# Chapter 7—Putting It All Together: Market Analysis

State insurance departments already have at their disposal the information needed to develop some key baseline indicators of market conduct concerns. This section of the handbook presents a framework for market analysis and provides a step-by-step outline for establishing a market analysis program. This chapter provides directions on identifying companies for analysis, performing baseline analysis, and analyzing and interpreting consumer complaint data, State Page data. and market share data.

## A. Framework for Market Analysis

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

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

Market analysis should be conducted on a regular basis, but no less frequently than annually. The data analyzed for a given market analysis year includes the prior calendar year financial and market conduct annual statement data. Companies are required to make quarterly and annual financial filings and market conduct filings by specific deadlines each year. In addition, companies are expected to respond to data calls and surveys.

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

The Level 1 Review is a second tool available to the states in their market analysis process. This tool involves looking at much of the same data in the MAPT but on a more detailed and thoughtful basis. Whereas the MAPTidentifies companies based on certain formulas and overall company performance, the Level 1 Review requires a more detailed and thoughtful analysis, where the analyst looks at company-specific information to determine if the anomalies can be explained. A Level 1 review is a more detailed review of certain information contained in NAIC databases, and is available to the analyst through the Market Analysis Review System (MARS). It is critical for the state to do this review to eliminate companies that do not warrant further analysis and to begin the process of identifying the cause of the anomaly for those that do warrant additional analysis.

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

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

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

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

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

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

## B. Developing a Market Analysis Program

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

### Step 1—Appoint a Market Analysis Chief (MAC)

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

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

### Step 2—Establish a Systematic Procedure for Interdivisional Communication

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

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

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

* + - * Significant changes in the ratio of consumer complaints against the insurer or significant numbers of complaints in a relatively short period of time;
      * Dramatic growth (> +33 percent) or decline (< -10 percent) in one or more lines of business;
      * Significant changes in the company’s book of business;
      * Rapid expansion into new states and significant premium volume in new states;
      * Significant concentrations of risk—geographically, by line of business or exposure—or significant changes in the concentrations of risk;
      * Significant changes in expense levels (such as defense costs or commissions);
      * Recent change of the state of domicile of a major writer in an insurer group;
      * Recent changes in ownership or senior management;
      * A high degree of reliance on third parties to perform company functions, such as managing general agents (MGAs) or third-party administrators (TPAs);
      * Significant problems with electronic data processing systems such that the integrity of data underlying claims, underwriting and financial systems is questionable;
      * Reports listed in the Regulatory Information Retrieval System (RIRS);
      * Reports listed in the Market Action Tracking System (MATS); and
      * Reports listed in the Market Analysis Review System (MARS).

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

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

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

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

### Step 5—Identify Potential Problems from Complaint Ratios

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

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

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

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

### Step 7—Market Conduct Annual Statement

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

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

On a coordinated basis, states should conduct baseline analysis as outlined in the Framework for Market Analysis document, reproduced in Section A of this chapter. All states should analyze the various data elements and indicators within the same general time frame to assist in the coordination of possible collaborative actions.

It is recommended that the analysis occurs as soon as possible after the Financial Annual Statement and MCAS submissions are received. Results should be compiled and reviewed regularly and as new information is received. If state Market Analysis Chiefs (MACs) find an issue with a particular company, they can share information with their state Collaborative Action Designees (CADs). CADs can then contact other state CADs to compare the most current information, and determine if a collaborative action or a Request for Review (RFR) to the Market Actions (D) Working Group is in order.

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

The Market Analysis Procedures (D) Working Group is responsible for the MARS Level 1 areas of review and questions. Level 1 Analysis questions have been reproduced in Chapter 10 of this handbook. Level 1 Analysis questions are subject to annual review by the Market Analysis Procedures (D) Working Group and state insurance regulators. A Level 1 User Guide is available in iSite+ under the MARS Help Files. As recommended by the MAP WG each state should conduct the minimum number of Level 1 and/or Level 2 reviews per year. Priority should be given to domestic carriers or foreign carriers involved in issues that are significant to the state.

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

A Level 2 Analysis allows market analysts to further investigate and review a company, without the need to contact the company. Unlike the Level 1 Analysis, a Level 2 Analysis requires the market analyst to seek input and gather information from sources outside of the NAIC databases and the company's financial and market conduct annual statements. By its very nature, a Level 2 Analysis is much more labor intensive than a Level 1 Analysis. To assist market analysts in completing a Level 2 Analysis of a company, the Level 2 Analysis Guide has been developed. The guide consists of six core areas of review and an additional 15 potential areas that the market analyst may review when performing a Level 2 Analysis. For each area of review, the guide includes information about the area to be reviewed and, where applicable, potential resources to aid in the review of that area. The guide also provides the user with specific items to consider during the review of a particular area. The Level 2 Analysis Guide is contained in Chapter 11 of this handbook. A Level 2 User Guide is available in iSite+ under the MARS Help Files.

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

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

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

## C. Identifying Markets and Companies for Analysis

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

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

**Additional Uses for Market Share Information**

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

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

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

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

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

## D. Baseline Analysis

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

**Tools Available for Conducting Baseline Analysis**

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

MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. MAPT can provide reports against market and financial data or Market Conduct Annual Statement (MCAS) data. Market and financial MAPT reports provide an overall prioritization ranking, a national prioritization ranking and a state prioritization ranking for companies by line of business, which allows market analysts to compare companies writing premiums in a specified line of business on a national and state basis using a uniform data set. Key market regulation components used in MAPT vary by line of business. They include, but are not limited to: losses, expenses and premiums, enrollments, regulatory actions, complaints, examinations and demographics.

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

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

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

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

**How to Conduct Baseline Analysis**

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

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

After the reports are downloaded, an analyst may:

* + - * Rearrange the columns so that areas of focus are more prominently displayed;
      * Sort on any column, such as:

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

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

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

**Other Methods Used to Conduct Baseline**

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

* + - * Utilizing the MAPT to focus on the companies with the highest score for each line, then applying the below-listed criteria to the companies chosen:

1. Does the applicable state have an open exam;
2. Is the last exam the applicable state performed less than one year old;
3. Does the company have less than $100,000 in written premium; and
4. Has the company notified the insurance department that it is ceasing to write business in the state.

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

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

## E. How to Analyze Consumer Complaint Data

In order to conduct a systematic and focused analysis, it is necessary to develop meaningful numerical indicators which will allow regulators to make comparisons between companies and track the activities over time of each company and of market averages. Outliers—companies whose complaint activity significantly exceed industry norms, historical conditions or established best practice guidelines—can be singled out for individualized attention.[[1]](#footnote-1)

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

**Basic Complaint Ratio Analysis**

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

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

**Definition of** “**Complaint**”

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

“Any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose.”

**Definition of “Confirmed Complaint”**

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

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

a) The insurer, licensee, producer, or other regulated entity committed any violation of:

1) An applicable state insurance law or regulation;

2) A federal requirement that the state department of insurance has the authority to enforce; or

3) The term/condition of an insurance policy or certificate; or

b) The complaint and entity’s response, considered together, indicate that the entity was in error.”

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

* + - * Although total complaints are useful for many purposes, the baseline complaint index should be based on confirmed complaints, both because these are a more meaningful indicator of company-specific shortcomings and because this enables consistent comparisons from state to state and between states and the Consumer Information Source (CIS). States should be tracking consumer complaints in a format consistent with the Complaints Database System (CDS) format and reporting complaints to the CDS. Confirmed complaints are complaints in which states submit a “confirmed” status, indicating if a complaint is confirmed or not, based upon the state’s analysis of the consumer complaint. Confirmed complaints typically reflect one of the following disposition codes which indicate a consumer’s complaint position was upheld 1208 Compromise Settlement/Resolution;
      * 1225 Claim Reopened;
      * 1230 Claim Settled;
      * 1257 Fine Assessed;
      * 1280 Referred to Other Division for Possible Disciplinary Action; and
      * 1311 Company Position Overturned.

**Complaint Ratios**

A company’s complaint ratio is defined as:

(number of confirmed complaints)

(gross premium written [in thousands of dollars])

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

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

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

**Complaint Indices**

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

**Complaint Index**

A complaint indexis defined as:

(complaint ratio for the company)

(complaint ratio for the aggregate market)

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

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

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

(company’s complaint share)

(company’s market share)

The “complaint share” is defined in the same manner as a company’s market share; i.e., by dividing the company’s complaints by the aggregate number of complaints in the relevant market.[[2]](#footnote-2) This is the format in which the NAIC CDS compilations are presented on iSite+.[[3]](#footnote-3) When doing the actual numerical calculations, in order to minimize rounding errors, the relevant data should be input directly, so that the complaint ratio is calculated as:

(number of complaints against company) × (market aggregate written premium)

(market aggregate complaints) × (company written premium)

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

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

*670 confirmed complaints/$61 million in premium: 670/61000 = 0.011*

This corresponds to complaint indices for the three insurers (rounded to two decimal places) of:[[4]](#footnote-4)

|  |  |  |
| --- | --- | --- |
| Insurer A | 0.010/0.011 | 0.91 |
| Insurer B | 0.015/0.011 | 1.37[[5]](#footnote-5) |
| Insurer C | 0.020/0.011 | 1.82 |

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

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

* + - * Although complaint indices should be calculated by line of business if possible, their accuracy depends on the availability (and the use) of accurate confirmed complaint counts by line of business. Complaint ratios and complaint indices draw a misleading picture if the complaint count and the gross premium figure are based on different sets of policies;
      * Premium volume may not be the best measure of market activity in many lines of business, particularly annuities and life insurance. States should give strong consideration to supplementing their basic complaint analysis with an alternative complaint index calculation based on policy count, when that information is available. For life insurers, the number of policies and group certificates in force is reported on the State Page, itemized by the type of coverage;
      * Complaint indices can be misleading for companies with small market presence. In particular, it is not appropriate for published tables or rankings to include (at least without a conspicuous disclaimer) companies whose complaint indices would be significantly different with one or two more or fewer confirmed complaints;[[6]](#footnote-6)
      * Using more states and/or more years provides a larger sample size, but this will only give more accurate results if the information from other states or earlier years is comparable. Inaccuracies may result from changes in company behavior over time, different company practices or market conditions in other states or inconsistencies in the ways different states gather or report complaint data. For example, all other things being equal, if the average policy in a given state is half as expensive as in a neighboring state, then complaint ratios, calculated by premium volume, will be twice as high in that state as the same level of complaint activity would generate in a neighboring state; and
      * A CDS Closed Complaint Summary Index Report can be run, using complaint information from one year and premium information from a different year, allowing multiple complaint years to be compared to a common baseline. This corrects for the effects of general economic conditions, such as inflation on premium growth, but will create other distortions when premium volume changes for other reasons.

**Reports from the NAIC Complaints Database System**

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

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

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

The NAIC also publishes complaint index information for the general public through its Consumer Information Source (CIS). These reports calculate complaint indices on a nationwide basis, based only on confirmed complaints, and rebalanced so that a score of 1.00 represents the median company for a particular line of business[[7]](#footnote-7)—half the companies in that line of business had better complaint ratios for that year, while the other half had worse, rather than the mean complaint ratio overall. To illustrate the difference, the median complaint index for group health insurers in 2002 was 1.28. This indicates that most companies in this line of business had complaint indices noticeably greater than 1.00—the most likely explanation for such a result is that those companies with high complaint indices tended to be smaller companies (or companies for which group health was not a major line of business), while the larger group health writers tended, on average, to have fewer complaints relative to premium volume.[[8]](#footnote-8) This brings down the average, so that a company could have a better complaint record than most of its competitors, but still have a complaint index of 1.1.

Therefore, the CIS would report such a company’s complaint score as 1.1/1.28 = 0.86, highlighting its performance relative to other companies rather than its proportionate share of the nationwide complaint total.[[9]](#footnote-9)

## F. Market Conduct Annual Statement Data

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

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

## G. How to Analyze State Page Data

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

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

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

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

### Review Data for Significant Changes in Premium Volume

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

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

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

* + - * Does the change correlate with complaints filed against the insurer?
      * How many rate, rule and form filings has the company made? Does the number, compared to the change in the company’s writings, suggest that the company is using a rate structure that is not filed or not approved, if required for that line of business?
      * Is the increase in premium volume due largely to an increase in the number of risks assumed or due largely to rate increases?[[11]](#footnote-11)16
      * If there are significant rate increases, do they reflect trends in the overall market or is the company an outlier?
      * If the company’s writings have changed, have the numbers of agents changed accordingly?
      * How many agent appointments and terminations has the company made?
      * For what lines are they licensed?
      * If the company’s writings have changed, have the number of adjusters changed? (If relevant to the line of business in question and the state requires a license for adjusters or this information is otherwise available.)

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

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

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

### Review Data for Changes in Reserves

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

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

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

### Review Loss Ratio Data

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

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

### Review Data on Defense Costs

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

1. Of course, the identification of a company as an outlier may be the result of factors entirely unrelated to the company’s actual performance in the market. For example, a report once identified a company as having a complaint index of 2,189,763.36730—that is, a complaint frequency more than two million times higher than “expected,” based on the company’s premium volume. However, this statistic was based on $1 in reported premium and a single consumer complaint. [↑](#footnote-ref-1)
2. This formula demonstrates why the complaint index will be the same whether the original complaint ratios are expressed in terms of complaints per dollar, complaints per thousand dollars or complaints per million dollars. [↑](#footnote-ref-2)
3. However, at this writing, those reports are based on raw complaint data, not confirmed complaints. The NAIC is developing a report framework based on confirmed complaints. [↑](#footnote-ref-3)
4. Additional precision, although readily available, is inappropriate because it would not reflect any meaningful distinction between companies. Indeed, even the two decimal place calculation will generally overstate the significance of the underlying data. [↑](#footnote-ref-4)
5. The careful reader might note that the approximation 15/11 actually rounds to 1.36. *See supra* note 9. [↑](#footnote-ref-5)
6. A company which returned more premium than it wrote will actually appear in computer-generated tables with a negative complaint ratio, which on its face is absurd and should be seen as a clear indication that the company had too little activity in that market to generate a credible report. On the other hand, if several complaints were filed against such a company, regulatory follow-up is clearly warranted. [↑](#footnote-ref-6)
7. The CIS report refers to the rebalanced complaint index as a “complaint ratio,” but that is different from the way that term is used in this guide. [↑](#footnote-ref-7)
8. Another possibility would be a bimodal (“camel hump”) distribution curve in which there are really two distinct market sectors being compared here, the larger of which (on average) has measurably higher complaint ratios. [↑](#footnote-ref-8)
9. The underlying question is which figure can most fairly be called “normal” market behavior. The use of the median is based on the premise that the market-wide complaint ratio (i.e., the mean complaint ratio) is disproportionately influenced by the behavior of a few large companies. Conversely, however, it can be argued that the median complaint ratio is disproportionately influenced by very small companies whose behavior affects relatively few consumers. [↑](#footnote-ref-9)
10. 15 It should also be noted that when a company is one of the dominant insurers in the market, there is less room to grow in the normal course of business, so a lower threshold for “significant” premium growth should be considered for those companies. [↑](#footnote-ref-10)
11. 16 In lines of business where rates are not filed, this will be more difficult to ascertain. [↑](#footnote-ref-11)