Enhancing State Market Analysis

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

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

Below are some examples of possible approaches.

A. Improving Consumer Complaint Analysis

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

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

Having uniform definitions and standards applicable in all states results in an accurate exchange of information, allows for the systematic analysis of that information, allows complaint information to be used effectively in the market surveillance process and allows accurate complaint summaries to be compiled for public distribution.

1. Key Elements of Best Practices

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

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

> A ***complaint*** is **"any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose."**[17]

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

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

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

- Insured;

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[17] Similarly, the 1974 Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act provides that "complaint" shall mean a written communication primarily expressing a grievance. This definition was adopted by the Market Regulation and Consumer Affairs (D) Committee in 2006 after a review of the complaint definition recommended in the NAIC Consumer Complaint White Paper dated March 2000.

- Service Provider; and
- Other.

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

- Third-Party Claimant;
- Counsel; and
- Public Adjuster.

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

2. More Detailed Information on Complaints and Regulatory Actions

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

- Entity Complained Against;
- Complainant Information;
- Type of Coverage (auto, life/annuity, accident/health, homeowners, liability);
- Reason for Complaint (underwriting, policyholder service, claim handling, marketing); and
- Disposition.

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

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

3. Calculating Complaint Ratios by Number of Policies

Another refinement states may consider for complaint analysis is to compare complaint ratios calculated in the standard manner, based on premium volume, to some alternative baseline, such as the number of transactions. Premium data is more easily obtained and, within a particular product line, is often a reasonable surrogate for policy count, but if an appropriate measure is available of the number of policies, policyholders or covered lives (or some other measure specific to a particular line of business such as car-years), it may provide a more meaningful measurement, depending on whether the level of activity on a policy is likely to increase as the premium increases. Annuity business, in particular, is a line of business where the dollars involved can vary so much from transaction to transaction that "premium" volume is a poor measure of the level of market activity. Similar concerns apply to life

insurance as well—the race-based premium scandal, for example, affected many more consumers than their share of the overall life insurance premium volume would indicate. Although mishandling a single "large case" policy has a significant impact and should not be taken lightly, the complaint analysis system should not encourage giving disproportionate attention to accounts with tens of thousands of dollars or more in annual premium at the expense of all the other consumers.

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

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

Example (complaint index by number of policies): Any alternative basis for calculating complaint ratios can also be used to develop complaint indices. In the prior example, the aggregate complaint ratio is 670 complaints/6,500 policies: 0.103 and the complaint indices for the three insurers are, therefore:

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

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

4. Improving Complaint Analysis through Use of CDS

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

It is important for insurance departments to establish a database to track key elements of the complaint process. The analysis of complaint data can identify potential company or industry trends or concerns including non-complying general business practices or acts that may adversely affect consumers. For instance, a large influx of complaints about premiums within a specific geographic area may be reflective of a rate increase by carriers, or possibly indicate a lack of affordable coverage in the area. The trends identified from analysis of the database can be used to trigger a simple inquiry or generate a

referral to the examination or enforcement area. The database might track the number of complaints against particular companies or producers for the improper cancellation or denial of coverage. When the number of such complaints reaches a certain level, other divisions of the insurance department should be notified.

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

5. Publishing Complaint Information

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

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

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

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

6. Confirmed Complaints
The NAIC definition of a confirmed complaint is:

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

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

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

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

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

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

B. Use of www.MyNAIC.org in Market Analysis

As part of the Framework for Market Analysis, market analysts identify companies of interest for analysis, monitoring or regulatory action. Monitoring companies occurs regardless of the analyst's decision to pursue any of the items within the continuum of regulatory responses. The market regulation tools for **regulators only** on www.mynaic.org can be used after a Level 1 Analysis or Level 2 Analysis in which a regulator may want to monitor a company or when a regulator has a potential or on-going examination of a company.

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

C. Use of IRIS Ratios in Market Analysis

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

Bearing in mind these limitations, the eight IRIS ratios that are most likely to be of value as market conduct indicators are:

- **Property/Casualty—Gross Premium to Surplus**
  This ratio tests the adequacy of the company's surplus, without the effects of reinsurance. The higher the ratio, the more risk the company bears in relation to the surplus available to absorb loss variations, without the benefit of reinsurance.

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

[18] Although the life/health series is numbered from 1 to 13, Ratio 4 has been discontinued.

- **Property/Casualty—Net Premium to Surplus**
  This ratio is similar to the Gross Premium to Surplus ratio, but it considers the effects of reinsurance. The higher this ratio, the more risk the company retains in relation to available surplus.

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

- **Property/Casualty—Change In Net Writings**
  Major increases or decreases in net premium written can indicate a lack of stability in the company's operations. A major increase in premium may signal abrupt entry into new lines of business or states or territories—this could have market conduct implications even if the new business is profitable financially. In addition, a company that is attempting to increase cash flow in order to make loss payments may do this by taking on risky or unprofitable business.

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

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

- **Property/Casualty—Liabilities to Liquid Assets**
  This ratio is a measure of the company's ability to meet the financial demands that may be placed upon it. If the company's ratio is out of the norm in this area, there may be problems with its ability to pay claims.

  Guidelines—The usual range is below 105 percent. Analysis of insolvent companies has shown that many insurers that later became insolvent had increasing ratios of total liabilities to liquid assets in their final years. Thus, when looking at this ratio, it is important to consider the trend, not just the current year.

- **Life/Health—Net Change in Capital and Surplus**
  This ratio compares the company's surplus in the current and immediately preceding years, adjusted to disregard contributed funds and surplus notes. It is considered the most general measure of improvement or deterioration in a company's financial condition.

  Guidelines—This ratio is usually less than 50 percent and greater than negative 10 percent. Any number that is significantly outside this range should be investigated further to determine the reason.

The four life/health ratios discussed here are not calculated for a newly formed company because they are dependent on prior year data.

- **Life/Health—Gross Change in Capital and Surplus**
  This ratio is similar to the Net Change in Capital and Surplus ratio, but it considers all changes in capital and surplus regardless of the source.

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

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

  Guidelines—This ratio is usually less than 50 percent and greater than negative 10 percent. Any number that is significantly outside this range should be investigated further to determine the reason. The issues presented are similar to those raised by sudden changes in property/casualty premium activity, as discussed above.

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

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

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

Since IRIS ratios were originally developed for financial purposes, market analysts must keep in mind the similarities and differences between market analysis and financial analysis and how these affect the use of IRIS ratios. As noted before, unusual IRIS scores do not necessarily indicate financial problems, but they could still be of interest to market analysts. For example, a company could have the capital to venture safely into a new, untested line of business, but might not have the customer service resources in place—or vice versa. The IRIS score indicating a significant change in writings calls for follow-up by both financial and market analysts, but they could be following up in different ways.

For example, one key market indicator tracked by IRIS is the change in premium volume (P/C Ratio 3 or L/H Ratio 10). A significant change in premium volume should suggest a series of inquiries for market analysts.

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

D. The Use of Underwriting Guidelines in Market Analysis

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

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

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

1. The Significance of Underwriting Guidelines

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

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

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

2. Reviewing Underwriting Guidelines

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

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

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

underwriting guidelines who has responsibility for maintaining the documents and tracking how the information is accessed within the insurance department.

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

3. Use of Information Obtained from Underwriting Guidelines

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

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

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

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

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

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

Example of Compilation of Underwriting Guidelines for Private Passenger Auto

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

Another illustration is the following historical compilation of the use of underwriting guidelines for personal auto and homeowners coverage in Texas, compiled by that state's Office of Public Insurance Counsel and available on its Web site at http://opic.state.tx.us.

AUTOMOBILE INSURANCE UNDERWRITING GUIDELINES

Changes in the Rate Regulated Market

Underwriting Guidelines	1994	1996	1999
Canceled by Another Company. Applicants are asked whether their insurance was canceled by another insurer. During the time period covered by the guidelines reviewed for 1996, a new rule made it illegal to base underwriting decisions on this information, although it was still legal to ask an applicant. It is unknown how this information was used. The rule prohibiting use of this guideline has been overturned by the Texas Supreme Court.	71%	65%	60%
No Prior Insurance. Insurer will not offer coverage to an applicant who is not currently insured or has not maintained continuous coverage for a specified period. Rules prohibit use of this guideline if applicant was uninsured for 30 days or less during the last year.	71%	46%	83%
Age. Applicants are denied based on their age, even though the rates set by the state allow for rating classification by age. Generally, these guidelines refuse coverage to young drivers, with some exceptions for those who are covered on their parents' policy and to older drivers.	91%	93%	84%
Occupation. Applicants are denied because of their occupation. Some guidelines allow certain occupations or professions to have more blemishes on their driving/claim record.	56%	65%	56%
Residential Stability. Applicants are denied if they have not lived at the same address for a specified period of time, usually two to three years, or if not a homeowner.	67%	85%	77%
Employment Stability. Applicants are denied if they have not worked for the same employer for a specified period of time, usually two to three years.	51%	47%	34%
Not-at-Fault Accidents and Claims. Applicants are denied because they have made a claim for, or been involved in, an accident or accidents in which the applicant was not at fault.	52%	21%	41%
Foreign Nationals. Applicants are denied because they do not meet the insurer's residency requirements and/or requirements that the applicant have driving experience in the United States for a required period of time, usually several years.	58%	44%	64%
Marital Status. Insurer considers the applicant's marital status. Many of the guidelines ask for specific information, such as widowed, divorced or separated, although the rating manual only distinguishes between married or not married for certain young driver categories.	48%	45%	1%
Other Coverage. Applicants are denied the minimum liability coverage required by law unless they agree to buy other coverage. While legal for the 1994 report, this guideline was illegal during the period covered by the 1996 guidelines. The department of insurance rules prohibiting its use is still in effect.	38%	2%	54%

Previous Insurer Nonstandard. Insurer refuses to sell to those who have been insured in the nonstandard market (county mutual or assigned risk plan). While legal for the 1994 report, this guideline was illegal during the period covered by the 1996 guidelines. The rule prohibiting use of this guideline has been overturned by the Texas Supreme Court.	15%	4%	40%
Credit History. Applicants are denied coverage because of their credit history. Insurers often use "risk scores" which combine credit information with demographic data.	25%	58%	46%
Driving Experience. Applicants are denied if they do not have at least three years of driving experience. The number of years of experience required varies by insurer, up to a maximum of 14 years.	43%	25%	71%

HOMEOWNERS INSURANCE UNDERWRITING GUIDELINES

Changes in the Market

Underwriting Guidelines	**1994**	**1996**	**1999**
Credit. Applicants are denied coverage or nonrenewed by insurance companies because of their credit history or credit/insurance risk score.	22%	34%	32%
Claims. Applicants are denied coverage, nonrenewed and surcharged by insurance companies because of the number and/or type of claims they have filed. It is illegal to nonrenew a policy for claims unless the insured has filed three or more non-weather related claims in any three-year period.	91%	92%	90%
Minimum Coverage. Applicants are denied a policy because they request or require an amount of insurance coverage below the minimum set by the company.	91%	77%	82%
Age of Home. Applicants are denied coverage, placed in a higher-priced company or nonrenewed by insurance companies because their home is too old.	88%	75%	53%
Location of Home. Applicants are denied coverage and nonrenewed by insurance companies because their home is located near substandard or commercial property or in a neighborhood with high crime and/or declining property values.	60%	62%	62%
Lifestyle. Applicants are denied coverage and nonrenewed by insurance companies because of their living arrangements and/or "morals."	29%	15%	57%
Territorial Restrictions. Applicants are denied coverage or required to purchase higher deductibles if they live in certain hail-prone areas, for instance, the Dallas/Fort Worth area. Other requirements include not offering replacement cost coverage on roofs or charging a higher rate based on the type of roofing material.	N/A	84%	93%

4. Conclusion

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

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

D. Modes of Analysis

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

1. Analysis of General Market Conditions

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

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

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

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

2. Individual Company Concerns

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

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

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

3. Global Objectives

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

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

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

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

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

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

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

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

Continuum of Regulatory Responses

The continuum of regulatory responses can be used to guide the decision-making process when moving from analysis to a regulatory response. Additionally, it can be used when further analysis is needed. This document provides guidelines for matching regulatory responses to specific situations and options to assist in the decision-making process. The continuum is not a "ladder," whereby one step must be taken prior to advancing to the next. Rather, it should be viewed as a spectrum of decision-making options.

A. Overview

Many of the techniques can be applied to market analysis, as well as to regulatory responses to market issues and concerns. This document will focus on use of continuum-type responses primarily as they apply to regulatory responses. Market analysts may also wish to consider use of the information gathering techniques as a useful tool. Insurance regulators can use a broad continuum of regulatory responses when determining the appropriate regulatory response to an identified issue or concern. Goals similar to the following should be kept in mind when determining the most appropriate response:

- Remediation of harm to impacted consumers and preventing future harm to consumers are primary goals. The form of remediation is generally determined through the administrative/legal process. Developing specific information to show specific impact can assist the administrative resolution;
- The manner of the response should address the problem or issue as widely as possible, with minimal impact to regulated entities that have not otherwise contributed to the problem;
- Regulatory responses should be commensurate to the identified problem;
- Regulatory responses should be selected to best leverage the resources at the regulator's disposal; and
- When possible, regulatory responses should be cost-effective for both the regulatory agency and the regulated entity. Consider less intrusive responses if the matter of regulatory concern can be effectively addressed with a less intrusive response.

Regulators should also determine the nature of the regulatory concerns by reviewing questions similar to the following. They may help set the stage for choosing the most appropriate response and might assist to prioritize regulatory projects:

- How immediate is the concern? What is the nature of the harm to consumers? What is the likelihood that consumer harm will occur if the issue is not addressed soon? What is the potential impact of the concern?
- How extensive is the issue? Does the concern involve one regulated entity or multiple regulated entities?
- What are the jurisdictional boundaries of the concern? Is this an issue that can be resolved with the combined efforts of multiple jurisdictions or the Market Analysis (D) Working Group? Has the concern already been addressed by another jurisdiction?
- How is the concern impacted by company self-audit or best practices organizations?
- What type of information is needed to evaluate the concern and to recommend corrective action? What is the expected volume of information necessary?
- Can audit software assist in analyzing the concern?
- Might the regulatory response result in an enforcement action?
- What is the regulated entity's history for being proactive with market conduct compliance?
- What types of market conduct responses have been effective with the specific entity in the past?

- What if an analyst or examiner discovers information or activities that raise suspicions of fraudulent activity? Should a report be promptly created and sent to the Market Analysis Chief (MAC) or Examiner-in-Charge (EIC)?

What is the continuum of market conduct regulatory responses?

- Office-based information gathering;
- Contact with the Regulated Entity;
- Interview with the company;
- Targeted information gathering;
- Correspondence;
- Policy and procedure reviews;
- Interrogatories;
- Desk audits;
- Company self-audits;
- Voluntary compliance programs;
- Information sharing;
- On-site reviews;
- Investigation;
- Targeted examination;
- Comprehensive examination;
- Multi-jurisdictional cooperative examination;
- Enforcement actions; and
- Proposal of new statutes or regulations.

B. Continuum of Responses

A brief discussion of each type of response follows. Examples provided should by no means be considered the sole use for each type of response.

When deciding which response is most appropriate for the situation, it is also important to determine the scope of where the response should be directed. The most common example would be toward a single insurer. It may also be most efficient to address multiple insurers within a holding company group. That would especially be appropriate when multiple insurers operate within the same operating procedures, locations or management. It may be necessary to contact the insurer to learn what companies within a group are relevant. Some company groups are comprised of almost completely autonomous operations. Some issues may involve industry-wide or nearly industry-wide situations, calling for an appropriate industry response.

States should choose a regulatory response action that is reasonable, appropriate and proportional to the type of market practices identified during market analysis. A determination about the appropriate regulatory response should consider mitigating factors, such as the least intrusive response that demands the least amount of regulatory resources, the regulated entity's history of cooperation with regulators and the potential amount of consumer harm. Regulatory responses may include:

Office-Based Information Gathering

Information gathering beyond what was developed in a Level 1 Analysis and/or Level 2 Analysis will occasionally be necessary. Sources of information to consider include:

- Market Conduct Annual Statement;

- Consumers;
- Insurance producers;
- Other divisions within the insurance department, such as the Consumer Services Division;
- Other state insurance departments;
- Other state and federal agencies;
- Trade publications;
- Trade associations;
- Media;
- Internet;
- NAIC I-SITE and National Portal, including the Regulatory Information Retrieval System (RIRS);
- Statistical agents and insurance advisory organizations;
- Policyholders and claimants;
- Data calls;
- Regulatory filings and other public documents;
- Court records; and
- Subject matter experts.

The Market Conduct Annual Statement (MCAS) is a multistate NAIC initiative to collect data from life, homeowners and automobile insurers in a uniform manner. Each state regulator is to identify companies whose data appears to fall outside the industry-wide pattern. The MCAS permits analysis of various data elements such as life insurance replacements, surrenders, complaints, claim handling and cancellations. The project anticipates that each state will also provide a "report card" to the participating insurers so they will be able to determine how their operations compare to industry-wide measures.

The Consumer Services Division within a state insurance department may hold a wealth of information relating to specific insurers. Retrieving, reviewing and summarizing case files are an excellent way to isolate issues and concerns.

Likewise, the NAIC I-SITE systems will provide a great deal of information that is derived from such sources as annual statement filings, regulatory actions (RIRS), established financial and market analysis programs, national complaint data, examination information and licensing data.

Practical examples of office-based information gathering include:

- Researching a class action lawsuit against an insurer using court records to determine if any of the allegations include regulatory compliance matters;
- Contacting producers to ask for their perspective about unusual market conduct observations;
- Reviewing enforcement actions against insurers or producers that were issued by entities other than insurance departments, such as attorneys general or federal agencies such as the SEC; and
- Requesting data from a statistical agent to evaluate market availability of homeowners insurance.

Should the states determine that additional data is required from the regulated entity, the NAIC uniform data requests should be followed. If there is a need to deviate from the uniform data requests to capture specialized information, the need for additional data should be explained and justified to the regulated entity.

Contact with the Regulated Entity

A domestic state, high-premium volume state or other selected lead state may be designated to correspond with the entity about the area of concern. This option provides for prompt communication about the concern. In addition, by corresponding directly with the insured, the states can request specific information or request that specific action be taken to quickly resolve the issue.

In each case, it is desirable for the regulator and regulated entity to know whether the resulting information obtained will be treated as confidential investigatory or examination materials or whether the materials will eventually become publicly available information. Additionally, it is desirable to let the regulated entity know the statutory authority for requesting information, the purpose for the request, expectations for timing of the response and how the response is expected to be resolved; for example, via a report, a letter, no further contact if deemed acceptable, a potential enforcement action, etc. In most cases, when initiating a formal request for information, it is desirable to advise of the regulatory authority for requesting the information. Providing a clear purpose for making the request should also assist in helping the insurer understand the importance of responding in a full and timely manner.

If state statutes require the regulatory agency to bill the regulated entity for time or expenses relating to the inquiry, it is a good practice to explain that when making the inquiry.

Correspondence with the regulated entity may not be a sufficient regulatory response action if the specific market practice has not been identified or if the regulated entity has previously been resistant and uncooperative with regulatory communications.

Interview with the Company

In the form of a face-to-face meeting or conference call, interviews with the company are useful when there is a need for open dialogue, discussion and clarification. It provides both the regulator and the regulated entity with an opportunity to ask questions, provide clarification and to verbalize each point of view about compliance matters. Interviews with company personnel can be useful to obtain information about specific company divisions or functions. The most formal interview method would be taking a statement under oath. Before conducting a statement under oath, it is recommended that the regulator review their insurance department's own policies and procedures or seek advice from insurance department counsel to become familiar with their state's specific requirements. General standards may require that persons examined under oath be permitted representation by counsel and be permitted to have access to a transcript of the proceeding.

Interviews may typically be utilized in those instances where the states have determined that the insurer is operating outside its standard operating policies and procedures. This option may require specific knowledge of the regulated entity's policies and procedures to understand that the analysis results indicate a deviation from those policies and procedures. As with the option to correspond with an entity, interviews may not be the best response if a regulated entity has resisted regulatory communications in the past.

Interviews might also be conducted to resolve questionable market analysis findings. That is, should market analysis findings indicate that the regulated entity might be engaged in questionable practices, interviews may be conducted to give states a better understanding of these activities.

Practical examples of performing an interview with the company include:

- Making a phone call to an insurance company compliance officer to discuss claim-related complaints that have increased noticeably over the past two months;
- Arranging a meeting with an insurance company compliance officer to discuss concerns relating to the company's change in marketing strategy;
- Meeting with an insurance company compliance officer to learn the details of a complicated new insurance program being rolled out;
- Requesting a meeting with a company underwriting manager to learn first-hand how the company uses loss history information; and
- Setting up a recorded statement under oath to ask a claims examiner about company instructions and procedures relating to the problematic handling of claims.

Targeted Information Gathering

Targeted information gathering may take the form of a survey or data request. A useful survey should include clear and understandable questions. Where possible, it will be helpful to limit the scope of a survey to one or two insurance company functional areas. When requesting data, use standardized data calls if possible. Also, if possible, be mindful of time constraints faced by insurance companies. For example, requesting a response date that is near the annual statement preparation date may create an undue workload and unnecessary cost upon an insurer.

Practical examples of targeted information gathering include:

- Sending a survey to domestic insurance companies relating to their progress toward compliance with a new law being enacted nationwide. The responses will be coordinated and shared with other states that likewise are contacting their domestic insurers; and
- Requesting a data file from a health insurer to analyze compliance with prompt-pay requirements.

Correspondence

Once a potential or fully identified problem has been detected, one method of addressing the concern is to correspond with the insurer. A letter may be used to discuss such issues as a perceived negative trend in complaints, or a specific problem that needs immediate attention. A distinct advantage of using a letter versus conducting an examination is that the problem can be more quickly focused upon and addressed by the insurer. Documenting the discussion of the issue in the form of a letter will also serve as an indicator of an insurer's intentions regarding regulatory compliance, in the event the problem is not subsequently corrected.

A well-designed letter will include the following components:

- Statutory authority for making the request;
- A clear explanation of the concern, along with the specific insurance laws or regulations that relate to the matter;
- A clear expectation of what action is being requested;
- If requesting information, an explanation of how that information will be used and how it will be treated for purposes of confidentiality; and
- A date by which a reply is expected, along with whom to respond.

Practical examples of using correspondence include the following:

- Sending a letter to an insurer reminding the company of a specific regulatory requirement after insurance department consumer affairs staff has noted cases of noncompliance; and
- Sending a letter to an insurer, advising of concerns noted during the market analysis process.

Policy and Procedure Reviews

For some cases, policy and procedure reviews may be a workable alternative to the traditional market conduct practice of performing sampling and file reviews. A review of written policies and procedures may also be supplemented with a review of a minimal number of files. This will help ensure that policies and procedures have actually been implemented. Reliance on such a review is dependent upon the company's inclusion of the compliance issue within its written policies and procedures.

A practical example of the use of policy and procedure reviews includes:

- Review of a company's written guidelines relating to protecting privacy of consumer financial and health information.

Interrogatories

An interrogatory is simply a set of questions used to evaluate an insurer's handling of compliance or processing issues. Interrogatories can be tailored to a very specific need for information. Interrogatories are a good option when attempting to determine compliance with a particular rule or law, especially if the review involves multiple insurers. Interrogatories might include a survey, certification or questionnaire.

A practical example of using interrogatories includes:

- Sending a questionnaire to an insurer, asking about claim-handling practices related to automobile total loss valuation, reimbursement of sales tax and special costs and branding of salvage titles.

Desk Audits

A desk examination is a targeted examination that is conducted at a location other than the regulated entity's premises. Desk examinations are typically performed at the insurance department's offices. The regulated entity provides requested documents by hard copy, microfiche, disc or other electronic media for review. This procedure is most suitable when there is a need to review documents that are either not original or that are specimen copies.

A desk audit is best suited for use when materials being reviewed can be sent to the insurance department. One simple example would be an advertising material review. A desk audit may not be appropriate for the review of original policyholder or claim files. The costs and difficulties with having materials forwarded to the regulator should be weighed against the costs and difficulties associated with travel and on-site accommodation of examiners. If agreeable to both parties, communications, critique

forms and other examination-related information can be expedited through use of secure e-mail or facsimile machines. Desk audit techniques can be combined with a regular examination, to reduce the amount of travel time. Guidelines for notification to the insurance company should be consistent with those established for a regular market conduct examination. Depending upon the scope of the desk audit, entry into the NAIC Examination Tracking System (ETS) is generally appropriate.

Company Self-Audits
After identification of a systematic compliance error being made by an insurer, regulators may request that the insurer conduct a self-audit. This permits an insurer to take corrective action (remediation) and to report its findings to the regulator.

Another use of self-audits involves a review of insurer-initiated audit programs. Use of this technique will vary by state; if uncertain, a regulator should consult their insurance department's legal counsel. Additional discussion may be found in the NAIC white paper, *Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege*. An advantage to reviewing self-audit reports is to prevent duplication in the review of compliance issues already actively managed by the insurer. A disadvantage is that scrutiny of an insurer's self-audit reports may place a damper on such self-audit practices because of fear that the insurer will be penalized for identified mistakes and that such mistakes will ultimately subject them to liability. One practice to consider is to learn the scope and structure of a company's self-audit program, rather than conducting a review of the resulting self-audit reports.

Practical examples of the use of self-audits include:

- Requesting that an insurer identify all health claims with a specific medical procedure code to correct a systematic payment error for the preceding 12 months; and
- Determining which functional areas and subject matters have been evaluated by a company's self-audit program during the preceding 12 months in order to better focus a market conduct review on company-neglected issues and concerns.

Voluntary Compliance Programs
The review of reports from a regulated entity's compliance programs or reports produced by best practices organizations such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Committee (URAC) and Insurance Marketplace Standards Association (IMSA) may be performed. These types of reviews might be helpful where the scope of the best practice organization's review is substantially similar to the scope of the issue, problem or concern that the states wish to address. States are encouraged to familiarize themselves with the best practice organization's review processes and, particularly, whether the review process includes verification of compliance.

Such organizations are generally willing to provide a list of participating companies and to share their review standards and methods with regulators. By comparing those review standards with examination review standards, regulators can make better decisions on how to focus the scope of a review. Regulators should also determine how their specific state laws apply to best practice organizations and accreditation services. It is possible that certain accreditation services are required for licensure purposes; two examples are managed care utilization review and provider credentialing.

Information Sharing
Regulators should become familiar with state insurance code provisions to determine the extent to which regulatory and investigatory materials may be shared with other state insurance regulators, other state agencies and other federal agencies. Some compliance issues involve multiple jurisdictions or multiple

agencies. There is a Web site available to regulators within I-SITE/StateNet that contains a listing of all states and territories that have signed the global confidentiality agreement.

Practical applications of information sharing include the following:

- Entering into a confidentiality agreement and sharing information with banking regulators to evaluate a licensed agency that has sold unregistered investments to insurance clients; and
- Sharing information with another state when both states' market analysis processes have identified similar concerns about a licensed insurer.

On-Site Reviews

On-site reviews traditionally have been used to review and evaluate actual insurance transactions in order to evaluate an insurer's level of compliance.

- Investigation;
- Targeted examination;
- Comprehensive examination; and
- Multi-jurisdictional cooperative examination.

There are two major types of on-site market conduct examinations.

Targeted examinations are focused examinations based on the results of market analysis indicating the need to review either a specific line of business or specific business practices, including, but not limited to, underwriting and rating, marketing and sales, complaint handling, operations/management, advertising materials, licensing, policyholder services, nonforfeitures, claim handling or policy forms and filings.

Comprehensive examinations are full-scope examinations that involve a review of all or most of the regulated entity's lines of business and all or most of the examination categories listed under targeted examinations. Comprehensive examinations should be utilized only in the event that market analysis findings indicate that such a comprehensive review of the regulated entity is necessary.

C. Bringing Closure to Regulatory Responses

No matter which continuum of regulatory response option is used to address a situation, regulators will be faced with the decision of how to bring closure to an issue. A discussion of some of the most common methods of closure follows. Possible closure outcomes include:

- Determining that no further action is needed;
- Communicating the insurance department's position on a matter;
- Ongoing monitoring;
- Referral to other agencies, fraud prevention divisions or law enforcement;
- Referral of the matter to the Market Analysis (D) Working Group (MAWG);
- Informal agreement to change practices or implement procedures;
- Seeking remediation for policyholders, claimants or other affected parties;
- Arranging a negotiated settlement;
- Arranging a multistate or national negotiated settlement;
- Administering penalties and relief after administrative adjudication;
- Agreeing that the regulated entity implement voluntary compliance plans;
- Providing industry education, communications or notices to insurers;
- Providing consumer outreach or education initiatives;

- Providing information by way of media; and
- Recommending legislative or regulatory rule changes.

Regulators should be aware of and abide by protocols established by their insurance department, commissioner and general counsel relating to the use of various closure outcomes. Insurance departments may have established procedures for communications with media, other governmental agencies and for the distribution of public information. Public information officers, governor liaisons, legislative liaisons, general counsels, deputies and commissioners are all possible sources of information regarding any such protocols within a state insurance department.

When deciding upon a method of closure or outcome, it is helpful to consider not only the nature of the issue and how it has affected consumers, but also the manner in which the issue was discovered and how it was addressed by the regulated entity. It would seldom be prudent to penalize a regulated entity that voluntarily communicated about a problem discovered by way of self-audit, if the regulated entity also took steps to rectify the problem and provide remediation where necessary.

Determining That No Further Action is Necessary
Justification for taking no further action might include such reasons as a determination that company actions were handled in accordance with the insurance laws or statutes, that there was no violation of insurance law or that a single problematic issue resulted from a miscommunication was acknowledged and addressed. Additionally, a regulatory response could produce findings that ease concerns raised by market analysis.

Communicating the Insurance Department's Position on a Matter
A written communication expressing the insurance department's position on a matter can serve not only as clarification, but also as a potential warning or admonishment. It can place the regulated entity on notice that future occurrences may be dealt with in a stricter fashion. Be certain any such communication is clear and accurate. Attempt to make the letter very specific to the issue at hand.

Ongoing Monitoring
Ongoing monitoring is often appropriate for issues with a high-dollar or high-volume impact. This is especially true if the regulator is not assured that the initial corrective action will be applied continuously and consistently. For example, a claims payment problem that was corrected by programming the correct reimbursement rate for a single medical procedure code into the computer system will probably not need further monitoring. A similar claims payment practice that involves numerous codes or repeated instances might warrant ongoing monitoring. Ongoing monitoring may also be appropriate when the regulatory response is not conclusive about the extent or nature of an identified problem.

Referral to Other Agencies, Fraud Prevention Divisions or Law Enforcement
Occasionally, regulatory issues or concerns may cross agency boundaries. Common examples include securities, banking, motor vehicle registration and financial responsibility, health and human services, consumer protection functions of attorneys general and senior protection agencies. It is helpful to know who within the state insurance agency may have established channels of communication with other applicable agencies. It is also helpful to have a general understanding of the functions within those agencies and how they might apply to insurance. Any indication of insurance fraud, whether directed against an insurer by an outside person or implemented from within the insurance organization, should immediately be reported to the applicable fraud prevention division. Referrals to law enforcement may be warranted when infractions, such as theft by deception or forgery, are noted.

Referral to the Market Analysis (D) Working Group (MAWG)
Issues of concern that have been developed through market analysis or by way of other channels may be referred to the NAIC Market Analysis (D) Working Group when there is a likelihood that the issue affects multiple jurisdictions and cannot be readily or simply resolved in a manner that will obviously satisfy the concerns of all jurisdictions. Each state should have a Collaborative Action Designee (CAD) to handle or coordinate the communication of these issues.

Informal Agreement to Change Practices or Implement Procedures
An informal agreement can be either written or verbal, and would be most appropriate for situations involving noncompliance with technical regulatory issues and where no significant harm has occurred to consumers or other affected parties. Such an agreement could also include such things as amendment of business practices, forms or rating plans.

Seeking Remediation for Policyholders, Claimants and Affected Parties
In cases where harm can be measured and corrected, remediation may take the form of such actions as premium refunds, supplemental claim payments, removal of unapproved or incorrectly administered restrictive endorsements or policy change options. Obtaining remediation for those affected by an adverse situation should generally be a primary goal. Where possible, recommend remediation be undertaken in all affected jurisdictions. This will reduce or eliminate the need for duplicate regulatory responses.

Arranging a Negotiated Settlement
A negotiated settlement may be used to arrive at a mutually agreeable conclusion to a matter of concern. Such an agreement is typically negotiated and placed into a written document by the insurance department's legal counsel. The agreed upon settlement may include such components as remediation, voluntary forfeitures (fines), agreements to cease and desist, agreements to implement action plans, etc. The settlement agreement may or may not lack an administrative determination that a specific violation has occurred and may or may not also indicate that the regulated entity neither affirms nor denies the specific allegations. The agreement is made as a means to resolve the conflict.

Arranging a Multistate or National Negotiated Settlement
Similar to the above discussion, this approach would involve multiple states agreeing to the terms of the settlement.

Administering Penalties and Relief after Administrative Adjudication
An administrative adjudication should follow the insurance department or state guidelines for administrative actions. A typical action would include the filing of a petition or formal complaint against the regulated entity, setting a time and place for an administrative hearing. The regulated entity would be provided an opportunity to offer testimony and evidence before a hearing officer, who would decide the outcome of the action. Likewise, the regulatory attorney would present evidence, request a finding or determination along with a request for resolution. Occasionally, a voluntary consent agreement may be reached prior to the hearing. On occasion, an enforcement action will clearly be the most practical solution for addressing cases of noncompliance. Regulators should contact their department counsel or market conduct chief to determine their state's practices and guidelines.

Practical examples of administering penalties and relief include:

- Referring a case for consideration of an administrative cease and desist against an unauthorized insurer; and
- Referring a market conduct finding for consideration of an administrative penalty against an entity that has demonstrated repeated violations.

Agreeing That the Regulated Entity Implement Voluntary Compliance Plans

Voluntary compliance plans would go beyond implementation of a single change in procedures or practices. Such an agreement may include self-monitoring, self-audits and possibly reporting back to the regulator after an agreed upon period of time.

Providing Industry Education, Communications or Notices

The use of targeted mailings, newsletter articles, bulletins and notices may allow regulators to widely address a concern or provide information relative to new issues, interpretations, relevant case law, implementation policies for new laws, or discussion of new industry practices or technologies. Education is an effective regulatory tool that can be used to provide information to the insurance industry. Two primary forms of education are proactive outreach and insurance department communications.

1. **Proactive outreach**

   Examples of proactive outreach include speaking engagements, insurance department-sponsored seminars and training events, press releases, interviews with the media, articles for publications, billboards and advertisements, brochures and radio spots. Identifying the target audience for an outreach and tailoring the delivery to that audience is one key to a successful outreach campaign.

   Practical examples of proactive outreach might include:

   - Sponsoring a seminar aimed at insurance compliance professionals to discuss changes to insurance laws;
   - Participating in an industry or regulator-sponsored trade organization seminar to share information about market regulation; and
   - Requesting trade organizations to place periodic reminders in their publications about the importance of flood insurance.

2. **Insurance department communications**

   Historically, insurance department communications have taken the form of bulletins, notices, advisory letters and newsletters. Most, if not all, states have a Web site. These Web sites offer a tremendous opportunity for providing information.

   Practical examples of insurance department communications include:

   - Issuing a formal bulletin to clarify the insurance department's interpretation of a specific law;
   - Posting an advisory letter to respond to multiple requests for information about a specific compliance issue;
   - Providing access to insurance laws and regulations through the insurance department's Web site;
   - Listing helpful suggestions for responding to insurance department inquiries on the insurance department's Web site; and

- Discussing specific regulatory concerns in an insurance department's quarterly newsletter.

Providing Consumer Outreach or Education Initiatives

Insurance departments have a unique opportunity for determining which insurance-related issues are confusing or unclear to consumers. The use of brochures, newspaper and magazine articles, press releases, outreach at public events and speaking engagements can help provide consumers with tips on how to be a more "savvy" insurance consumer. Working with the insurance department's public information officer can be beneficial.

Practical examples of consumer outreach or education initiatives include:

- Initiating a "Fight Fake Insurance" campaign to inform consumers about the danger of fraudulent and unauthorized health insurers;
- Developing press releases to teach consumers how to best file insurance claims after a natural disaster; and
- Use of billboards to remind the public that insurance fraud is a crime.

Providing Information through Media

It is important to use the insurance department's established guidelines for media contact and generally best to coordinate any media requests for information with the department's public information officer.

Recommending Legislative or Regulatory Rule Changes

Occasionally, a market conduct issue or problem will be noted, for which no regulatory authority exists to address the concern. These situations often come about with the introduction of new types of insurance, new marketing mechanisms and industry use of emerging technology and tools. Most insurance departments will have an established protocol for discussing and proposal of new statutes and regulations. Most insurance departments will require that all such proposals be channeled directly to the agency director or commissioner. When evaluating the need for a proposal, it is helpful to review existing NAIC model laws and regulations and to request feedback from other states to see if anyone has already addressed the concern. The NAIC, consumer advocacy groups and insurance trade organizations can also be valuable sources of information.

Practical examples of recommending legislative or regulatory rule changes include:

- Evaluating the need to amend Medicare supplement regulations to accommodate changes in Medicare Part D.

How to Order a Market Regulation Handbook

The 2009 edition of the Market Regulation Handbook (MRH) was released May 2009. The goal of the MRH is to help market regulators conduct uniform, standardized market analysis and market conduct examinations.

Cost: $450

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The 2009 edition of the MRH incorporates all revisions adopted by the Market Regulation and Consumer Affairs (D) Committee in 2008.

The 2010 edition of the MRH will be released in early summer of 2010 and will incorporate all revisions adopted by the Market Regulation and Consumer Affairs (D) Committee in 2009.