	2 Not-At-Fault Claims	3 Years					
		5 Years					
	No Prior Insurance		×	×		×	
	Prior Nonstandard		×				
	Prior Liability Limits	25/50			×		
		50/100		×			
		100/300					

Conclusion

A review of underwriting guidelines is important since their use impacts both the availability and affordability of insurance to consumers. Insurance data is critical in the review of underwriting guidelines, because the data can show whether the underwriting guideline identifies a group of consumers for whom the costs of the coverage are higher or lower than expected, or impacts one group more than another. A review of actual policies written or declined will show how the company is actually using these underwriting guidelines in the marketplace.

As more states begin to rely upon other states' regulatory functions, regulators will need to know which companies are writing what (the types of coverage, the use of endorsements); when (are certain companies writing more or less when the market is hard or soft?); where (are all markets being adequately served?); why (is a company suddenly writing a new line it has little expertise in?); and how (the various agent distribution methods, Internet sales, etc.). A review of underwriting guidelines can assist a state with answering some of these questions.

E. Modes of Analysis

Market analysis can be conducted at a variety of levels, using a variety of techniques, ranging from rigorous statistical modeling to more informal discussion and information-sharing about how to address specific market problems. These can be categorized in various ways. For example, distinctions and comparisons can be drawn between quantitative (data-driven) and qualitative (event-driven) techniques and between macro (entire markets) and micro (specific companies or issues) techniques. Below are brief overviews of a few of these approaches.

1. Analysis of General Market Conditions

Analysis of general market conditions is important in fast-changing markets, such as the health marketplace with its shifting mix of delivery systems; in markets with unique characteristics, such as reverse competitive dynamics in the credit and title industries; and in markets with a history of availability problems, such as certain liability lines or homeowners insurance in some regions. Key factors to look for include:

Competitive pricing and availability of products: These are the traditional core concerns of macroanalysis, since it is always essential to identify underserved markets and population factors and evaluate how the industry and the state can best work together to correct the situation.

New laws: Implementation of new laws, such as prompt-pay and patient protection laws, deserves special attention since passage of such laws generally indicates an important consumer protection priority.

Emerging issues: Market changes, such as the expanding use of credit reports and genetic testing in underwriting and rating, often raise new consumer protection concerns.

2. Individual Company Concerns

At the individual company level, analysis can be broadened to include a number of other factors that may serve as potential warning signs warranting further inquiry. Although some of these are unlikely to surface in any systematic way outside of an examination, others will be readily available from reported data or common knowledge in the marketplace. Indicators that have been identified include:

- Company showing rapid market share growth;
- Low premium for coverage in comparison to competitors;
- Company making requests for rate rate increases (in lines of business subject to rate regulation);
- Company implementing severe underwriting restrictions;
- Company implementing new claims payment rules;
- Company experiencing rapid growth in number of producers;
- Company hiring producers with questionable reputation or prior disciplinary history;
- Increase in consumer complaints;
- Producers targeting a specific demographic group;
- Unusual number of occurrences of replacements;
- Major reallocation of agent sales force;

- Company moving from one area of the state to another;
- Introduction of new policy types;
- Company submitting and/or using unusual policy language;
- Excessive prerequisite conditions for claim payment;
- Company getting into long-tail business hoping to build assets while waiting for lag in claims;
- Company increasingly dependent upon one producer or managing general agent (MGA);
- Agencies emphasizing production of business at the expense of sound underwriting;
- Life or health company affiliated with questionable associations or trusts;
- Company not cooperating with states on examinations or other regulatory review activities; and
- Company writing new business funded by old business.

3. Global Objectives

Although the goal of a market conduct program is often perceived narrowly as identifying issues centered on specific companies and bringing those companies into compliance, market analysis can also be an important tool in programs directed toward broader market conditions. Some examples include:

Identify underserved and noncompetitive markets: Markets are typically defined by line and by geographic location, perhaps the state or perhaps a more local unit. It is important to recognize that market operation can also be impacted by demographic factors, such as level of urbanization and income. For example, automobile insurance costs are significantly higher in high-density, low-income areas, especially when these factors are accompanied by inferior transportation infrastructures and elevated crime rates. Consequently, insurers may find such markets less attractive. Particularly for private passenger automobile and homeowners insurance, data should be collected in sufficient detail to enable regulators to adequately identify underserved or noncompetitive markets. Data should include exposure, premium and loss fields and also fields permitting identification of complainant and producer location, which can prove useful in identifying areas with a shortage of distribution channels. States may also want to monitor health coverage by geographic location, tracking both the number of insureds and the availability medical services within various regions. If data aggregated by ZIP code is available, it can easily be merged with other relevant data, such as the U.S. census and then aggregated upward to other geographic levels, such as county or metropolitan area, or by demographic characteristics, such as income. Relevant statewide data may also be compared to data from neighboring states, and market share concentrations in different lines of business within the state can be compared in order to gain insight into the relative levels of competition in those markets. In some states, detailed territorial information may be subject to trade secret protection or the state of the law may be unsettled as to whether this information can be disclosed to the public. In jurisdictions where certain market analysis information is confidential, regulators who collect such information must be careful to use it in ways that disclose only aggregate, nonconfidential information to the public.

Monitor insurers' use of territories, fire protection classifications or other geographic rating mechanisms: Although territorial rating is not inherently inappropriate for lines such as homeowners and automobile insurance, significant variations in rates are understandably controversial among the consumers who pay the higher rates. It is, therefore, essential to ensure that like risks are being treated alike and that the territories that are used have actuarial validity. In theory, competitive markets will ensure that this is the case, but it is necessary to test whether the theory is borne out by actual market conditions. Few states now have the means to adequately monitor the actuarial adequacy and fairness of territories. Existing territories may lag considerably behind changing risk characteristics associated with geographic areas. In addition, territory structure may be driven more by marketing than by risk analysis. Appropriate statistical methodologies should be developed and territories, once approved, should be re-analyzed periodically.

Identify underwriting and rating variables that may have a significant disparate impact or are proxy variables for prohibited characteristics: Some variables may serve to disproportionately deny coverage to specific geographic markets and may also lack strong actuarial justification. Data could be collected in sufficient detail to monitor the impact of specific variables across geographic areas. In some cases, a special data request may be warranted if a reasonable cause for concern exists. Existing complaint data should also be monitored for “refusal to insure,” cancellations and “premium and rating” complaints. To the extent possible, specific data regarding the reasons for such actions should be collected.

Identify patterns of market behavior adversely impacting consumers, by line, company and geographic area: Where possible, data should be geographically coded (for example, if appropriate, at the ZIP code level), so that complaints can be normalized by the number of policies at specific locations. Complaints should be analyzed by category; for example, claim handling issues (denial of claim, unsatisfactory settlement) and premium and rating issues.

Monitor geographic areas and lines of business with significant business written through residual markets: By definition, residual market placement indicates the inability to find adequate coverage in the voluntary market, so unusual residual market concentrations are a clear indicator of availability problems. Once they are found, further inquiry needs to be made into the reasons.

Analyze known problem markets to evaluate likely causes: Identify indicators that would shed light on the sources of the problems and suggest promising approaches for corrective action.

Develop data sources and methodologies that serve as triggers for further market conduct review: The value of hindsight should not be overlooked. A key component of any analytical program is validation of the results obtained, and the communication between analysts and examiners needs to run both ways. Once problem companies have been identified, data collected on those companies should be compared with baseline data for the market to see what patterns can be observed and whether these patterns suggest the development of new indicators or second thoughts about indicators currently in use.

Not for Distribution

Chapter 9—iSite+ Reports

The NAIC systems contain a variety of data related to companies and individuals operating in the insurance industry. Insurance department personnel and NAIC staff may receive access to the NAIC databases through iSite+. The reports in this chapter are confidential, for regulator use only. Several reports may require a role assignment to the regulator user's ID or specific permissions enabled in order to view and/or add report content.

In many of the reports described in this chapter, regulators can inquire about a company or individual and readily identify which applications contain information about that entity. The NAIC also provides many sources of market analysis information to state regulators. In particular, summary reports provide a variety of financial and market conduct information. Most of these reports provide information related to a group of entities with similar attributes (e.g., companies that write business in a particular state), rather than individual entities.

The following is not a list of all reports currently available on iSite+. A current, comprehensive listing of all available iSite+ reports, their descriptions and how they can be used by regulators is available in the Index of Help Topics on iSite+. To obtain a history of iSite+ updates, click on Documentation on the Welcome tab in iSite+.

Market-related reports can be categorized as follows:

1. Market applications;
2. Market analysis summary reports; and
3. Other NAIC resources

1. Market Applications

1033 State Decision Repository

The 1033 State Decision Repository (SDR) application allows regulators to enter and search for 1033 decisions, which state regulators have made for individuals who have requested to work in the business of insurance but have been prohibited to do so by Section 1033 of the Violent Crime Control and Law Enforcement Act of 1994. 1033 waivers and denials which were previously located in the Special Activities Database (SAD) were migrated to the 1033 State Decision Repository on December 1, 2016. The SAD database was no longer functional as of December 2, 2016.

Complaints Database System (CDS)

The Complaints Database System contains information about closed consumer complaints filed against insurance entities and producers. The information contained in this database may be submitted by states at varying times and should be used only as an indicator. There are four closed consumer complaint reports available for selected entities and National Producer Numbers: closed complaint counts by code, closed complaint counts by state, closed complaint trend report and closed complaint index.

Market Action Tracking System (MATS)

The Market Action Tracking System allows market conduct examiners and analysts to communicate schedules and results of examinations and other market actions. MATS allows for the calling of market conduct examinations and non-examination inquiries and market actions, in addition to providing easy access to complete information about the entities involved in the action. MATS can be used to view or update market actions for a specific entity or a number of entities. Information in MATS is maintained for both ongoing and completed market conduct actions. Market actions captured in MATS are: comprehensive examinations, targeted examinations, focused inquiries (typically inquiries made of multiple market participants), and other non-examination regulator interventions. MATS also provides notification of new and updated action information via the Personalized Information Change System (PICS).

Market Analysis Prioritization Tool (MAPT)

The Market Analysis Prioritization Tool, released in 2006, expands upon the Company Listings by creating a scoring system so companies can more easily be prioritized. MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. Key market regulation components used in MAPT vary by line of business. They include, but are not limited to: losses, expenses and premiums, enrollments, regulatory actions, complaints, examinations and demographics.

Market Analysis Review System (MARS)

MARS is available to regulators for the purposes of tracking, recording and reviewing Level 1 Analysis and Level 2 Analysis done by other states, as defined by the Market Analysis Procedures (D) Working Group. In order to submit data into MARS, a role assignment must be granted to the user's Oracle ID.

Regulatory Information Retrieval System (RIRS)

The Regulatory Information Retrieval System contains records of regulatory actions taken by participating departments of insurance against insurance producers, companies and other entities engaged in the business of insurance.

Special Activity Archive PDF

The Special Activity Archive PDF consists of SAD records—other than 1033 waivers and denials and FINRA actions—which were migrated from the Special Activities Database (SAD) as it existed on December 1, 2016, and which were less than 7 years old based upon the SAD entry date. SAD had contained information related to market activities and legal actions involving entities engaged in the business of insurance. Not all states actively participated in SAD. SAD was no longer functional as of December 2, 2016.

1033 waivers and denials which were previously located in SAD were migrated to the 1033 State Decision Repository on December 1, 2016. FINRA actions that were in SAD are available through FINRA's Broker Check public website.

NAIC staff will, on a yearly basis, remove SAD records that are more than 7 years' old and create and post an updated Special Activity Archive PDF on iSite+. Regulators are able to perform searches of the data in the Special Activity Archive PDF. The absence of data in the Special Activity Archive PDF is not conclusive information that no market activities are or have been under investigation or that no legal actions have been taken against an entity.

2. Market Analysis Summary ReportsCDS Closed Complaint Summary Index Report

The Closed Complaint Summary Index report gives the user the option to choose a grouping of U.S.-domiciled insurers filing an annual financial statement with the NAIC, with a designated line of business for a specific state(s), premium year and complaint year. Users may also choose a comparison grouping of states, if desired.

Life Policy Locator Report

The Life Policy Locator report lists details concerning consumer requests to locate and identify individual life insurance policies and annuity contracts of a deceased family member. This report is useful in determining the number of consumer requests, the number of found policies and the insurer associated with the policy.

Market Action Tracking System (MATS) Detailed Report

The Market Action Tracking System (MATS) Detailed report allows regulators to review a list of examinations and other market actions based on business practices reviewed. The report allows for searching by domiciliary state, action type, entered date, status of action, and nature of violations. The report also displays the company name, NAIC company code and line of business.

Market Analysis Market Share Report

The Market Analysis Market Share report lists the market share and premiums for the past three years for companies matching the line of business and state grouping criteria selected.

Market Analysis Profile (MAP) Demographics

The Market Analysis (MAP) demographic information is composed of data received from the various market regulation applications. This data is submitted to the NAIC with updates and when a regulatory action or closed consumer complaint is submitted. Market analysis demographics include the firm name, federal employer identification number (FEIN) and the NAIC entity number.

Market Analysis Profile (MAP) Reports

The following reports pull data from other areas within iSite+ in order to create comprehensive reports without the regulator having to manually retrieve the data from multiple locations:

- **State-Specific Premium Volume Written—5 Years:** This report is a summary of the data on the Schedule T report for a five-year period for those companies filing a property, life, health, fraternal or title annual statement. This differs from the Schedule T report under “Financial Company Search,” as those reports are national in scope and each report is for a single specified year;
- **Modified Financial Summary Profile—5 Years:** This report is similar to the profile reports available under “Financial Company Search” for the state of the user requesting the report. It is limited to those companies filing a property, life, health, fraternal or title annual statement;
- **Confirmed Complaints Index Report—5 Years:** This reports lists the index, complaint share, complaint count, U.S. market share and premiums written for the specified company for a five-year period. The complaint index report allows the user to select policy types instead of including all policy types;
- **Regulatory Actions Report—5 Years:** The Regulatory Information Retrieval System (RIRS) contains regulatory actions taken by participating departments of insurance. A summary of the RIRS information appears below the identifying demographic information. The actions are listed in reverse chronological order from the “Action Date;”
- **Closed Complaints Report—5 Years:** The closed complaints report displays the number of complaints selected for an entity or National Producer Number based on various complaint codes (e.g., type, reason and disposition). The report also displays percentages of the number of complaint records considered justified (confirmed) for the policy types and the reasons. There are percentages of the total number of complaints that each disposition type represents;
- **Closed Complaint Code Summary—5 Years:** The closed complaint code summary report displays the number of complaints selected for an entity or national producer number based on various complaint codes (type, reason and disposition). The report also displays percentages of the number of complaint records considered justified (confirmed) for the policy types and the reasons. There are percentages of the total number of complaints that each disposition type represents;

- **Market Action Exam Summary—5 Years:** The Market Action Exam summary report displays a history of examinations called through the Market Action Tracking system (MATS) for the stated company over a 5-year span;
- **Defense Costs Against Reserves—5 Years:** The defense costs against reserves report is available for property and casualty companies. It contains data from financial statements related to defense costs incurred by the company over a five-year span;
- **Resisted Claims Against Reserves—5 Years:** The resisted claims against reserves report is available for life companies. The data comes from Exhibit 8, the Life Insurance Exhibit and Schedule F. It contains a summarized table for each of the five years, as well as the percentage change from the previous year;
- **Unpaid Claims to Incurred Claims—5 Years:** The unpaid claims to incurred claims report is available for health companies. It contains data from the financial statements related to incurred and paid claims by the company over a five-year span. The data for health companies comes from the claims unpaid and claim incurred schedules on the health financial statements; and
- **Market Action Initiatives Summary—5 years:** This report provides regulators with a listing of actions where the action types were “Focused Inquiry” and “Non-Exam Regulatory Intervention” associated with the company and includes:
 - Action name;
 - Managing lead state;
 - Participating state(s);
 - Line(s) of business;
 - Trigger(s);
 - Conclusion; and
 - Action type(s).

Market Analysis Review System (MARS) Reports

The Market Analysis Review System (MARS) provides four reports to assist regulators in viewing and managing data related to market analysis reviews: the Completed Reviews report, the Market Analyst Reviews report, Reviews Automatically Deleted report and Companies with No Reviews report.

Market Analysis Tracking System (MATS) Participating States Report

The Market Analysis Tracking System (MATS) Participating States report lists by state/territory the number of open and closed actions, the most recent entry date and the total number of actions. This report is useful in determining which states/territories are actively using MATS to alert NAIC members of action calls.

Market Conduct Annual Statement (MCAS) Filing Status Report

The Market Conduct Annual Statement (MCAS) Filing Status report provides the latest status for each company's Market Conduct Annual Statement filing by state and line of business. The companies listed on this report are those doing enough business in a given state to likely meet the threshold requirements for filing.

Market Conduct Annual Statement (MCAS) Market Analysis Prioritization Tool (MAPT) Report

The Market Conduct Annual Statement (MCAS) Market Analysis Prioritization Tool (MAPT) report utilizes MCAS data and financial premium information to generate a report of company ratios and rankings. The report contains current year data values for each of the MCAS elements and ratios as well as rankings for the last three years.

Market Conduct Annual Statement (MCAS) Ratio Summary Report

The Market Conduct Annual Statement (MCAS) Ratio Summary report shows ratios at the state level for each state selected, at each of the relevant NAIC zone levels, and at the national level as well as the percentage of change between the base year and the year prior to the base year. By displaying up to three years of ratios derived from Market Conduct Annual Statement data, this report provides a way to examine trends at the various geographic levels.

Market Conduct Annual Statement (MCAS) State Ratio Distribution Report

The Market Conduct Annual Statement (MCAS) State Ratio Distribution report uses data from the Market Conduct Annual Statement to provide state ratios for each line of business. This report provides regulators with 1) a distribution of the number of companies that fall into each of twelve ranges based upon their individual ratio values; and 2) the state value that is calculated for each ratio using all the data from companies reporting in that state. The aggregated company totals are entered into the ratio formulas resulting in the state ratio value.

Market Conduct Annual Statement (MCAS) Validation Exception Summary Report

The Market Conduct Annual Statement (MCAS) Validation Exception Summary report provides a matrix of errors by company found in the Market Conduct Annual Statement filing for the selected criteria.

Market Systems Participation Report

The Market Systems Participation report displays information regarding each state's frequency, completeness and accuracy of data submissions to the NAIC's Market Systems. The report reflects information by year, for a 5 year period. A report of the number of Market Analysis Level 1 Reviews (MARS) by line of business for the current year is also included.

Regulatory Information Retrieval System (RIRS) Summary—Firms and Individuals Report

The Regulatory Information Retrieval System (RIRS) Summary—Firms and Individuals report provides a listing of entities and National Producer Numbers that have common regulatory action elements, such as the same action state, a common penalty amount range or a common date range. Separate reports for firms and individuals are available.

3. Other NAIC Resources

Personalized Information Capture System (PICS)

The Personalized Information Capture System (PICS) allows regulators to set up a customized notification system for changes to the NAIC databases. When information changes within the scope of the profile a subscriber has created, an email alert is sent. Events for which alerts are available include company name change, group code change, company status change, financial filings available, company scoring, IRIS results summary, key financial data change and Analyst Team level assignment. There are also specific events designed for market conduct, including producer loss of resident license, regulatory action for producers licensed in a state and six various events for tracking the status of examination. Also available is an alert to notify a state when a producer has applied for and been granted a resident license, when an active resident license is already reflected in the State Producer Licensing Database (SPLD).

State Producer Licensing Database (SPLD)

The State Producer Licensing Database (SPLD) is a database of state licensing and regulatory information designed to aid states with the producer licensing process. The SPLD is a facet of the National Insurance Producer Registry (NIPR), which is an affiliate of the NAIC that creates and maintains applications specific to the producer licensing process. SPLD is a regulator-only database accessible through iSite+, and is not subject to the Fair Credit Reporting Act (FCRA).

Uniform Certificate of Authority Application (UCAA) Summary Report

The Uniform Certificate of Authority Application (UCAA) Summary report lists UCAA applications that have been submitted for either licensure expansion or corporate amendments. The UCAA process is designed to allow insurers to file copies of the same application for admission in numerous states.

Specific Issuer—Schedule D Securities Summary Report

The Specific Issuer—Schedule D Securities Summary report provides a listing of all companies licensed in a specified state that own a particular security.

Statistical Reports

The NAIC produces several statistical reports that summarize many types of insurance industry data for use by regulators, educators, financial analysts, insurance industry members, lawyers and statisticians. Regulators can view an alphabetical list of all statistical reports published by the NAIC and download these reports for free from StateNet; non-regulators can purchase and download statistical reports and all NAIC publications available to non-regulators from the NAIC Store at https://www.naic.org/prod_serv_home.htm.

Chapter 10—Market Analysis Level 1 Questions

The following are the questions that are included in Level 1 Analysis in the NAIC Market Analysis Review System (MARS). Level 1 Analysis questions are subject to annual review by state insurance regulators.

Operations

1. Has there been a significant change in the contacts for the financial annual statement, officers, directors or trustees of the company as reported in the financial annual statements over the last three years?
2. Are you aware of any changes in the company's organization, management or operations that might change the way the company operates in the marketplace?
3. Has the insurer reported in its financial annual statements over the last three years that it has:
 - a. Been involved in or a party to a merger or consolidation, or;
 - b. Had any certificates of authority, licenses, or registrations (including corporate registrations, if applicable) suspended or revoked by any governmental entity, or;
 - c. Changed its state of domicile?

Financial Ratios

4. Review the company's risk-based capital (RBC) ratios and Financial Analysis Solvency Tool (FAST) scores for the last five year period to determine whether financial results may have the potential to have an adverse impact on the market conduct activities of the company.
 - a. Review RBC ratios for the last five-year period. Has the company's RBC ratio triggered any action level events or has the RBC ratio significantly declined during the period reviewed?
 - b. Review total FAST scores for the last five year period. Are there any concerns related to the total FAST score or individual scores?

Regulatory Actions

5. Review the Regulatory Actions Report—5 Years, the Substantive Regulatory Actions report and the summary information of these reports. Are there any regulatory actions reported of concern or are there concerns with any patterns in the origins of action, reasons for action, disposition etc., of the actions listed in the Regulatory Actions Report—5 Years?

Market Action Examinations

6. Review the Market Actions Summary—5 Years report and the summary information of the report.
 - a. Have there been more than three examinations entered in the last 12 months?
 - b. Identify and describe any examinations reported of substantive concern or concerns in the exam triggers, types, areas, status, etc. of the examinations listed in the Market Action Exam Summary—5 Years report?

Market Action Initiatives

7. Review the Market Action Initiative Summary—5 Years report and the summary information of the report. Identify and describe any initiatives reported of substantive concern or any concerns with patterns in the lines of business, triggers, action types, conclusions, etc., of the initiatives listed in the Market Action Initiative Summary—5 Years report.

Premiums

P&C Statement Blank

8. Review the company's direct written premium reported on a national and state basis.
 - a. Has the company's direct written premium in any one jurisdiction increased or decreased by more than 33% in any single year during the last five years?
 - b. For the state under review, has the company's direct written premium for any of the top five lines of business increased or decreased by more than 33% in any single year during the last five years?
 - c. For the state under review, has the company's direct written premium for the line(s) of business under review increased or decreased by more than 33% in any single year during the last five years?

Life, Accident & Health Statement Blank (when performing a Level 1 Analysis on companies writing long-term care, review earned premium)

8. Review the company's direct business reported on a national and state basis.
 - a. Has the company's direct business for any line of business in any one jurisdiction increased or decreased by more than 33% in any single year during the last five years?
 - b. For the state under review, have the company's direct premiums and/or annuity consideration for any of the top five lines of business increased or decreased by more than 33% in any single year during the last five years?
 - c. For the state under review, have the company's direct premiums and/or annuity considerations for the line(s) of business under review increased or decreased by more than 33% in any single year during the last five years?

Health Blank

8. Review the company's direct business reported on a national and state basis.
 - a. Has the company's direct business for any line of business in any one jurisdiction increased or decreased by more than 33% in any single year during the last five years?
 - b. For the state under review, have the company's premiums written for any of the top five lines of business increased or decreased by more than 33% in any single year during the last five years?
 - c. For the state under review, have the company's premium written for the line(s) of business under review increased or decreased by more than 33% in any single year during the last five years?

U.S. Market Share

9. Review the company's U.S. market share information for the state under review over the last five years. Has there been a significant change in the company's U.S. market share for the line(s) of business under review over the last five years?

Loss and Expense Ratios

P&C Statement Blank

10. Review the company's loss and expense ratio information on a national and state-specific basis for the line(s) of business under review for the last five years.
 - a. For the line(s) of business under review in all jurisdictions, are the loss and expense ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's loss ratios?
 - b. For the state and line(s) of business under review, are the loss and expense ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's loss ratios?

Life, Accident & Health Statement Blank

10. For individual and group accident and health, review the company's loss and expense ratio information on a national and state-specific basis for the last five years.
- For the line(s) of business under review in all jurisdictions, are the loss and expense ratios for the company unusually high or low as compared to the industry trends averages or are there any unusual trends in the company's loss ratios?
 - For the state and line(s) of business under review, are the loss and expense ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's loss ratios?

Health Blank

10. Review the company's loss, administrative expense and combined ratio information on a national and state-specific basis for the last five years.
- For all jurisdictions, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?
 - For the state under review, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?
 - For the line(s) of business under review, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?
 - For the state and line(s) of business under review, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?

Resisted or Unpaid ClaimsP&C Statement Blank

11. Review the premium written, direct defense and cost containment expenses paid, direct losses incurred and industry averages for the last five years on a national and state-specific basis.
- On a national basis, are the direct defense and cost containment expenses paid unusually high when measured against premium volume and industry averages or are there any unusual patterns with the direct defense and cost containment expenses paid and direct losses incurred?
 - On a state-specific basis, are the direct defense and cost containment expenses paid unusually high when measured against premium volume and industry averages, or are there any unusual patterns with the direct defense and cost containment expenses paid and direct losses incurred?

Life, Accident & Health Statement Blank

11. Review the summary information related to resisted claims for the last five years.
- On a national basis, are there any unusual patterns in the amount of resisted claims compared to the total claims for either the entire body of business or an individual line(s) of business?
 - For those claims disposed of or resisted during the current year, are there any unusual patterns in the state of residence of the claimant?
 - For those claims disposed of or resisted during the current year, are there any unusual patterns regarding the reason claims were compromised or resisted?

Health Blank

11. Review the unpaid claims information for the company over the last five years. Are there any significant changes in the average number of days of unpaid claims, claims unpaid, claims incurred or the unpaid claims to incurred claims expense ratio over the last five years?

Complaints

12. Review the company's complaint data:
 - a. Has there been a significant change in the CONFIRMED complaint index for the current year plus four years?
 - b. Has there been a significant change in the COMPLETE complaint index for the current year plus four years?
 - c. Review the Closed Complaint By Code—5 Year report and the Summary of the Closed Complaint By Code—5 Year report. Are there any areas of concern noted in these reports?

Market Conduct Annual Statement

13. Does your state participate in the Market Conduct Annual Statement?

If yes, did the company file a Market Conduct Annual Statement for the data year under review?

 - a. Review the ratio and rank results at the state level for the state being reviewed. According to this review, does the company have any areas of concern?

If yes, in what areas are the ratios and/or rankings of concern?
 - b. Review the ratio and rank results at the national level. According to this review, does the company have any areas of concern?

If yes, in what areas are the ratios and/or rankings of concern?
 - c. Review the company ratio results by coverage type and compare them with the state ratio results by coverage type. Are there any coverage types that show particular concern?

If yes, what are the coverage types of concern?
 - d. Does any of the company data indicate a trend that causes concern?
 - e. Was the company identified as an "outlier" through analysis of the Market Conduct Annual Statement data?

If yes, in which line(s) of business is the company considered an outlier?

Conclusion

14. What is your recommended next step?
 - Incomplete review
 - Direct contact with the company is scheduled
 - Investigation is scheduled
 - Examination is scheduled
 - Enforcement action is scheduled
 - We will contact the Collaborative Action Designee (CAD) of other states with similar concerns regarding possible collaborative activity
 - We will proceed with another option on the continuum of market actions (if known, please explain the option to be used along with the rationale description)
 - No further analysis is necessary
 - No further analysis this year, but review again next year
 - Level 2 Analysis is scheduled

Chapter 11—Level 2 Analysis Guide

The Level 2 Analysis Guide is a guide to assist market analysts in performing a Level 2 Analysis of a specific company. The Guide consists of 2 sections, Core Areas of Review and Additional Areas of Review. The core areas of review are required for every Level 2 Analysis of a company unless there is a valid reason not to review a particular area. The number and specific additional areas reviewed during a Level 2 Analysis of a company will be dependent on many different factors, such as the line of business under review, the areas of concern identified during earlier analysis, the rules and regulations of the jurisdiction performing the analysis and the company itself.

Prior to beginning any additional areas of review, the analyst should identify which of the additional areas of the Level 2 Analysis Guide should be completed based on the specific situation of the company under review and the areas of concern identified via other levels of review. Identification of these key areas prior to starting the review of any additional areas will help the analyst focus on the areas of concern and assist in obtaining and reviewing the information necessary to complete a Level 2 Analysis.

During the course of completing a Level 2 Analysis of a company, the analyst may find information that requires the review of one or more areas not initially selected for review. If this happens, the analyst should expand the scope of the Level 2 Analysis to include those areas of review not previously identified. The analyst may also want to do a Level 2 Analysis on related companies (companies under the same management or ownership) if the areas of concern for the company under review have the potential to be present in the related company.

Note: It is important for the analyst to be familiar with the line of business under review and the marketplace within the analyst's state. The analyst should also be familiar with the rules/regulations applicable to the line of business under review, including any recent legislative changes that might affect the company's operations. The analyst may want to review the applicable rules/regulations and general marketplace information for the line of business under review before beginning a Level 2 Analysis.

In 2006, the Level 2 Analysis Ad Hoc Technical Group recommended automation of the Level 2 Analysis process. The automation of Level 2 Analysis was placed into production in the MARCS system in December of 2008.

Core Areas of Review

Six core areas should be reviewed for each Level 2 Analysis done on a company unless there is a valid reason why a review of the area is not warranted. The six core areas of review are:

1. Consumer complaints;
2. Continuum activity;
3. Examinations;
4. Interdepartmental communications;
5. Market analysis; and
6. Regulatory actions.

For each core area of review, the following provides the analyst with information about the area to be reviewed, where applicable potential resources to aid in the review of the area and specific items to consider during the review of the area.

Area of Review:	Consumer Complaints
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Suggested Review

A detailed analysis of actual complaints filed with the insurance department by consumers against a company can provide valuable information about the company and its business practices. It can also help pinpoint specific areas of concern that may be having an adverse impact on consumers.

The analyst should review summary information about consumer complaints against the company for the line of business under review for both the analyst's state and other states. In addition, the analyst should also review the complaint file itself for the complaints filed in the analyst's state for line of business under review.

In cases where the complaint volume is significant, internal system reports can assist in identifying specific complaint reasons that appear to be problematic. This should help the analyst to focus on reviewing only those complaints that appear to stem from areas of concern.

For example, if a company received 1,000 complaints over the last year for the line of business under review, it may not be possible to review all of the complaints. If a review of an internal system report summarizing the complaint reasons indicates that the most material area of concern is claim delays, the analyst may want to focus specifically on those complaints that involve allegations of claim delays.

If it is not practical to review all of the complaints against the company for the line of business under review even after narrowing the scope of complaints, the analyst may review a random sample of the complaints filed against the company, or a random sample of the specific type of complaint.

Note: Not all states currently produce summary reports that will allow the analyst to complete some of the suggested review items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing summary information regarding consumer complaints that involve the company for the line of business under review, the following items should be considered:

1. Are there trends in particular areas of noncompliance, number of complaints, the origin of the complaints or areas of consumer concern? For example, are there any patterns in who is complaining, the geographic origin (zip code/county) of the complaints, the reasons for the complaints, whom the complaints are about, or the outcome of the complaints?
2. Does the data on iSite+ for other states indicate similar patterns of noncompliance, number of complaints or areas of consumer concern?
3. How long has any pattern or trend been occurring?
4. Are there any regulatory actions or market conduct examination findings in the analyst's or other states related to similar complaint patterns? If yes, has the company been advised to correct the situation and has it reportedly done so?
5. Do the complaint patterns align with the industry norms for the line of business under review? For example, if 30% of the complaints received by the insurance department for the line of business under review are usually claims related, one would expect that the company's ratio would be similar to the rest of the industry.

In reviewing specific complaints that involve the company regarding the line of business under review, the following items should be considered:

1. Are there complaints of a specific nature related to a growing area of concern in the market (i.e. credit; mold; underground storage tanks) even if the company is compliant with the laws?
2. Are there problems with specific vendors, adjusters, other company personnel, producers, providers, networks or business segments?
3. How quickly and completely does the company respond to a complaint?
4. Are there complaints that involve a specific business practice of the company that may be technically compliant with the laws but a questionable business practice?
5. Are there consumer complaints that involve a previously identified issue that the company has been ordered to or agreed to correct? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Area of Review:	Continuum Activity
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Suggested Review

Insurance regulators have a broad continuum of market actions available to them when determining the appropriate regulatory response to an identified issue or concern. The continuum of market actions includes such initiatives as office-based information gathering, interview with the company, correspondence, policy and procedure reviews, interrogatories, desk audits, on-site audits, investigations, enforcement actions, company self-audits and voluntary compliance programs.

The NAIC Market Action Tracking System (MATS) database is used to track both market conduct examinations and other significant market conduct actions not tracked in the Regulatory Information Retrieval System (RIRS). A review of the non-examination initiatives (focused inquiries and other non-examination regulatory intervention) related to the company contained in MATS may provide the analyst with useful information about the company.

The analyst may also find it helpful to contact the originating state of a MATS initiative related to the company to discuss the initiative in detail. However, the decision to contact a state directly to discuss a specific initiative is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing a summary of non-examination initiatives involving the company, the following items should be considered:

1. Are there a high number of MATS actions involving the company? If yes, are the majority of the initiatives originating from just a few states, or are the initiatives spread across the states in which the company does business?
2. Have the number of market actions increased, decreased or remained the same over the last 5 years?
3. How old are the majority of the initiatives? Have the initiatives been concluded within the past 3 years?
4. Are the reasons for the initiatives similar? Are there any patterns of concern in the reason for the initiatives?
5. Are the dispositions of the initiatives similar? Are there any patterns of concern in the dispositions of the initiatives?

In reviewing an individual initiative involving the company (whether the initiative has been finalized or is pending), the following items should be considered:

1. How old is the specific initiative? Was it concluded within the past 3 years?
2. Are the functional areas and/or line(s) of business currently under review covered under the subject of the initiative?
3. Does the initiative identify issues that are similar to the areas of concern currently under review?

4. Could the issues related to the initiative also manifest themselves in the analyst's state and/or the line of business or functional areas currently under review?
5. To what extent would the issues contained in the initiative have an affect on the consumers in the analyst's state (consider statutes, codes, Unfair Trade Practices Act, Unfair Claims Settlement Practices Act, etc.)?
6. Are the issues contained in the initiative considered "repeat" issues in either the analyst's state or other states (i.e., was the company cited previously for violations related to the issues)?
7. Are the issues involved with the initiative isolated occurrences, or systemic in nature and likely to affect an entire class of business and/or consumers in the analyst's state?
8. Are there any regulatory actions or market conduct examination findings in the analyst's or other states similar to the issues involved with the initiative? If yes, has the company been advised to correct the situation and has it reportedly done so?
9. Was the company required to implement a remedial action plan or take other corrective measures as a result of the initiative that might address issues that have a potential impact on consumers in the analyst's state? If so, has the company reportedly implemented the action plan or reportedly taken the necessary corrective measures?
10. Was the company required to refund restitution and/or interest because of the initiative? If yes, is the amount a concern?
11. For issues that may have a direct impact on consumers in the analyst's state, does the company response appear to adequately address the areas of concern?
12. Has the analyst's state received consumer complaints regarding the subject of the initiative? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Area of Review:	Examinations
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Suggested Review

Examination reports that include a market conduct component and the company response to the examination reports can be valuable sources of information about a company. By reviewing the reports and the company's response, the analyst may be able to identify specific issues found during an examination that have the potential to have an adverse impact on the consumers in the analyst's state. The analyst may also discover that a situation has already been corrected by the company as a result of the examination and therefore may not present an issue in the analyst's state that requires further investigation.

Review the history of the examinations called on the company over the last five years. When readily available, review the most recent examination reports of the company and any company response to the report for examinations done by:

1. Analyst's insurance department; and
2. Other state insurance departments.

In addition to reviewing recent examination reports, it may also be helpful to contact the market conduct area of the insurance department that conducted the examination should a review of an examination report raise concern regarding the company's operations in the analyst's state.

The analyst should also review information about examinations that are pending within the insurance department. It may also be helpful for the analyst to contact other states with pending examinations to discuss the examinations.

Information about examinations called on the company is available via the NAIC Market Action Tracking System (MATS) accessible on iSite. The MATS Detailed Report provides a history of examinations called through MATS for the company under review over a five-year period. It is important to note that MATS is an essential resource for market regulators and states should ensure its high quality by taking care to accurately record all

examinations. Analysts however, should not rely solely on the MATS reports, as the potential exists that all examinations and any related actions might not be recorded in MATS for a variety of reasons. The analyst may find it helpful to:

1. Cross check the MATS Detailed Report with the RIRS Action Report; and/or
2. Check individual state insurance department websites for recent examinations.

Examination reports and any company response may be posted on iSite+, available on the website of the examining state insurance department or in the company files of the analyst's insurance department. If an examination report is not readily available, the analyst may be able to obtain a copy of the examination report by contacting the state that did the examination. However, the decision to contact a state directly to obtain or discuss a specific examination report is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing a summary of examinations that involve the company, the following items should be considered:

1. Are there a high number of market examinations? If yes, are the majority of the examinations originating from just a few states? Or are the examinations spread across the states in which the company does business?
2. Have the number of examinations increased, decreased or remained the same over the last 5 years?
3. How many of the examinations were conducted within the past 3 years?
4. Are the examination triggers (statutory, complaints, market share analysis, etc.) similar? Are there any patterns of concern in the examination triggers?
5. Are the lines of business covered by the examinations the same or different?
6. Are the types of examinations (comprehensive, targeted, etc.) similar?
7. How many of the market examinations are currently open? How many are closed? How many were closed with an order? How many were closed with an order and fine?

In reviewing an individual examination report and the company response or a pending examination, the following items should be considered where applicable:

1. How old is the examination/report? Was the examination conducted within the past 3 years?
2. Are the functional areas and line(s) of business under review covered in the examination/report?
3. Could the findings of the examination also manifest themselves in the analyst's state and/or the line of business or functional areas under review?
4. To what extent would the violations contained in the examination report have an affect on the consumers in the analyst's state (consider statutes, codes, Unfair Trade Practices Act, Unfair Claims Settlement Practices Act, etc.)?
5. Are the violations contained in the examination report considered to be "repeat" violations in either the analyst's state or another state (i.e., was the company cited previously for the violations)?
6. Are the violations isolated occurrences, or systemic in nature and likely to affect an entire class of business? Could the cause of the violations have implications that would affect consumers in the analyst's state?
7. Did the examination report include discussion of any non-violation business practices of concern?
8. Does the examination require the company to implement a remedial action plan or take other corrective measures that might address issues that have a potential impact on consumers in the analyst's state? If yes, has the company reportedly implemented the action plan or taken the necessary corrective measures addressed?
9. Was a monetary penalty imposed on the company as a result of the examination? If yes, is the size of the penalty a concern?

10. For issues that may have a direct impact on consumers in the analyst's state, does the company response appear to adequately address the cited violations and/or areas of concern?
11. Was the company required to refund restitution and/or interest as a result of the examination? If yes, is the amount a concern?
12. Has the analyst's state received consumer complaints related to the findings of the examination? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Area of Review:	Interdepartmental Communications
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Suggested Review

One of the 3 basic mechanisms for gathering information described within the *Market Regulation Handbook* is the analysis of existing information that insurance departments already collect. The best way of doing this is to survey and communicate with other units through a "Systematic Interdepartmental Communication Program" as outlined in the *Market Regulation Handbook*. This should be a process of formalizing and improving the communication between the analyst and other work units within the insurance department.

A discussion of the companies selected for a Level 2 Analysis should be included during intradepartmental meetings. However, because the timing of regularly scheduled interdepartmental meetings may not be conducive to the timely completion of a Level 2 Analysis, the analyst may want to contact other insurance departments individually in between the regularly scheduled meetings regarding a specific company.

Establishing a 'best practice' to notify other areas of companies selected for a Level 2 Analysis is highly recommended. States may find it helpful to notify all other units about companies selected for Level 2 Analysis and solicit information and documentation from these other units. In addition, other work units should be encouraged to initiate communication regularly about any other companies or issues they may have about a company as the issues/concerns arise.

Note: A substantial amount of information will already be gathered by other areas of review for the Level 2 Analysis. The intent of this section is to capture information that is not already being collected in other areas of review.

Examples of sources of interdepartmental information not specifically outlined in other areas of the guide include, but are not limited to:

1. Meetings with companies: Other sections of the insurance department may have meetings with companies that the analyst may not be aware of. These meetings may be related to the introduction of a new product, withdrawal from a line of business or geographical area within the analyst's state, a systems problem, or other possible noncompliant areas;
2. Correspondence from companies: Other sections of the insurance department may periodically receive correspondence from companies informing them of new products, marketing changes, discovery of noncompliance in a certain area, etc.;
3. Outreach program(s): Some insurance departments have specific outreach employees who meet with other government agencies (e.g., SUIP) regarding insurance matters or attend consumer outreach programs. These individuals may include staff from the consumer services area or the public information office. Because of their interaction with other agencies and consumers, these individuals may be a valuable source of information about the general market and specific companies; and
4. Other types of consumer requests: Certain inquiries and/or grievances may not be handled by the area that handles consumer complaints (e.g., health care appeals or prompt-pay/provider grievances). Information regarding these areas may need to be gathered from other work units.

Specific Items to Look For

In reviewing the interdepartmental communication section, the following items should be considered:

1. Meetings with companies: Has the section met with the company? If so, was the meeting requested by the company or the section? What was the purpose for and outcome of the meeting?
2. Correspondence from companies: Has the section received correspondence from the company notifying it of substantial changes that may have potential impact on the consumers in the analyst's state? If so, what markets are affected and how will these markets be affected?
3. Outreach program(s):
 - a. Have the "outreach" program employees met with any other governmental agencies regarding insurance matters? If so, what was the nature of the meeting? What companies or market(s) are affected?
 - b. Have the "outreach" program employees met with any insurance consumer groups? If so, what was the nature of the meeting? What companies or market(s) were affected?
 - c. Have the "outreach" program employees received a high volume of calls related to a particular insurance company or issue? If so, what was the nature and outcome of the calls?
4. Other types of consumer requests:
 - a. Have there been a high number of provider grievances or prompt-pay complaints received against this company? If so, what was the resolution of the grievances?
 - b. Have there been any health care appeals received against this company? Of the health care appeals received, 1) how many were upheld in favor of the insurance company, 2) how many were overturned in favor of the consumer, or 3) how many remain pending?

Area of Review:	Market Analysis
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Suggested Review

Companies doing business in multiple states may have similar issues arise in those states. As such, the analyst may not be the first analyst to identify potential issues with a company. Reviewing any recent Level 1 Analysis completed by the analyst's insurance department and/or another state for the company under review may provide the analyst with additional information and/or insight related to the analyst's Level 2 Analysis.

An analyst may find it useful to review the Baseline Analysis results (available since summer 2006) for the line of business under review before reviewing any Level 1 or Level 2 Analysis of the company. A review of the Baseline Analysis results may allow the analyst to gain an understanding of how the various measures contained in this prioritization tool for the company compare to the other companies writing business in the state.

When a state similar to the analyst's own has not performed a recent Level 1 Analysis of the company, the analyst may find it useful to conduct a Level 1 Analysis of the company using the company's data for that state.

In addition, the analyst may find it helpful to contact a particular state regarding a recently completed Level 1 Analysis and/or Level 2 Analysis recently completed for the company. However, the decision to contact another state directly to discuss a specific analysis is at the discretion of the state performing the Level 2 Analysis.

Note: Level 1 Analyses completed on specific companies are available in the Market Analysis Review System (MARS), which can be accessed on iSIRI. Access to MARS is restricted to those people authorized by the individual insurance departments. If the analyst does not currently have access to MARS, the analyst must follow his/her insurance department's internal procedures for obtaining proper authority to access MARS.

Specific Items to Look For

In reviewing the Level 1 Analysis completed by the analyst's insurance department, another state, the analyst's own Level 1 Analysis of the company's data for a similar state, or a Level 2 Analysis completed by another state, the following items should be considered:

1. Does the analysis cover the same line of business of currently under review?
2. Does the analysis identify any significant issues that could have implications in the analyst's state? If yes, consider referring to the Market Actions (D) Working Group.
3. Does the analysis identify issues that are similar to the areas of concern currently under review?

Area of Review:	Regulatory Actions
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Suggested Review

Regulatory actions taken against a company can provide a great deal of information about a company. It is important to note, that a prior regulatory action in and of itself does not necessarily mean that the company is currently doing anything wrong. However, reviewing information about specific actions taken against the company, may allow the analyst to identify specific issues that may have the potential to have an adverse impact on the consumers in the analyst's state. The analyst could also discover that the company as a result of the action in another state may have already addressed an area of concern identified by his/her analysis.

Review the history of the regulatory actions taken against the company over the last five years. When readily available, review the details of recent regulatory actions taken against the company by:

1. The analyst's insurance department; and
2. Other state departments.

In addition to reviewing the regulatory actions, it may also be helpful to contact the enforcement area of the department that took the action should a review of an action raise concern regarding the company's operations in the analyst's state.

The analyst should also review information about enforcement actions that are pending within the insurance department and are therefore, not yet recorded in RIRS.

Information about finalized regulatory actions is available via the NAIC Regulatory Information Retrieval System (RIRS) accessible on iSite+. RIRS tracks adjudicated regulatory actions against companies, producers and agencies reported to the NAIC by the state that took the action. RIRS provides a 5-year history of information on regulatory actions against companies including the origin, reason, and disposition of the regulatory action.

It is important to note that RIRS is an essential resource for market regulators and states should ensure its high quality by taking care to accurately report all actions. Analysts however, should not rely solely on the RIRS reports, as the potential exists that all adjudicated actions may not be recorded in RIRS for variety of reasons. The analyst may find it helpful to:

1. Cross check the RIRS Action Report with the MAFS Detailed Report; and/or
2. Check individual state insurance department websites for recent actions.

More detailed information about each regulatory action, such as a copy of the order issued by the state, may also be available on the website of the state insurance department that took the action or in the company files of the analyst's insurance department. If information about a regulatory action is not readily available, the analyst may be able to obtain information about the action by contacting the state that took the action. However, the decision to contact a state directly to obtain or discuss a specific regulatory action is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing the 5-year summary report of regulatory actions against the company, the following items should be considered:

1. Are there a high number of RIRS actions against the company? If yes, are the majority of the actions originating from just a few states? Or are the actions spread across the states in which the company does business?
2. Have the number of regulatory actions increased, decreased or remained the same over the last 5 years?
3. How old are the majority of the regulatory actions? Have a higher percentage of the regulatory actions been concluded within the past 3 years?
4. Are the origins of the regulatory actions similar? Are there any patterns of concern in the origins of the actions?
5. Are the reasons for the actions similar? Are there any patterns of concern in the reason for the actions?

In reviewing an individual regulatory action against the company (whether the action has been finalized or is pending), the following items should be considered:

1. How old is the specific regulatory action? Was it concluded within the past 3 years?
2. Are the functional areas and/or line(s) of business under review covered under the subject of the regulatory action?
3. Could the findings of the regulatory action also manifest themselves in the analyst's state and/or the line of business or functional areas being researched?
4. To what extent would the violations contained in the regulatory action have an affect on the consumers in the analyst's state (consider statutes, codes, Unfair Trade Practices Act, Unfair Claims Settlement Practices Act, etc)?
5. Are the violations contained in the regulatory action considered to be "repeat" violations in either the analyst's state or other states (i.e., was the company cited previously for the violations)?
6. Are the violations isolated occurrences, or systemic in nature and likely to affect an entire class of business? Could the cause of the violations have implications that would affect consumers in the analyst's state?
7. Does the regulatory action require the company to implement a remedial action plan or take other corrective measures that might address issues that have a potential impact on consumers in the analyst's state? If yes, has the company reportedly implemented the action plan or reportedly taken the necessary corrective measures?
8. Was a monetary penalty imposed on the company as a result of the regulatory action? If yes, is the amount of penalty a concern?
9. Was the company required to refund restitution and/or interest as a result of the regulatory action? If yes, is the amount a concern?
10. For issues that may have a direct impact on consumers in the analyst's state, does the company response appear to adequately address the cited violations and/or areas of concern?
11. Has the analyst's state received consumer complaints regarding the subject of the regulatory action? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Additional Areas for Review

For a Level 2 Analysis, any areas of additional review done by the analyst of a specific company will be dependent on many different factors, such as the line of business under review, the areas of concern identified during earlier analysis, the rules and regulations of the jurisdiction performing the analysis and the company itself.

The additional areas of review are:

1. Insurance Department Filings (Rates, Rules, Policy Forms, and/or Underwriting Manuals);
2. Dispute Resolution Activity;
3. Financial Analysis;
4. Financial Rating Agencies;
5. Geographic Analysis;
6. Human Resource Department;
7. Internet/World Wide Web;
8. Legal Information;
9. NAIC Bulletin Boards;
10. Other Governmental and Quasi-Governmental Agencies;
11. Producer Licensing;
12. State-Mandated Items (Reports, Data Requests, Surveys and Exhibits);
13. Trade Publications and Other Media Sources; and
14. Voluntary Accreditation/Certification Programs

For each additional area of review, the following provides the analyst with information about the area to be reviewed, where applicable potential resources to aid in the review of the area and specific items to consider during the review of the area.

Area of Review:	Insurance Department Filings (Rates, Rules, Policy Forms, and/or Underwriting Manuals)
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Suggested Review

Many states require companies to file and sometimes receive prior approval of rates, rules, underwriting manuals and/or policy forms before the company can use these items. For those states that have such filing requirements, a review of the information on file with the insurance department can provide valuable information about the company and its marketing strategies.

It is important for the analyst to know the filing requirements that apply to the rates, rules, underwriting guidelines and/or policy forms (e.g., file & use; prior approval, etc.) for the line of business under review before beginning the review of this area. In addition, the analyst should be familiar with any laws specific to the line of business under review that would affect the company's filings.

For those states that have filing requirements, the analyst may need to review the various filings on file with the insurance department. For those states that have prior approval requirements, the analyst should talk with the rate/form analysts involved regarding any concerns he/she may have about the company and/or its filings.

Note: Not all states currently produce summary reports that will allow the analyst to complete some of the suggested review items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing information about the filing activity for the company, the following items should be considered:

1. Has there been a significant change in the number and/or types of filings being made by the company over the last 3 years? A change in the volume or types of filings may indicate a change in the marketing focus of the company.
2. Has the company made any filings within the past 3 years that would indicate a substantial change in marketing practice/focus of the company?
3. Are there an unusually high number of filings rejected and/or questioned by the rate/form analysts? A high number of rejected/questioned filings may be an indication of the company's attitude toward compliance and how well it keeps up to date on compliance issues.

4. Is there a lack of filing activity by the company over the last 3 years where the marketplace for the line of business under review is currently experiencing change? A lack of filing activity may be an indication that the company is not keeping its filings up-to-date or keeping up with changes in the marketplace.
5. Are there filings currently under review for this line or with the company overall? If yes, does the rate/form analyst or analysts reviewing the filings have any specific concerns about the pending filings?
6. Are there any pending filings related to a growing area of concern in the market (e.g., use of credit in underwriting/rating, coverage for mold, etc.)?
7. Are there consumer complaints related to the filings (specifically any evidence that the company is not complying with filed rates, forms or utilizing appropriate guidelines to cancel or nonrenew coverage, etc.)?
8. Are there any regulatory actions or market conduct examination findings of concern, in the analyst's or other states related to the company's filings?
9. Are any areas of concern identified through Level 1 Analysis problematic in the company's filings?
 - a. Rates: Do any of the recent filings by the company contain rate increases or decreases that are not in line with the industry average or current norms for the line of business under review? Is the company requesting rate increases or decreases for a specific territory or block of business that could be a source of concern for the line of business under review?
 - b. Underwriting manuals: Do the procedures/provisions of the company's underwriting manual comply with the laws applicable to the line of business under review?
 - c. Policy forms: Has the company made any recent filings that introduce new or unusual policy language (including any language that may be unusually restrictive) that could be a source of concern for the line of business under review?

Area of Review:	Dispute Resolution Activity
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Suggested Review

Many states have formal dispute resolution processes (such as external reviews by independent review organizations or IROs) available to its consumers to assist in resolving insurance issues. These formal dispute resolution processes are those processes in addition to any complaint resolution process available to the consumer via the insurance department. A review of the information related to the use of these formal resolution processes by consumers of the analyst's state that involve the company can provide valuable information about the company's business practices.

Note: Not all states currently produce summary reports that will allow the analyst to complete some of the suggested review items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing information about the activity of the company in any dispute resolution process available within the analyst's state, the following items should be considered:

1. Has there been a sharp increase or decrease in the number of cases filed against the company?
2. Are there any trends of concern in the nature of the appeals involving the company going through the dispute resolution processes?
3. How does the number of cases against the company compare to the industry averages or with the number of cases against companies of similar premium volume, lives insured and/or market segment?
4. Are resolutions available and if so, does the company have a high number of adverse decisions compared to the industry average or with the number of adverse decision for companies of similar premium volume, lives insured and/or market segment?
5. For managed care plans where the company is required to file a grievance report with the state, do the patterns in the number of reviews requested move in the same direction as the number of grievances received?

Area of Review:	Financial Analysis
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Suggested Review

There may be a correlation between significant financial risk for a company and a firm's market behavior. Currently, the relationship between financial indicators and market behavior has not been studied in any rigorous or scientific way. Analysts should therefore exercise caution when interpreting financial ratios. Analysts should seek the counsel of a financial analyst in those instances where summary ratios indicate financial stress, to determine what, if any, implications for market behavior might be indicated.

Numerous summary financial ratios and other financial information are available on iSite+. This information includes:

1. Analyst Team Summary Report;
2. Handbook Summary (last annual and most recent quarterly summary);
3. Financial Analysis Solvency Tools (FAST);
 - a. Annual/Quarterly Scoring System—Summary Totals Report;
 - b. Company Profile Report; and
 - c. Insurance Regulatory Information System (IRIS) Ratios
4. Information Systems Questionnaire (ISQ);
5. Analyst Team Summary Report; and
6. Company Summary Report (if further detailed information is required).

Analysts not trained in financial analysis should not attempt to formulate conclusions about the financial state of a company on their own. After reviewing the summary indicators and ratios, an expert within an insurance department's financial division should be consulted. If it appears that a company is financially stressed, the analyst should formulate specific and explicit conclusions about how a specific form of financial impairment might impact market behavior. When formulating such conclusions, the financial data should be interpreted within the context of all other available market-related information.

Analysts should, however, have some familiarity with the basic financial surveillance tools. The following resources for the appropriate line of business are available from the NAIC website (StateNet/NAIC Publications Online/Financial Analysis and Receivership):

1. *Financial Analysis Handbook*;
2. *NAIC Scoring System*; and
3. *Using the Insurance Regulatory Information System*.

Specific Items to Look For

In reviewing financial information for the company, the following items should be considered:

1. Analyst team summary report: Has the company been designated Level A (highest priority) or B (elevated priority)?
2. Handbook summary: Did the handbook summary report return a high number of "yes" responses for any one area, or in total? If so, what areas of possible concern were identified (categories are those of the *Financial Analysis Handbook* checklists)?
3. Annual/Quarterly scoring system summary: Did the annual or quarterly summary report ratios indicate areas of financial stress? If so, which ones (for P&C, for example, RBC, Profitability, Leverage, Asset & Liquidity (A&L) or Miss)?
4. ISQ: Did the ISQ reveal any vulnerabilities or systemic IS problems that might have implications for policyholders or claimants? If yes, what areas of possible concern were identified?
5. IRIS ratios: Are areas of financial stress indicated by IRIS ratio outliers? If yes, what areas (e.g., P&C—Overall, Profitability, Liquidity and Reserves)?
6. Is there a pattern demonstrated by the financial data that would raise concern for market behavior? If so, in what way? Document overall conclusion.

Area of Review:	Financial Rating Agencies
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Suggested Review

It is common for a company's compliance and/or marketing strategies to change when there is a change in the company's rating by one or more of the five principal rating agencies. The analyst should review the company's financial rating from one or more of the main financial rating agencies to determine if there is a possible correlation between the company's rating and market regulatory practices.

Review rating history for the last five years and the most current analysis of the company provided by one or more of the following financial rating agencies:

1. **A.M. Best Company:** The A.M. Best Company has been rating insurance companies since 1900. The objective of A.M. Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Ratings are available at www.ambest.com;
2. **Fitch Ratings:** Fitch Ratings was founded as the Fitch Publishing Company in 1913. Fitch's rating evaluations are qualitative and quantitative and provide two basic types of ratings—insurer financial strength ratings and issuer and fixed income security ratings. Fitch Ratings are available at www.fitchratings.com;
3. **Moody's Investors Service:** Moody's Investors Service was founded in 1900. Moody's insurance financial strength ratings reflect its opinion as to an insurer's ability to discharge senior policyholder claims and obligations. Ratings are available at www.moody's.com;
4. **Standard & Poor's:** Standard & Poor's has been rating bonds since 1923 and insurance companies' claims-paying ability since 1983. Standard & Poor's claims-paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policyholder obligations in accordance with its terms. Ratings are available at www.standardandpoors.com; and
5. **Weiss Ratings, LLC** (formerly TheStreet.com): In 2006, Weiss Group sold Weiss Ratings to TheStreet.com. In 2010, TheStreet.com sold the insurance and bank ratings back to the Weiss Group. Weiss' financial strength rating indicates its opinion regarding an insurer's ability to meet its commitments to its policyholders under current economic conditions. Ratings are available at www.weissratings.com.

Note: The amount of information available free of charge varies with each rating agency. It is recommended that the analyst check with other areas within his/her insurance department to determine if the information is currently being maintained elsewhere in the agency. For example, the financial area of many states may already be subscribing to the one or more of the services.

Information about rating changes for individual companies can also be found in news articles of the various trade publications that may currently be available within the analyst's state insurance department. In addition, information regarding company ratings from A.M. Best may be available through the NAIC library.

Specific Items to Look For

In reviewing the rating history and any additional information about the company available from a rating agency, the following items should be considered:

1. Has the company's rating changed in the last 5 years? If the company rating has changed, is there anything of concern in the rationale behind the rating change?
2. Is there anything of concern in the most recent rating rationale provided by the rating agency?
3. Is there anything of concern in the operations areas of any additional information about the company provided by the rating agency?
4. Is the company currently on a watch list for potential change in its rating? If so, why was it placed on the watch list?

Note: Ratings from each agency should be reviewed independently. Each rating agency uses its own rating methodology to rate a company. Therefore a cross comparison of the ratings between agencies would not be appropriate.

Area of Review:	Geographic Analysis
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Suggested Review

Some states collect personal lines data by ZIP code, county, or other sub-state level of geography. This data may be put to good use for market analysis. Additional analytical value can be realized by merging insurance with census data, vehicle registration data obtained from states' DMVs, and a DOI's own internal data, including complaints and agent appointments.

ZIP code data can be aggregated into larger geographic units, such as metropolitan statistical areas (MSAs), or areas with common demographic features. For example, the analyst might want to examine all poorer urban areas. In some instances, the use of larger geographic units is necessary to ensure that results are credible.

Areas of potential review for a geographic analysis include, but are not limited to:

1. Underserved areas: Analysts should review the *Market Regulation Handbook* (Chapter 8: Enhancing State Market Analysis) for information on how to identify underserved or non-competitive areas, and evaluating geographic based rating variables (such as automobile insurance rating territories). When, or not a formal and comprehensive analysis is produced, the analyst should have a good working knowledge of which areas of the state exhibit affordability and availability problems.

Useful indicators include market penetration ratios, residual market share, average premium relativities, agent location, complaint rates, and other indicators of market structure and performance. Markets in geographic areas that score highly on a multitude of these indicators might be candidates for a designation of "underserved":

1. Spatial business patterns: Assess a company's market share across different areas of the state, including underserved areas. Examine such patterns through time;
2. Underwriting and rating variables: Identify any likely relationships between spatial patterns and underwriting and rating variables employed by a company. Rating territories bear the most obvious and direct relationship to geographic patterns, but there may well be non-geographic variables that possess geographic implications;
3. Agents per capita: Calculate the number of agents per 10,000 residents (or homes or autos). Select a geographic unit of analysis that is large enough to support credible inferences. ZIP codes are unlikely to be sufficient for this purpose; and
4. Complaint rates: Identify areas where complaint rates (e.g. complaints per 10,000 insureds) are unusually high. Complaints may be interpreted as an indicator of the level of service and adherence to obligations by a company. Again, ZIP codes are probably too small to support credible inferences based on a single company's complaints.

Note: Geographic or statistical patterns by themselves do not indicate anything untoward about a company's business practices. Rather, such patterns, when interpreted within the context of an analyst's total knowledge about a company's market conduct, may merit additional scrutiny. Analysts should be able to formulate explicit and logical connections between particular business practices and a market outcome prior to initiating any heightened regulatory scrutiny.

Census data can be downloaded from the website of the Bureau of the Census (www.census.gov), or purchased on other storage media. In some instances, this data can be obtained in a form that is relatively ready for use. If not, the raw summary file data can be downloaded and the necessary information extracted at the appropriate geographic level, from census blocks to ZIP code to county, etc. A good introduction to data available from the 2010 census can be found at: <http://www.census.gov/2010census/>.

Vehicle registration data should also be obtained from the state DMV where possible.

Specific Items to Look For

In reviewing geographic data, emphasis should be placed on overall patterns across a variety of indicators and the following items should be considered:

1. Underserved areas: Are there areas of the state that score highly on a variety of indicators? For example, do some areas exhibit elevated premiums, high rates of uninsured vehicles or homes, few available agents, high complaint rates, and so forth?
2. Market share: Are there dramatic market share differences for the company in different areas of the state? Have there been any significant increases or decreases over time in some areas, compared to the statewide market share?
3. Agent location: Do geographic patterns of agent location suggest anything about the company's business strategies?
4. Complaint rates: Are there geographic areas where complaint rates are unusually elevated? If so, what appears to be the cause of such complaints?
5. Rating territories: Are there any identifiable geographic patterns in territorial rating factors? Do loss ratios across territories indicate that premiums are commensurate with losses?
6. Underwriting and rating variables: Can underwriting or rating variables account for observed patterns? If so, does a company employ atypical variables or factors that are not well understood or actuarially supported? Might such variables be applied in an arbitrary and capricious manner? If so, such variables may warrant additional scrutiny.
7. Loss ratio: Loss ratios, or losses expressed as a percent of premium, are an indicator of whether the price of coverage is commensurate with risk. Analysts should identify whether there are patterned variations in loss ratios across geographic areas, and determine whether such patterns might indicate a problem with a company's rating structure or a lack of market competition. Loss ratios that are consistently and significantly lower than the statewide average in a geographic area may indicate that an area is comparatively over-charged (policyholders receive less "return" per premium dollar than average). Conversely, consistently high loss ratios indicate that an area is systematically under-charged. In the event that either trend is found, an analyst should try to determine whether cross-subsidies exist, whereby an over-charged area in effect subsidizes an under-priced area.

Depending on the line of business or the presence of unpredictable or catastrophic losses, loss ratios may be subject to significant random fluctuations from year to year. Analysts should therefore assess trends over a period of several years. An examination of loss ratios over 3, 5 or even more years may be appropriate.

Analysts should try to determine whether patterns have a identifiable systemic origin, such as territorial rating structures, other aspects of rating plans, catastrophe loading, in rates, underwriting criteria, or other business or marketing practices.

Area of Review:	Human Resource Department
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Suggested Review

When possible the analyst may also want to check with the Human Resource Department for his/her insurance department as it may have useful information regarding a company. For example, the Human Resource Department may have noticed a large number of applications to the insurance department from employees of a specific company. An influx of resumes or applicants from a single company could be a sign of stress and/or change at the company.

Specific Items to Look For

In checking with the Human Resource Department about the company, the following item should be considered:

1. Has there been an influx in the number of resumes or applications to the insurance department from employees of the company? If yes, are the resumes or applications being submitted coming from a specific functional or geographic area?

Area of Review:	Internet/World Wide Web
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Suggested Review

The Internet/World Wide Web (the web) makes a lot of information available on virtually any topic imaginable. It can be a very useful tool and the analyst can learn a great deal about a specific insurance company. However, the amount of information can itself be a problem. It can be overwhelming, especially to those that are not proficient in navigating the web successfully. Nevertheless, finding relevant information about a specific insurance company can be easy if the analyst is able to search the web in an effective and efficient manner.

It is important to note that much of the information gathered for other areas of review for the Level 2 Analysis will be collected via the web. However, the information collected in this section relates to items not covered in the other areas of review. For example, the web contains a large variety of information about legal activity. Information found on the web regarding legal activity that involves the insurance company under review should be considered in the Legal Information area of review, not this section.

Information located on the web related to the company not covered in other areas includes items such as:

1. Company's website;
2. Agent websites; and
3. Other independent websites.

The company's website may contain a wealth of information related to the company itself and its history. It is common for a company to post information about the company's mission, core business and its affiliates. Many companies also post items such as its annual report, news releases and employment opportunities with the company. Reviewing the company website may also give the analyst insight on the company's marketing strategies, distribution system, business territories and product mix.

A review of agent websites may also provide a great deal of information about the company under review. Reviewing a sample of agent websites may help the analyst determine what types of business the company is marketing, the extent of the company's agency system and the territories in which the company is operating.

Independent sites that contain information about the company may include quoting services or anti-company sites. Anti-company sites are those sites that attack the company, perhaps set up by an aggrieved employee or consumer. A review of these sites may provide the analyst with additional information about the company that may not find elsewhere and it may help the analyst identify potential areas of regulatory concern.

As noted above, the web can be overwhelming and the analyst can easily spend hours "surfing" the web for information only to turn up little or no relevant information about a company. As such, it is important to develop skills that allow the analyst to quickly locate information about the target company.

It is also important that the analyst develop skills on how to evaluate the information that is found. Because so much information is available, and because anyone can write a review, information of the widest range of quality, written by authors of the widest range of authority, is available. Excellent relevant sources of information exist right along side the most suspect so it is important that in addition to reviewing the information the analyst evaluate the source.

The University of California – Berkeley has a very good online tutorial program about the web that provides general information about the web itself, how to perform effective efficient searches and how to evaluate the information presented.

This tutorial is found at <http://www.lib.berkeley.edu/TeachingLib/Guides/Internet/FindInfo.html>.

Specific Items to Look For

In reviewing information available about the company via the web, the following items should be considered:

Company Website

1. Are there any recent (within the last 2 years) new releases by the company regarding the insurance company itself and/or the line of business under review that are noteworthy? If so, explain.
2. Does the Annual Report highlight any area of concern for the company? If so, in what area and what is the concern?
3. Are there any proposed or recent changes in company structure, management, mergers or acquisitions, change in product offerings, etc. that are of concern? If so, in what area and what is the concern?
4. Does the company provide links to individual agent websites? If yes, do these agents maintain information regarding the specific insurance under review on his or her website?
5. Are there consumer complaints against the company regarding the company's website?
6. Does the company allow an individual to get quotes or apply for insurance online? If yes:
 - a. What sort of information is requested from the consumer?
 - b. Is any of the information collected considered to be personally identifiable information covered by the applicable privacy rules and regulations?
 - c. Does the information presented comply with the applicable advertising rules and regulations?
7. Does the website contain a privacy statement or privacy policy?
8. Does the company post current job openings on the website? If yes, are there an unusual number of openings for a specific functional area or in a particular location?

Agent Websites

1. Do individual agents maintain information regarding the specific insurance under review on his or her website? If yes:
 - a. What sort of information is presented?
 - b. Does the information presented comply with the applicable advertising rules and regulations?
 - c. If the information provided appears to target a particularly vulnerable group of consumers, such as senior citizens, does the information appear to conform to suitability standards (set forth in either statute or regulation, or commonly enforced suitability provisions) for marketing to these consumers?
 - d. Is the agent representing just the company under review? Or does he/she represent additional unrelated companies and is information about these other companies also contained on the agent's website?
2. Are there any consumer complaints against the company that involve an agent's website and the company?

Other Independent Websites—Quote Sites

1. Does the company allow third-party quoting services to provide a quote for the line of business under review? If yes,
 - a. What sort of information is requested from the consumer?
 - b. Is any of the information collected considered to be personally identifiable information covered by the applicable privacy rules and regulations?
 - c. Does the information presented comply with the applicable advertising rules and regulations?

Other Independent Websites—Anti-Company Websites

1. Did the analyst find any anti-company websites? If yes,
 - a. Is the subject matter on the website related to the line of business under review?
 - b. Are there consumer complaints against the company regarding the issues noted on the website?
 - c. Do the allegations seem credible and warrant further investigation?
 - d. Is there any reason to suspect that a competitor might be sponsoring or assisting the website?

Area of Review:	Legal Information
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Suggested Review

Pending legal activity that a company is involved in may be an indication of potential issues with a company that may have an adverse impact on consumers in the analyst's state. Investigating the legal activity involving a company may alert the analyst to litigation that may adversely affect the company's financial situation and may eventually have an adverse impact on the consumers of the analyst's state.

Check to see if there is any legal activity of concern involving the company under review using some or all of the following resources:

1. Insurance department staff responsible for this area;
2. State-specific court system accessible via the Internet; and
3. Miscellaneous Internet sites that collect/maintain information about litigation, such as:
 - a. <https://www.lawyersandsettlements.com/>;
 - b. <https://www.ama-assn.org/litigation-center/>;
 - c. LexisNexis (<https://www.lexisnexis.com/en-us/gateway.page>)—provides access to legal, news, public records and business information; including tax and regulatory publications in online, print or CD-ROM formats; and
 - d. Westlaw (<https://legal.thomsonreuters.com/en>)—a legal research service that provides access to a collection of statutes, case law materials, public records, and other legal resources, along with current news articles and business information.

Note: LexisNexis and Westlaw are fee-based services. It is recommended that the analyst check with other areas within his/her agency to determine if access to either service is available elsewhere in the agency. For example, the legal department in many states may already be subscribing to one of these services and depending on the terms of the contract between the state insurance department and the service, it may be possible for the analyst to obtain access to the service at little or no additional cost to the agency.

Specific Items to Look For

In reviewing information regarding legal activity involving the company, the following items should be considered:

1. Is the company involved in any significant litigation that could affect its financial condition?
2. Was the litigation noted in the management discussion or in other areas of the financial statement?
3. Is the subject of the litigation related to the line of business under review?
4. Does the subject of the litigation have potential impact on the policyholders in the analyst's state?
5. Is the litigation a class action suit and if so, is it at the state or federal level? Has the class been certified?
6. What state, county court or federal district court is involved?
7. Are there consumer complaints against the company regarding the subject of the litigation?
8. Is the conduct alleged in the litigation an area for which the company has been fined or cited on market conduct exams in the analyst's or other states?
9. If known, is the company attempting to settle the litigation or defending the suit?

Area of Review:	NAIC Bulletin Boards
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Suggested Review

The NAIC maintains market-related electronic bulletin boards to which members of the boards may post and receive messages regarding specific companies and/or issues. The two market regulation-related bulletin boards are the Market Regulation Bulletin Board and the Market Analysis Bulletin Board; both bulletin boards are available on iSite+ and on StateNet.

The Market Regulation Bulletin Board is an electronic forum designed for state market conduct regulators to communicate global issues, concerns and information about entities engaged in the business of insurance or the specific rules/laws that help to govern the industry.

The Market Analysis Bulletin Board is an electronic forum designed for state analysts to communicate issues, questions, concerns and information about the market analysis process.

A review of these bulletin boards for postings regarding the company under review may provide useful information about the company that the analyst may not otherwise discover. Postings regarding individual companies may be found by logging on to the desired bulletin board and using the search function to query for postings related to a specific company.

Caution: There is no uniform method used by the members of the boards for identifying a specific company by name. As a result, a single company could appear on the boards in multiple postings each with a slightly different name. This can make it very difficult to search for postings for a specific company.

To ensure that as many references as possible to the company are found, the analyst may want to try several different versions of the specific company name when querying the boards. The analyst may also want to use a shortened version of the company name or the generic group name for the company in another query. While this method will produce more false hits, it will help ensure that all possible postings related to a company are unearthed.

To help reduce the problems associated with inconsistent use of company names, individuals posting to the bulletin boards are strongly encouraged to include the 5-digit NAIC company code in posting when ever possible.

Note: To access either bulletin board, a regulator must be a registered member of the board which the regulator wishes to access.

Specific Items to Look For

In reviewing postings about the company from either bulletin board, the following items should be considered:

1. Are there any recent (within the last 2 years) postings regarding the insurance company that are noteworthy? If yes,
 - a. Are the functional areas and/or line(s) of business under review covered under the subject of the posting?
 - b. Does the posting identify any significant issues that could have implications in the analyst's state? Could the issue(s) presented in the posting manifest itself in the analyst's state? If so, to what extent would the issues contained in the posting have an affect on the consumers of the analyst's state?
 - c. Are there areas of concern or need for further review identified in Level 1 Analysis that are the subject of a posting?
 - d. Has the analyst's state received any consumer complaints regarding the issue raised in the posting?

Area of Review:	Other Governmental and Quasi-Governmental Agencies
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Suggested Review

The review of information collected by other governmental agencies and quasi-governmental agencies may provide the analyst with information about a company and related activity involving the company not found elsewhere.

Other governmental and quasi-governmental agencies that may have relevant information about a company, include, but are not limited to:

1. **U.S. Securities and Exchange Commission (SEC);**

U.S. Securities and Exchange Commission (SEC): The SEC oversees the key participants in the securities world, including securities exchanges, securities brokers and dealers, investment advisors and mutual funds. The SEC is concerned primarily with promoting the disclosure of important market-related information, maintaining fair dealing and protecting against fraud. The SEC website (www.sec.gov) provides information on publicly held companies, as well as on entities licensed to sell securities products. The SEC's Electronic Data Gathering, Analysis and Retrieval (EDGAR) database provides free public access to corporate information, allowing the user to research a company's financial information and operations by reviewing registration statements, prospectuses and periodic reports filed on Forms 10-K and 10-Q.

Documents that may be helpful to the analyst regarding a particular company include:

- a. Annual and quarterly filings (Forms 10-K and 10-Q), which can provide additional information about the company's structure, management, products and distribution and detailed management discussion of the financial condition and operating results, and
- b. The 8-K report, which contains information if a company has undergone a major change such as change in control or bankruptcy.

These reports can be lengthy and some information may have already been reviewed in a Level 1 Analysis. The analyst may wish to only review these records if a Level 1 Analysis of financial information and/or the Management Discussion and Analysis page of the company's NAIC Annual Financial Statement identifies areas of concern or need for further review.

2. **U.S. Centers for Medicare & Medicaid Services (CMS);**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established minimum federal standards regarding access to and the portability and renewability of private health insurance, including provisions that assist individuals who change or lose their job in maintaining health coverage. Congress has also enacted a number of amendments to HIPAA, which provided additional federal standards that addressed private health insurance coverage of mental health, maternity and newborn and post-mastectomy reconstructive surgical benefits.

In states that have standards that substantially conform to or exceed these federal standards, or in states that otherwise enforce the federal standard, state insurance regulators have primary enforcement authority for companies. For those states that do not have such standards, CMS enforces HIPAA and the related amendments.

In states in which CMS is responsible for enforcement, CMS has assumed many of the responsibilities undertaken by state insurance regulators, such as responding to consumers' inquiries and complaints, reviewing company policy terms and business practices, performing market conduct examinations, and imposing civil money penalties, if necessary, for violations of HIPAA and the amendments.

3. **Financial Industry Regulatory Authority (FINRA);**

FINRA is the largest non-governmental regulatory organization for all securities firms doing business in the United States. FINRA was created through the consolidation of NASD and the member regulation, enforcement and arbitration operations of the New York Stock Exchange. The consolidation, which was announced on Nov. 28, 2006, and approved by the Securities and Exchange Commission on July 26, 2007, became effective July 30, 2007.

FINRA's chief role is to protect investors by maintaining the fairness of the U.S. capital markets. FINRA is responsible for rule writing, firm examination, enforcement and arbitration and mediation functions, along with all functions that were previously overseen solely by NASD, including market regulation under contract for NASDAQ, the American Stock Exchange, the International Securities Exchange and the Chicago Climate Exchange.

FINRA is involved in registering and educating industry participants to examining securities firms; writing rules; enforcing those rules and the federal securities laws; informing and educating the investing public; providing trade reporting and other industry utilities; and administering the largest dispute resolution forum for investors and registered firms.

FINRA takes disciplinary actions against firms and individuals for violations of NASD rules, federal securities laws, rules and regulations; and the rules of the Municipal Securities Rulemaking Board. Information about disciplinary actions taken by FINRA is available via FINRA's BrokerCheck at www.finra.org/BrokerCheck.

4. **Joint Commission on Accreditation of Healthcare Organizations (Joint Commission);**

The Joint Commission is a not-for-profit organization that sets the standards by which health care quality is measured and evaluates the quality and safety of care for health care organizations. The Joint Commission maintains an accreditation program under which health care organizations are reviewed at least once every 3 years to determine if it meets or exceeds the Joint Commission standards and quality expectations. A list of Joint Commission accredited organizations and survey results are posted in the Quality Check section of the Joint Commission website at www.jointcommission.org.

5. **Better Business Bureau (BBB); and**

The BBB is a voluntary system of regional BBBs. The BBB collects information about companies who are members or nonmembers of the BBB and makes Reliability Reports on companies (complaint information filed by consumers with the BBB) available to the public on its website (www.bbb.org).

Complaint information on companies is generally national without state-specific data. The number of complaints received by the BBB on a given company tends to drive the detail in the report. For larger companies with more complaints, information is broken out by nature of complaint (service, sales, refunds, contracts, billing) and type of resolution (resolved, company made good faith effort to resolve, unresolved, no response, etc.). In some cases, government action information, such as multistate resolution of national problems is indicated.

Note: It is important to note that a "clean" BBB report does not necessarily indicate that there are no problems, only that complaints were not processed by this voluntary system.

6. **Other State Agencies/Departments/Divisions.**

- a. Securities;
- b. Banking;
- c. Consumer Affairs/Protection;
- d. Labor; and
- e. Attorney general.

Other state insurance departments not primarily engaged in regulating insurance, that may share joint regulation of certain activities of a company may provide additional information to the analyst. These may include departments regulating financial institutions and securities, the state insurance departments for consumer affairs/protection, the state attorney general and the state department of labor.

Specific Items to Look For

In reviewing SEC filings that involve the company, the following items should be considered:

1. Does the annual filing highlight an area of concern for the company? If so, in what area and what is the concern?
2. Are there any proposed or recent changes in company structure, management, mergers or acquisitions, etc. that are of concern? If so, in what area and what is the concern?
3. Are there any significant changes in the marketing of the line of business under review for this company? Is the company expanding or limiting marketing?
4. Has the company changed product offerings and if so, will this change impact the line of business under review?
5. Are there any 8-K filings for the company and if so, what change is indicated and is this of concern?
6. Are there any significant lawsuits discussed in the 10-K filing that have not been previously noted by the analyst? If so, are the lawsuits in areas of concern to the analyst's state?
7. Is there a pattern demonstrated in the management discussion information and financial data that would raise concern for market behavior? If so, in what way?

In reviewing enforcement actions taken against the company by CMS or market conduct examinations of the company done by CMS, the following items should be considered:

1. Are there any recent (within the last 2 years) CMS enforcement actions against the company that are noteworthy? If yes,
 - a. Are the functional areas and/or line(s) of business under review covered under the subject of the CMS enforcement action?
 - b. Does the CMS enforcement action identify any significant issues that could have implications in the analyst's state?
 - c. Does the CMS enforcement action involve issues that are similar to the areas of concern currently under review?
 - d. Does the CMS enforcement action highlight an area of concern for the company? If so, in what area?
 - e. Has the analyst's state received any consumer complaints regarding the issue(s) raised in the CMS enforcement action?
2. Are there any recent (within the last 2 years) CMS market conduct examinations of the company? If yes,
 - a. Are the functional areas and/or line(s) of business under review covered under the CMS examination report?
 - b. Does the CMS examination report identify any significant issues that could have implications in the analyst's state?
 - c. Does the CMS examination report involve issues that are similar to the areas of concern currently under review?
 - d. Does the CMS examination report highlight an area of concern for the company? If so, in what area?
 - e. Has the analyst's state received any consumer complaints regarding the issue(s) raised in the CMS examination report?

In reviewing disciplinary actions taken against the company by FINRA, the following items should be considered:

1. Are there any recent (within the last 2 years) FINRA disciplinary actions against the company that are noteworthy? If yes,
 - a. Are the functional areas and/or line(s) of business under review covered under the subject of the FINRA disciplinary action?
 - b. Does the FINRA disciplinary action identify any significant issues that could have implications in the analyst's state?
 - c. Does the FINRA disciplinary action involve issues that are similar to the areas of concern currently under review?
 - d. Does the FINRA disciplinary action highlight an area of concern for the company? If so, in what area?
 - e. Has the analyst's state received any consumer complaints regarding the issue(s) raised in the FINRA disciplinary action?

In reviewing information about health care organizations used by the company's PPO or HMO network(s), the following item should be considered:

1. Does the network use health care organizations accredited by the Joint Commission? If yes,
 - a. What percentage of the network's health care organizations is accredited?
 - b. Is there a wide variety in the types of health care organizations accredited?
 - c. Are the major health care organizations in the network accredited?

In reviewing information from the BBB about the company, the following items should be considered:

1. Does the information highlight an area of concern for the company or the product line under review? If so, in what area?
2. Are areas of concern or need for further review identified in Level 1 Analysis the subject of information available? If so, what are the areas of concern?
3. Are there complaints about the company and/or the line of business under review reported to BBB? Does a review of iSite+ and state-specific complaint information show similar areas of concern?

In reviewing information for the company from a non-insurance regulatory or quasi-regulatory entity, the following items should be considered:

1. Does the information highlight an area of concern for the company or the product line under review? If so, in what area?
2. Are areas of concern or need for further review identified in Level 1 Analysis the subject of information available from the entity? If so, what are the areas of concern?
3. Are there complaints about the company and/or the line of business under review reported to entity? Does a review of iSite+ and state-specific complaint information show similar areas of concern?
4. Has the entity taken any sort of administrative action against the company? If so, what was it for and does it affect the consumers in the analyst's state?

Area of Review:	Producer Licensing
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Suggested Review

A review of the state's producer licensing data for a company over the last 3 years could provide valuable insight about the company's producer licensing activity and its marketing focus. By reviewing the state's producer licensing data, the analyst may be able to identify trends that may signal changes in the company's marketing strategies or focus that have the potential to have an adverse impact on the consumers of the analyst's state.

For example, a large increase in the number of new producers appointed to represent the company in the last year may be an indication that the company is preparing for a major marketing campaign to increase sales within the analyst's state. On the other hand, a large increase in the number of producers being terminated by the company may signal a significant reduction in the amount of business the company plans to write in the analyst's state or a total withdrawal from a particular market.

A change in the types of appointments being made by the company could also be of importance. For example, if a company has recently begun appointing producers for a specific line of business it historically has not had producers for, this may indicate that the company is gearing up to start writing a line of business that it has not written in the past.

Note: Not all states require that a company appoint specific producers to represent the company. In addition, those states that do require an appointment may not require the company to appoint a producer for a specific line of business. Finally, those states that do require an appointment may not capture the appointment/termination information in such a manner that will allow the analyst to complete some of the suggested items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing information about the producer licensing activity for the company, the following items should be considered:

1. What type of agency relationship does the company have (e.g., direct writer, independent agents, exclusive agents)?
2. Has the company appointed or terminated an unusual number of producers in the last two to three years? If yes, are the appointments and/or terminations for a particular line of business?
3. Are there any producers representing the company that are the subject of consumer complaints, whether closed or pending?
4. Are there any producers representing the company that are the subject of regulatory actions, whether finalized or pending?
5. Has the company terminated producers for cause?

Area of Review:	State-Mandated Items (Reports, Data Requests, Surveys and Exhibits)
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Suggested Review

Many states require companies to file various reports, data requests, surveys and exhibits with the insurance department. A review of the information provided in the mandated items related to the line of business under review can provide valuable information about a company. Items covered under this area would include, but not be limited to:

1. Grievance reports;
2. Market Conduct Annual Statement (MCAS);
3. Prompt-pay reports;
4. ZIP code reports; and
5. Premium comparison surveys.

Specific Items to Look For

It is important for the analyst to identify all of the specific mandated items applicable to the line of business under review. Once the applicable items to review have been identified, the following should be considered in the review of mandated items:

1. Did the company's response or data deviate from the norm? Did it deviate from prior years' data? If so, in what way?
2. Was there follow-up with the company on any specific areas of concern? If so, what was the outcome?
3. Have any issues been identified that the company has been advised to correct? If yes, has the company reportedly corrected the issues?
4. Are there any regulatory actions or market conduct examination findings of concern related to the mandated item in the analyst's or other states?
5. Are there any consumer complaints related to a specific issue previously identified through a mandated filing and reported corrected by the company? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?
6. Grievance reports: When the company is required to file a grievance report, do the patterns in the number of complaints received move in the same direction as the number of grievances reported over the last 3 years?
7. Market Conduct Annual Statement: If the company must file the MCAS in other states, are there similar areas where the company data is outside the norm? Was there follow-up with the company by that state on any specific areas of concern? If so, what areas and what was the outcome?

Area of Review:	Trade Publications & Other Media Sources
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Suggested Review

Trade publications and media sources inform regulators about emerging issues and other regulatory concerns. Reviewing articles and information from other readily available media sources may alert the analyst to potential issues that could adversely impact consumers in the analyst's state.

Review trade publications and other media sources for pertinent information related to the company. The various media sources may include, but not be limited to:

1. Agent/Company newsletters;
2. Local/National media:
 - a. Newspaper articles (*Wall Street Journal*, *Business Insurance*, *National Underwriter*, *A.M. Best*, *American Banker*, *Kiplinger's Personal Finance*, etc.);
 - b. Print advertisements (Magazines, direct mail, billboard, buses, etc.); and
 - c. Television (News, "Dateline," "60 Minutes," etc.);
3. News wire on myNAIC—accessible to regulators with a myNAIC login ID and password;
4. KPMG—KPMG provides audit, tax and advisory services:
 - a. *KPMG Institutes*, a network dedicated to helping organizations and their stakeholders identify and understand emerging trends and risks. To access, go to www.kpmg-institutes.com/; and
 - b. *KPMG Global M&A Insurance Newsletters*, an electronic monthly newsletter focused on transaction activity and trends specific to the global insurance industry including news and analysis about the trends behind the headlines. To view global mergers and acquisitions insurance news, go to <http://www.kpmg.com/Global/en/industry/Insurance/Pages/mergers-acquisitions-for-insurers.aspx>;
5. www.findarticles.com/;
6. www.insure.com/;
7. Internal clipping folders—some states maintain internal folders for companies that contain press clippings and other media-related information;

8. LexisNexis (<https://www.lexisnexis.com/en-us/gateway.page>)—provides access to legal, news, public records and business information; including tax and regulatory publications in online, print or CD-ROM formats; and
9. Westlaw (<https://legal.thomsonreuters.com/en>)—a legal research service that provides access to a collection of statutes, case law materials, public records, and other legal resources, along with current news articles and business information.

Note: LexisNexis and Thomson Reuters Westlaw are fee-based services. It is recommended that the analyst check with other areas within his/her agency to determine if access to either of these services is available elsewhere in the agency. For example, the legal department in many states may already be subscribing to one of these services and depending on the terms of the contract between the state department and the service, it may be possible for the analyst to obtain access to the service at little or no additional cost to the insurance department.

Specific Items to Look For

In reviewing information from trade publications and other media sources regarding the company, the following items should be considered:

1. Are there any recent (within the last 2 years) publications regarding the company and/or the line of business under review that are noteworthy? If so, explain.
2. Does the publication/report highlight an area of concern for the company? If so, in what area?
3. Are areas of concern or need for further review identified in Level 1 Analysis the subject of recent publications?
4. Are there any proposed or recent changes in company structure, management, members or acquisitions, change in product offerings, etc. that are highlighted in any publications?
5. If the company contracts with independent agents, do any producer trade publications make reference the company in a way that if of concern or would require further review?
6. If an article references alleged misconduct is the conduct alleged an area for which the company has been fined, been the subject of prior regulatory action or cited on market conduct exams in the analyst's or other states?

Area of Review:	Voluntary Accreditation/Certification Programs
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Suggested Review

The growing use of voluntary accreditation/certification programs has the potential of providing regulators with important information about a company. Many of these organizations require companies to actively monitor their compliance practices and take appropriate corrective actions when necessary. This information may provide the analyst with insight regarding a company's commitment to establishing and maintaining a culture of compliance designed to continually improve its market conduct and compliance practices. It can be considered as one relevant indicator of compliance with related state statutes and regulations.

Where applicable for the line of business under review, check the website of any applicable voluntary accreditation/certification program to see if the company participates in a voluntary accreditation/certification program. Voluntary accreditation/certification programs include, but may not be limited to the National Council on Quality Assurance (www.ncqa.org) and the Utilization Review Accreditation Commission (www.urac.org).

Note: Any self assessment/review done by the company to meet the certification/accreditation standards of these organizations must be obtained directly from the individual company under review. While the document may contain useful information, the decision to contact the company directly to obtain the document is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing information regarding the participation of the company in a voluntary accreditation/certification program, the following items should be considered:

1. Does the company participate in a voluntary accreditation/certification program? If yes,
 - a. How long has the company participated and when was it last accredited or certified?
 - b. Does the company use the accreditation/certification in its marketing materials (letterhead, advertisements, brochures, website, etc.)? If so, is the use of it in its marketing materials appropriate?

Note: Access to the NAIC systems noted above (regulator-only myNAIC, iSite+, StateNet, MATS, RIRS, MARS, etc.) is restricted to those people authorized by the individual insurance departments. If the analyst does not currently have access to any of the systems, the analyst must follow his/her insurance department's internal procedures for obtaining proper authority to access the needed system.

Not for Distribution

Not for Distribution