# Chapter 6—Basic Analytical Tools

## A. Market Conduct Indicators and Priorities

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

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

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

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

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

Other factors for state regulators to consider when setting priorities include consumer complaint activity and the lines of insurance transacted. Some lines of insurance are more prone than others to particular types of market conduct problems. A more proactive market regulation program is generally better suited to personal lines than to commercial lines and generally better suited to small business markets than to other commercial lines markets. However, none of these criteria should be applied too rigidly. There is no foolproof way to predict which market issues will rise to the forefront, as demonstrated, for example, by the impact of the COVID-19 pandemic on both health insurance and business interruption insurance.

## B. NAIC iSite+

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

iSite+ provides state insurance department regulators with access to applications used by regulators. Regulators may access iSite+ via the myNAIC link on the NAIC website. In order to log into myNAIC, regulators must have an active NAIC login credential..

iSite+ reports are standardized reports that provide regulators with a variety of financial and market regulation information. Summary reports provide information related to a group of entities with similar attributes (e.g. companies that write business in a particular state), Company/Firm reports provide information related to individual entities. A comprehensive listing and description of available iSite+ reports are located under the Tools tab.

## C. Use of Complaint Data in Market Analysis

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

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

* Complaints are to some degree anecdotal and often are not documented in sufficient numbers to be statistically credible. Although this deficiency can be mitigated to some degree by using multistate data, inconsistencies between different state approaches raise other concerns;
* One reason for the small sample size is that not every problem gives rise to a documented complaint. States need to gauge how informed state consumers are about voicing concerns or complaints regarding insurance;
* Conversely, the customer might not always be right. The presence of a complaint points to the existence of a conflict, but not the nature or the cause. A complaint could be the result of an insurer failing to live up to its obligations or the result of a breakdown in communications, but it could also be the result of unrealistic expectations on the part of the consumer. To address this concern, “confirmed” complaints, meaning complaints that have been confirmed by the the state insurance department as the insurer as being in violation or in error, (Link to definition in chapter 7) should be distinguished from other consumer complaints;
* There are some lines of insurance for which there are no useful complaint records because the nature of the business makes it unlikely that consumers will file complaints or because the insurance department does not have an active complaint resolution program. For example, violations of disclosure requirements might never generate complaints because, in the absence of disclosure, consumers do not know their rights have been violated. Similar problems also arise when premiums or benefits involve complex calculations because of the nature of the product; and
* Some markets are inherently more prone to complaints than others. For example, this is likely to be true for the higher risk or non-standard sector within any line of insurance. Such differences must be taken into account before trying to compare the performance of different companies serving different markets. When there are problems with life insurance products, they are less likely to become visible through the consumer complaint process. Similarly, complaints are more likely in lines of business where consumers have more frequent interactions with their insurer, such as health or private passenger auto, regardless of how serious the potential problems might be.

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

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

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

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

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

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

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

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

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

## D. Use of Annual Statement Data in Market Analysis

### Market Conduct Annual Statement

Similar to a Financial Annual Statement, the Market Conduct Annual Statement (MCAS) provides regulators with market conduct information not otherwise available on a regular basis. The first MCAS was adopted by the NAIC in 1991. It was designed as an aid in targeting examinations, as well as an alternative to examinations. MCAS data collection has grown from one area within one line of business, private passenger auto claim payment information, to multiple market regulation concerns within multiple lines of businesses.

Currently, MCAS data is collected on eight lines of business: individual life cash and non-cash value products; individual fixed and variable annuities; individual stand-alone and hybrid long-term care policies; private passenger automobile policies; homeowners policies; in-exchange and out-of-exchange health plans; lender placed home and automobile policies; and disability income. In addition, the collection of private flood MCAS data will begin for the 2020 data year reported in 2021. Travel insurance and other health MCAS will be reported in future years.

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

Additional information regarding the Market Conduct Annual Statement program may be found at [*https://www.naic.org/mcas\_main.htm*](https://www.naic.org/mcas_main.htm)or by contacting NAIC Market Regulation Department staff at mcas@naic.org .

### Financial Annual Statements and State Pages

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

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

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

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

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

Claims-related information is of particular relevance to market performance, so one of the key items of financial data for market analysts is claim reserves, which is itemized on the property/casualty Blank as “Direct Losses Unpaid” and “Direct Defense and Cost Containment Expense Unpaid.”[[1]](#footnote-1) A spike in reserves can occur for a number of reasons, some of which might signal market conduct problems. If losses and reserves are both moving in the same direction, there is less concern. A spike in reserves without a corresponding change in losses paid should be investigated. Perhaps a major lawsuit was filed against one of the company’s insureds, or there may be a correction of reserves on pending claims. The insurance regulator should investigate the reason and also check the complaints made against the insurer, trends over time, and reserve activity for comparable companies in the market.

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

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

Financial statement data also allows the analysis of how a state fits into the company’s overall operations, what the rest of its market looks like and how that pattern compares to other companies doing business in a regulator’s state marketplace.

From the State Page data, a regulator can run three categories of reports: Aggregate Reports; Detail Reports; and Market Share Reports. Aggregate Reports includes two kinds of reports: (1) Credit and A&H Pure Direct Loss Ratio; and (2) Lines of Business by State. Detail Reports include: By Line of Business; Life Premium & Annuity Considerations; Life Summary; PA& or Health Summary by Line of Business; and Unlicensed Premiums: Market Share Reports can be run on : A& H; Credit A & H; Credit Life; Life & Annuity; and By Line of Business. The Aggregate Report for Credit and A&H Pure Direct Loss Ratio can be tailored to data year (2010 to current). The loss ratio information will help identify companies with greater contact with consumers through the claims settlement process and significant deviations from the norm could indicate financial stress if the loss ratio is too high—or the potential for concerns about claim handling or underwriting practices if the loss ratio is unusually low. It must be kept in mind, however, that what might be considered a “normal” loss ratio—consistent with profitable operations—may vary significantly, depending upon the line of business and (especially for “long-tail” lines of business) upon changes in general economic conditions. The Aggregate Report By Line of Business can be tailored to data year (2010 to current) and statement type (property, life and health).

The Detail Report for Lines of Business can be tailored by data year (2010 to current), statement type (property, life, life – A&H, and Health), financial amount (e.g. direct premiums written), and multiple unique sub-types of business (e.g. private crop under Property; industrial under Life; federal employees health benefits plan premium under Life – A&H; and dental only under Health).

The Insurance Regulatory Information System (IRIS) tool, based on financial statement data, should also be noted. IRIS ratios are available for Fraternal, Property, and Life companies. The IRIS Worksheet calculates acceptable ranges for twelve ratios and notes when a company falls outside of that range. A company that consistently has multiple unusual IRIS values or fails to improve those ratios is of concern. Although the IRIS ratios were developed to assist solvency regulators, they also capture some information that can be useful to market analysts.

## E. Issues Specific to Particular Types of Companies

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

**Health Insurance**

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

Personal lines property/casualty coverage is another key focus of consumer assistance and complaint resolution programs. A high proportion of consumer concerns in these lines of business relate to claims and to policy termination, andoften the two go together. This is a dynamic market with many emerging issues. There are also significant state-to-state variations in property/casualty lines of business. Many of the variations in the liability insurance markets reflect variations in the underlying substantive laws giving rise to the liability exposure. This is especially true for automobile insurance, where several states have modified the traditional tort law for automobile collisions with some form of “no-fault” coverage.

**Life Insurance**

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

**Workers’ Compensation Insurance**

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

## F. Other Useful Information

While complaint records and financial statements may be the most comprehensive and concentrated sources of data on market activity, there are many additional sources that should be reviewed in order to obtain the complete picture of a company or an industry. For example, a high proportion of the activity in the insurance marketplace involves licensed insurance producers. Records of disciplinary actions or appointment terminations may reveal patterns of questionable practices in certain market sectors or implicate certain companies. Even routine activities, such as increases or decreases in new licenses or appointments or changes in lines of authority, can indicate market trends which might warrant further inquiry to evaluate whether the effects are positive, negative, or mixed. The information contained in this section of the handbook provides additional resources and tools for assisting with the analysis of a company..

**Financial Reporting (Public and Private Sector)**

Statutory annual and quarterly statements are the principal source of financial information on insurers, but they are not the only source. If the insurer is publicly traded, it will also be filing with the U.S. Securities and Exchange Commission (SEC). Filings can be accessed at the SEC website using EDGAR at <https://www.sec.gov/edgar/search-and-access> . The most useful filings for market regulation purposes are: 10-K and 10-Q; 8-K; and 4. There are a variety of private-sector sources that compile and evaluate financial information, such as rating agencies, statistical and ratemaking advisory organizations, trade associations, securities analysts, and academic and nonprofit research institutions. Some of these data compilations are directed towards specialized information, such as claims activity,. Surveys and reports on particular topics by research institutions, consumer groups, and trade organizations may also yield valuable data.

**Rating Agencies**

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

**Informational Filings**

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

**Interdepartmental Communication**

A continuous dialogue with regulators in other areas within a department of insurance is essential, as issues arising in other areas may be mirrored by related problems consumers are having with the same companies or markets. For lines of business that are subject to form or rate review or certification, incidents where a company has been observed using unapproved or improperly certified rates or forms should trigger further inquiry, since such incidents often are part of a wider pattern.

**Communication with other Regulators**

Communications with other state agencies, other state insurance departments, and the federal counterparts is instrumental in maintaining a seamless review of companies, keeping a fair playing field, and providing the most protection to consumers.

**Enforcement Actions**

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

**Regulatory Information Retrieval System**

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

**Market Action Tracking System (MATS)**

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

**Self-Audits and “Best Practices” Reviews**

Reports from voluntary examinations of companies provide another potential source of useful market analysis information at any stage of the analysis process. In addition to self-audits conducted by companies, evaluations are also prepared when insurers apply for membership or accreditation to “best practices organizations” or independent standard-setting organizations and when those organizations conduct periodic reviews.[[2]](#footnote-3)

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

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

In some states, self-evaluative privilege statutes provide specific guidance on the regulators’ access rights and confidentiality obligations, whereas regulators in other states must consider a variety of issues related to the protection of proprietary information, attorney work product, trade secrets, and other privileged information. Addressing these concerns and working with companies’ voluntary review activities is important, because a full understanding of a company’s market activities encompasses the company’s policies and the practices that implement the company’s policies. An active compliance program at a company often reflects a corporate culture that places a high value on compliance. Since “bottom-up” information on a company’s market practices is more accessible to regulators, the “top-down” policy focus often found in insurer peer reviews can be a useful complement to the information that is otherwise available.

**Consumer Dispute Resolution Processes**

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

**Matched Pair Testing**

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

**Rating Territories**

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

**Miscellaneous**

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

Other information collected by some regulators, though not necessarily available in all states, includes underwriting guidelines, detailed geographic market performance data, surveys of market participants and marketplace testing. Detailed geographic data—such as ZIP code data by company and type coverage—has been used by some regulators to identify underserved markets and investigate redlining allegations. Surveys of market participants—including agents, realtors and consumers—are another source of real-time market performance information. Testing—sending people to purchase insurance who have similar risk characteristics but different races or other characteristics that may make them targets of unfair discrimination—adapts a tool that has long been used in the fields of housing, lending and employment to verify compliance with fair practices. In addition, a review of recent insurance-related lawsuits can provide insight into consumer perceptions of market abuses, and this information is publicly available.

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

1. Although this information may also be of value when studying accident and health insurers, particularly in lines like long-term disability and long-term care, there is no analogous line item on the health or life and health state pages. Because calendar year paid loss data aggregates layers of the losses incurred in many different years, unpaid losses cannot be backed out by comparing calendar year paid and incurred loss data. [↑](#footnote-ref-1)
2. Market analysts should refer to the NAIC white paper *Best Practices Organizations* for additional guidance related to the application of such evaluations and standards. [↑](#footnote-ref-3)