Basic Analytical Tools

A. Market Conduct Indicators and Priorities

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 the change is undeniably for the better, it may still 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 the changes, it is essential to have meaningful data. This document explains the use of the NAIC's I-SITE 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 the 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 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 the states on I-SITE. 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 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 their medical malpractice insurance markets and by the broad-ranging consequences of the property insurance market's response to Sept. 11, 2001.

B. The NAIC's I-SITE Application

To avoid reinventing the wheel, regulators should familiarize themselves with I-SITE, a **secure regulator-only area** within the NAIC Web site providing access to NAIC databases and a wide variety of reports prepared from those databases. Of particular importance to market analysis are complaint and annual statement information.

The I-SITE summary reports range from the high-level overview found in the "Aggregate Market Share and Loss Ratio" report, which compares market aggregate data for different lines of business, to company-by-company comparisons of complaint information and financial information, which can be customized by selecting one or more states, one or more lines of business and a particular time period. In particular, there are five sets of market conduct summary reports compiled from the Complaint Database System, the Examination Tracking System, the Special Activities Database (two sets, one for firms and one for individuals) and the Regulatory Information Retrieval System (enforcement actions).

A regulator can also select one or more companies or a list of companies matching particular search criteria and drill down to obtain detailed information, including direct access to the electronic annual and quarterly financial statements. I-SITE contains market analysis profile reports, which provide five-year reports for the selected company on state-specific premium volume written, a modified financial summary profile and a complaint index report. I-SITE contains a total of 10 market analysis profile reports that also include reports that review special activities, RIRS, complaints and other financial analysis reports. For a more comprehensive listing of the resources available on I-SITE, see Appendix A.

I-SITE also contains a summary report called the "Market Analysis Company Listing Report," which contains five years' worth of information for all companies, with an optional filter for companies with premiums over $100,000. This spreadsheet also contains both state and national data on (1) premium volume written; (2) modified financial summary profile; (3) complaints index report; (4) regulatory actions report; (5) special activities report; (6) closed complaints report; (7) exam tracking systems summary; (8) IRIS ratios; (9) defense costs against reserves information; and (10) Schedule T information. The reports are available for a variety of lines of business. The report is available in a downloadable Microsoft Excel file format.

The Market Analysis Prioritization Tool (MAPT), released in 2006, expands upon the Company Listings by creating a weighting 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 include losses, enrollments, claims, expenses and premiums; market components, regulatory actions, complaints, examinations and demographics.

MAPT should be used in conjunction with a market analyst's professional judgment and experience as a starting point to select companies for further action (such as a Level 1 Analysis). The Market Analysis Research & Development (D) Subgroup (MARD) is responsible for monitoring the effectiveness of MAPT and determining the components and weights used.

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.
- 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, these limitations should not be overstated. 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 the insurance department has determined that a problematic complaint trend is occurring, the 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 the 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 to schools and community groups and placement public service announcements in the media.

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 will allow 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 an industry-wide level, by line or from individual companies.

Supplemental information, such as the complaint data fields and user guides, about the NAIC Complaints Database System (CDS) is available via I-SITE/StateNet.

The NAIC recommends the use of its Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act. The 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 the insurance department to a problem area within the company.

The NAIC has promulgated a model complaint recording form for many years. The most recent version is available through I-SITE/StateNet on the Market Information Systems Web page.

In October 1991, the NAIC released the Complaints Database System (CDS). The CDS provides on-line access to a database, which consists of the complaints data collected from NAIC members. The database enables state and territorial insurance departments 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 the 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. More than a million complaints are now available to regulators through CDS.

Whatever system of recording and classifying complaints is used, complaint analysis must relate the raw complaint data to a meaningful analysis.

Although the focus of analysis is on patterns and trends, it should also be kept in mind that 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. It was designed as an aid in targeting examinations, as well as an alternative to examinations. The MCAS was designed to capture private passenger automobile claim payment information. Companies writing private passenger automobile coverage submitted a diskette containing specified claim information on an annual basis. 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; the number of first- and third-party suits filed during the reporting period and the suit ratio. This reporting detects insurers that exhibited reporting 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 annual statement 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. Collected MCAS data can be used to review market activity of the entire insurance marketplace in a consistent manner and to identify companies whose practices are outside normal ranges.

As of January 2009, five new states (Alabama, California, Montana, Rhode Island and Washington) will be collecting 2008 information with filings due in 2009. Due to a proposal to centralize the data and database limitations, no new states can be added for collection of 2009 information in 2010.

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

Short-Term:

The first part of the plan provides 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 Access Database format. The proposal also provides 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 focuses on the long-term commitment of the NAIC to centralize collection of market conduct data. Although centralized data collection has been contemplated by the NAIC Market Regulation and Consumer Affairs (D) Committee since at least December 2007, the key difference from prior proposals is that the NAIC did not move forward with the Committee's recommendation to collect 2010 market data via the NAIC Annual Statement.

For the year 2008, information will be collected for individual life cash and non-cash value products, group life cash and non-cash value products, individual fixed and variable annuities, private passenger automobile and homeowners.

By using common data and analysis, states will have a uniform method of comparing the performance of companies. Data is collected about claims, nonrenewals and cancellations, replacement-related activity and complaints on an industry-wide basis. If a company's performance appears to be unusual as compared to the industry, the state will want to 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 http://www.naic.org/committees_d_mcas.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 is the annual (and quarterly) financial statement, which all nationally significant insurers must file with the states and with the NAIC. These statements include specific schedules and interrogatories that provide very detailed information, such as premium volume, losses and changes in business. As discussed earlier, the NAIC compiles a wide variety of reports from this database and makes them available to regulators through I-SITE. 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 also 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.

In particular, 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 referred to for historical reasons as "Statutory Page 14." This page is officially called "Exhibit of Premium 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 defense costs, commissions and taxes, while the health Blank reports ambulatory patient encounters, hospital admissions and inpatient days.

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. It could 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 on 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

[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.

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 publishes a 10-year history on its Web site for insurers doing 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.

For property/casualty companies, market share information is readily available on I-SITE through the NAIC's financial summary report titled, "Detail—Market Share and Loss Ratio," 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. This report indicates the market share by line of business, by company and also shows each company's incurred loss ratio (incurred losses to earned premium),[4] calculated excluding all loss adjustment expenses. 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 is a "normal" loss ratio, consistent with profitable operations and may vary significantly depending on the line of business and, especially for "long-tail" lines of business, on changes in general economic conditions.

For life and health companies, there is less detail available in the standard summary reports. There are four market share reports on I-SITE: "Market Share—Life & Annuity," "Market Share—Credit Life," "Market Share—A&H" and "Market Share—Credit A&H." The latter two reports can be configured to combine companies filing the life and health annual statement with companies filing the property/casualty annual statement. The Market Share—Credit Life report is available for companies filing the health organization annual statement (orange Blank).

One other tool based on financial statement data should also be noted. Although the Insurance Regulatory Information System (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 three major annual statement formats—property/casualty, health organization and life and health—but there are also issues specific to particular lines of business that regulators need to take into consideration.

[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.

Health Insurance
In many insurance departments, there are consumer assistance resources dedicated specifically to health insurance. There might be 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. Federal law [Health Insurance Portability and Accountability Act (HIPAA) and Employee Retirement Income Security Act (ERISA)] plays 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.

Property/Casualty Insurance
Personal lines property/casualty coverage is another key focus of consumer assistance and complaint resolution programs. A high proportion of consumer concerns in these lines 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. 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. 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 consumer complaints.

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 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 terminations 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.

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, Weiss Ratings, Moody's Investor Service, Fitch Ratings and Standard & Poor's. 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 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 an "A" rating from Standard & Poor's or Fitch but fail to receive a "B" rating from Weiss. There are also variances in the areas rated by each rating firm and analysts should consider the areas of review completed by each of the rating organizations. Market analysts are encouraged to review rating changes over a period of five years for substantive changes. This does not necessarily require subscriber access, since many of the rating changes may be documented through industry and news periodicals.

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 is essential, since their problems 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 analysis 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. But 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's 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 actions. 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 will 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 through I-SITE/StateNet at the Market Information Systems page.

Examination Tracking System

Examination information may be quickly obtained on I-SITE/StateNet through the NAIC's Examination Tracking System (ETS) Summary Report, which provides a history of examinations matching specified criteria. A report may be generated displaying all market conduct examinations called in a specified state for a specified date range. Again, the NAIC compiles summary reports and makes them available on I-SITE. Since enforcement actions may arise from other sources besides market conduct examinations, this is not a substitute for consulting RIRS.

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]

---

[5] Market analysts should refer to the NAIC white paper on Best Practice Organizations for additional guidance related to the application of such evaluations and standards.

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 IMSA (for life insurers) and NCQA and 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 one 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 (such as IMSA's Supplemental Report), which are designed to provide market conduct analysts and examiners with a comprehensive summary of the testing and review activities that took place during the 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's 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. Addressing these concerns and working with companies' voluntary review activities is important, because a full understanding of a company's market activities encompasses both the company's policies and the practices by which they are implemented. 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 that 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 on 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 its 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.

Needless to say, 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, e-mail 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.

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 document 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 Analysis (D) Working Group.

The NAIC's Framework for Market Analysis document, which has been reproduced in Section A, provides an overview of the principles and structure of market analysis. The Framework for Market Analysis 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 (P&C) and by June 30 (L&H). The market analysis year runs from July 1 to June 30 as defined by the Market Analysis Priorities (D) Working Group because all information required for analysis is available to the states by July 1. Any measurement of the states' market analysis activities will look at this period. For example, if the measurement focuses on the 2006 data year (calendar year 2006), the analysis year runs from July 1, 2007 to June 30, 2008.

To accomplish its purposes, market analysis has an array of tools for states to use. The first of these is the Company Listing Spreadsheet 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, expands upon the Company Listings by creating a weighting system so companies can more easily be prioritized. Using the information on the Company Listing Spreadsheet, 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, no final conclusions about actual behaviors can be drawn 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 Company Listing Spreadsheet but on a more detailed and thoughtful basis. Whereas the Prioritization Tool identifies companies based on certain formulas and overall company performance, the Level 1 Review requires an analyst to actually look at specific company 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 which is provided 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 web site, 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 regulatory 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 regulatory 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 it causes 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 NAIC's Market Analysis (D) Working Group (MAWG). 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, running 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's 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 on the NAIC Regulatory Information Retrieval System (RIRS); and
- Reports listed on the confidential NAIC Special Activities Database (SAD).

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 so as to determine whether an inquiry should be generated or if prompt regulatory action is required. After compiling the complaint ratios for the individual insurers, the department can compare these 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 practice.

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 changes 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

All states should analyze the various data elements and indicators within the same general time frame, so that if one or more of the states has an issue with a particular company for which they determine they are taking immediate action rather than further analysis, then they can discuss it first within the framework of MAWG before any one state strikes out on its own. Results should be compiled and reviewed on a quarterly schedule. For example, a state should complete a complaint ratio on last year's complaint data during the second quarter of the following year (April–June). In this way, the MAWG meeting in June could be used to discuss each state's second quarter results and whether there is any need to follow-up with problematic companies on a coordinated basis.

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

In September of 2006, a revised list of MARS Level 1 Analysis questions was adopted by the Market Analysis Priorities (D) Working Group. The revised Level 1 Analysis questions were placed into production in the regulator-only MARS Web-based system in December of 2008.

Step 10—Conduct Level 2 Analysis

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 core areas of review are required for every Level 2 Analysis unless there is a valid reason not to review a specific area. The number and specific 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.

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 MARS system in December 2008.

Step 11—Coordinate Results with the NAIC Market Analysis (D) Working Group
In addition to reporting plans for examinations and investigations, all noteworthy market analysis results should be communicated to the NAIC Market Analysis (D) Working Group (MAWG), whether or not current regulatory action has been triggered, to enable meaningful evaluation of state market analysis efforts and to ensure that meaningful big-picture market analysis can be conducted and patterns or trends which cross state lines can be identified. Concerns with nationally significant companies should be specifically noted when reporting to MAWG and issues that appear to focus on a small number of other states should be brought to those states' attention.

C. Identifying Markets and Companies for Analysis

The insurance department's periodic review 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 1 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 useful 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 incident reports and MAWG referrals.

Additional Uses for Market Share Information
While an insurer's market share is not an indicator of its market conduct, 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 the market analysis program for the first time may well 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, on its Web site, California publishes a 10-year aggregate history for each annual statement line of business: the number of licensed companies writing the lines; total premiums written; total earned premiums; total losses incurred; and the annual loss ratio for the line. These reports can be found at www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share. Another example is the state of Missouri, whose reports are published at http://insurance.mo.gov.

Finally, market share information can be used to evaluate the degree of competition in a market sector. For example, the NAIC has a Commercial Lines Competition Database and publishes an annual survey for 10 commercial lines: commercial auto liability, commercial auto physical damage, commercial auto total, commercial multiple peril, fire, allied lines, inland marine, medical malpractice, other liability and workers' compensation. In each state, for each of the 10 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 for the market (the HHI is a formula used to measure market concentration which is widely used in antitrust analysis); the number of groups participating in the market; the numbers of entries and exits during the last five years; the market growth in the past three years and last 10 years; the residual market share in the past year and averaged over the past five years; the surplus lines market share in the past year and averaged over the past five years; and the 10-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 to regulators for conducting Baseline Analysis

The Market Analysis Research and Development Subgroup (MARD) developed the Market Analysis Company Prioritization Tool (MAPT) to allow regulators to narrow down the number of companies to a manageable list by creating a weighting 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 states to better focus their resources and to develop more efficient regulatory policies and practices.

MAPT provides an overall prioritization ranking, a national prioritization ranking and a state prioritization ranking for companies writing a specific line of business. These rankings are based on both market and financial data available from NAIC databases such as complaint and regulatory activity information. The MAPT report allows market analysts to compare companies doing business in a particular line of business on a national and state basis using a uniform data set. The seven available lines of business for this report are: group accident and health; group life; homeowners; individual accident and health; individual life; Medicare supplement and private passenger.

Insurance departments should use MAPT as a regular starting point to identify companies that may need further regulator attention, such as a more detailed analysis via a Level 1 Review. 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.

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 an 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 also important to keep in mind that the underlying data in MAPT should be analyzed—analysts should not rely solely on the prioritization ranking of individual companies.

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 MARD Subgroup. 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 I-SITE 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 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:

1. 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:
    - Does our state have an open exam?
    - Is the last exam our state performed less than one year old?
    - Does the company have less than $100,000 in written premium?
    - Did the company notify the insurance department that it is pulling out of 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.

2. Utilizing state Market Conduct Annual Statement (MCAS) data to identify outliers.

3. 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.

4. Utilizing internal referrals from other work units/divisions, such as the consumer complaint department and the provider grievance department.

5. Utilizing internal resources, such as health care claims survey results, market monitoring reports, data calls and annual prompt pay reports.

6. Utilizing market share reports that include premium data, market share and loss information that can be analyzed in conjunction with MAPT.

7. Utilizing CDS, ETS, RIRS, company Web sites, the various rating entities, news articles, internal complaints and various on-line search engines.

8. 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.

9. 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 ratios relative to market average)

Definition of "Complaint"
The NAIC definition of 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."

Definition of "Confirmed Complaint"
The NAIC definition of a confirmed complaint is:

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

---

[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 recent report identified one 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.

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.

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 NAIC's Consumer Information Source (CIS). States should be tracking their complaints in a format consistent with the NAIC's Complaints Database System (CDS) format and reporting them to the CDS. This provides a consistent definition of "confirmed complaint"—a complaint that was not resolved within any of the following CDS disposition codes. If more than one code applies to a complaint, the complaint is considered unless all disposition codes fall within the following list:

- 1223: Unable to Assist ("The state lacked the necessary power, authority or means to resolve the complaint.");
- 1227: Cancellation Upheld ("The annulment or invalidation of a policy falls within state guidelines.");
- 1228: Nonrenewal Upheld ("The insurer's election not to renew a policy falls within state guidelines.");
- 1235: No Action Requested/Required ("Handling was satisfactory.");
- 1240: Referred to Proper Agency/Section ("Due to the subject of the complaint, the resolution required referral to another agency or section.");
- 1293: Company in Compliance ("The company's tendencies to comply with the state insurance regulations.");
- 1295: Company Position Upheld ("The party complained against has a valid basis for not yielding to the complainant's request, demand or claim, whether the state department of insurance agrees or disagrees.");
- 1300: No Jurisdiction ("Lack of state department of insurance statutory authority."); and
- 1305: Insufficient Information ("No evidence to substantiate complaint. The correspondent failed to provide the information or documentation requested which is required for determining appropriate action.").

Complaint Ratios
A company's complaint ratio is defined as:

(number of confirmed complaints)
(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 the complaint ratios per $1 with all the leading zeros left in.

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:

(complaint ratio for the company)
(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 I-SITE.[8] When doing the actual numerical calculations, in order to minimize round-off error, the relevant data should be inputted 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 confirmed complaints/$61 million in premium: 670/61000 = 0.011

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

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

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 do need to keep in mind its limitations, which include:

---

[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.

- 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 readily 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

- The NAIC CDS Summary Complaint Index Report can be presented 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 I-SITE. These reports are compiled from the NAIC's 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 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.

The following standard CDS reports are available on I-SITE. In addition, states are able to run ad hoc queries against the database using their own spreadsheet software packages:

---

[11] A company which returned more premium than it wrote will actually appear in computer-generated tables with a negative complaint ratio, which on 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.

- **CDS Summary Index Report**—The complaint index reports (calculated with respect to written premium volume) are available for years beginning in 1997 for 10 lines of business: private passenger, homeowners, all property, individual life, group life, individual accident and health, group accident and health, credit, long term care and Medicare supplement. They can be calculated for a single state (or territory), selected states, an NAIC zone or nationwide, and a second state or region can be selected for comparison purposes. The report lists companies by name and NAIC company code, and for each company displays its complaint count, premium volume, complaint share, market share and complaint index;

- **CDS Summary Closed Complaint Counts by Code**—The report displays a list of all the complaints and the number of complaints, based on a variety of criteria. These reports allow regulators to see what types of complaints are most prevalent;

- **CDS Summary Closed Complaint Counts by State**—The report displays a list of all the NAIC member jurisdictions and the number of complaints received from each jurisdiction, based on a variety of criteria. This report can only be viewed on a nationwide basis;

- **CDS Summary Closed Complaint Trend Report**—The report displays the number of complaints and the percent of change on both a monthly basis and an annual basis for a predetermined date range. A three-year period is shown on a month-by-month basis, beginning with the previous calendar month. A six-year period is shown on the year-by-year breakdown; and

- **CDS Closed Complaint Filing Status**—The report lists, by state, the number of closed complaints entered in CDS, the earliest recorded closed date and the most recent recorded closed date.

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 (i.e., complaints with CDS disposition codes such as "Company Position Upheld" and "No Jurisdiction" are not used) and rebalanced so that a score of 1.00 represents the median company for a particular line of business[12]—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—mathematically, 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.

---

[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.

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]

F. Market Conduct Annual Statement Data

The Market Conduct Annual Statement (MCAS) is a uniform method for states to collect key data regarding individual life cash and non-cash value products, group life cash and non-cash value products, individual fixed and variable annuities, private passenger automobile and homeowners. Regulated entities may download instructions and a data collection program from the NAIC. The collection of MCAS data allows state regulators to compare and contrast entity-specific results with the remainder of the industry regarding such issues as replacements, nonforfeitures, complaints, life insurance face values, cancellations and claims taking longer than 60 days to finalize. The MAC should review the results of this analysis. The MAC should then consult the continuum of regulatory responses.

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 departments. 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.

---

[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.

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) in 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.

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 the 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 in which there is a significant increase?

---

[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.

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

- 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 is 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

The 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.

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

Incurred loss ratios (incurred losses as a percentage of earned premium) are readily available for property/casualty insurers on I-SITE using the financial summary report titled "Detail—Market Share and Loss Ratio." 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.

H. Coordination with the Market Analysis (D) Working Group

Once concerns are identified with particular companies, based on a systematic quantitative analysis of data, Level 1 and Level 2 Analysis, review of annual statement data or a qualitative inquiry triggered by particular issues or events, it is essential to conduct further review and follow-up with the company as appropriate. The appropriate regulatory response could be a determination that no actual problem exists, an enforcement action or a wide range of intermediate measures.

The results of both the market analysis and any follow-up activities should also be shared with MAWG, and MAWG should also be consulted regularly to ascertain whether they are aware of any issues affecting a regulator's domestic insurers or the market in a regulator's state. Similarly, regulators in other states should be consulted when there are significant issues at a regional level or with a particular impact on one or more specific states. The reason for sharing market analysis results with MAWG is two-fold. First, MAWG is the forum for coordinating state market analysis programs and for evaluating the effectiveness of market analysis on an ongoing basis. Second, MAWG is the forum for identifying and addressing issues of multistate concern. In particular, therefore, MAWG should be kept apprised of any concerns a regulator's state has identified with nationally significant insurers. A property/casualty insurer is considered "nationally significant" if, during any of the past three years, it has either (1) been licensed or written business in at least 17 states and had gross premium written of at least $30 million; or (2) been licensed or written business in at least five states and had gross premium written of at least $50 million. A life/health insurer is considered "nationally significant" if, during any of the past three years, it has been licensed or written business in at least five states and had written or assumed at least $50 million in gross premium.

MAWG has developed the following "Procedures for Coordination of State Collaborative Efforts" when a nationally significant insurer has been identified as exhibiting characteristics that might indicate current or potential future market regulatory issues that impact multiple jurisdictions.

MAWG will send a formal letter of correspondence to the state of domicile for each specific insurer for which a significant concern that impacts multiple jurisdictions is identified. For issues of less significance, a phone call will be made by NAIC staff requesting that the domestic state report to MAWG on the issue. MAWG will determine the method of communication used in each instance. A response time of 30 calendar days is given to the state of domicile to address the issues of concern outlined in the letter. At a minimum, the domestic state's response should disclose the following:

- The state is aware of the nature and extent of the problem enumerated;
- The state concurs with the Working Group's identified issues of concern or provides specific information to rebut or redefine the issues of concern;

- The state is monitoring the situation;
- The state or the company has a corrective plan of action for all states impacted by the issue;
- The state is monitoring the corrective plan of action; and
- The state has effectively communicated concerns and any regulatory actions to other states that might be at risk.

If MAWG concludes that the response has open issues remaining, a request may be made to the state of domicile to make a written and oral presentation to MAWG at one of its meetings during NAIC national meetings. A formal collaborative regulatory action may be initiated subsequent to this presentation. All such collaborative actions should adhere to the following guidelines:

- A company's domestic regulator, in collaboration with additional lead states, will assume the lead for the collaborative regulatory effort or delegate that responsibility to an appropriate alternative primary state;
- The domestic regulator will identify additional states to help lead the regulatory effort and provide a presentation to MAWG outlining the general scope of the regulatory effort prior to the initiation of the effort;
- Selection criteria for the other lead states should include the following: (1) a domestic state for a company within a group being examined; and (2) a state in which the company has a significant premium volume;
- The domestic regulator, in collaboration with the other lead states of the regulatory effort, will request all states to participate in the regulatory effort;
- Participating states shall agree to accept the findings of the collaborative regulatory effort and to forego examining the identified company unless the state has a specific reason that requires a separate regulatory effort to be initiated;
- All participating states will have access to confidential and privileged information as long as they have signed the NAIC's Information Sharing and Confidentiality Agreement;
- The domestic regulator, in collaboration with the other lead states, will provide periodic written and oral updates about the regulatory effort under a timeframe mutually agreed upon by the domestic regulator and MAWG;
- The domestic regulator, in collaboration with the other lead states, will provide a written and oral presentation to MAWG summarizing the examination findings and proposed settlement prior to the formal issuance of any regulatory report to the company;
- After 20 calendar days for advisory comment by MAWG, the domestic regulator, who will retain final authority over the examination findings and settlement in collaboration with the other lead states, will consider these comments and present the final examination report and proposed settlement to the company; and
- The domestic regulator, in collaboration with the other lead states, will communicate additional changes to the examination report and proposed settlement to MAWG.