# Chapter 8—Enhancing State Market Analysis

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

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

Below are some examples of possible approaches.

## A. Improving Consumer Complaint Analysis

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

As we have seen in Chapter 6 - - Basic Analytical Tools, the NAIC Complaints Database System (CDS) is one of the key resources for market analysts, but it can only be as good as the information it receives from participating states. Meaningful comparison of complaint data from state to state requires nationwide uniformity in state insurance departments’ treatment of complaints. If an insurance department fails to code complaints properly or if departments use conflicting coding systems, other states will receive an inaccurate picture of general business practices, emerging issues and changes in the marketplace. In particular, the distinction between “complaints” and “inquiries” must be drawn in a consistent manner. States that call on insurers to self-report complaints and other consumer actions should be particularly vigilant in this regard, to ensure that companies that give themselves the benefit of the doubt do not have an unfair advantage over companies that bend over backwards to provide full disclosure.

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

### 1. Key Elements of Best Practices

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

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

A complaintis **“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.”**[[1]](#footnote-1)

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

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

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

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

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

* Insured;
* Service provider; and
* Other.

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

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

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

### 2. More Detailed Information on Complaints and Regulatory Actions

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

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

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

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

### 3. Calculating Complaint Ratios by Number of Policies

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

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

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

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

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

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

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

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

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

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

### 5. Publishing Complaint Information

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

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

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

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

### 6. Confirmed Complaints

The 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.”

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

## B. Use of myNAIC and iSite+ in Market Analysis

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

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

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

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

## C. Use of IRIS Ratios in Market Analysis

As discussed more fully on the NAIC website, the Insurance Regulatory Information System (IRIS) is a tool designed to assist state insurance departments in monitoring the industry’s financial condition. A key component of IRIS is a series of financial ratios based on annual statement information, developed for the purpose of identifying companies with potential financial difficulties. There is a separate series of IRIS ratios for property/casualty companies and for life/health companies.[[2]](#footnote-2)18 IRIS ratios are a preliminary screening tool and IRIS ratios outside the pre-established norm do not necessarily indicate an adverse financial condition, let alone constitute evidence of market conduct problems. IRIS ratios are monitored as part of the domestic state’s financial analysis program. The IRIS ratio merely provides a signal for the regulator to follow-up to determine the cause of the changes in the company measured by the ratio or ratios in question. Bearing in mind these limitations, the eight IRIS ratios that are most likely to be of value as market conduct indicators are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This ratio represents the percentage change in premium from the prior year to the current year. The calculation is the change in total premiums, deposit-type contract fund considerations and other considerations from the prior year to the current year, divided by total premiums, deposit-type fund considerations and other considerations for the prior year.

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

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

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

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

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

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

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

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

## D. The Use of Underwriting Guidelines in Market Analysis

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

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

When carriers use software and additional third-party data to replace manual tasks, the carrier is then involved in accelerated underwriting. For example, during the Covid-19 pandemic, life insurance carriers were reluctant to send parameds to potential customers’ homes. Instead, insurance carriers used algorithms to assist in the underwriting of insurance policies.

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

### 1. The Significance of Underwriting Guidelines

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

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

### A timely review of an insurer’s amendments to its underwriting guidelines may assist regulators in the early detection of practices that could be detrimental to insurance consumers. For example, in the case of homeowner’s insurance, a review of underwriting guidelines may provide information that will assist in determining whether or not certain market segments are underserved. In particular, underwriting guidelines that limit the availability of insurance, or of replacement cost insurance, on the basis of the age or value of the house or the ratio of value to replacement cost, may disproportionately affect homeowners in minority or inner-city neighborhoods. Inner-city neighborhoods tend to be older than suburban neighborhoods and undervalued, and frequently have a higher ratio of minority residents. For these reasons, some insurers have modified or eliminated such criteria from their underwriting guidelines. Some classes may also have lower credit scores due circumstances beyond their control. 2. Reviewing Underwriting Guidelines

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

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

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

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

### 3. Use of Information Obtained from Underwriting Guidelines

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

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

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

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

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

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

**Example of Compilation of Underwriting Guidelines for Private Passenger Auto**

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

### Conclusion

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

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

**E. Modes of Analysis**

Market analysis can be conducted at a variety of levels, using a variety of techniques, ranging from rigorous statistical modeling and performing Level 1 or Level 2 analyses, to more informal discussion and information-sharing about how to address specific market problems. These can be categorized in various ways. For example, distinctions and comparisons can be drawn between quantitative (data-driven) and qualitative (event-driven) techniques and between macro (entire markets) and micro (specific companies or issues) techniques. Below are brief overviews of a few of these approaches.

### 1. Analysis of General Market Conditions

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

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

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

**Emerging issues**: Market changes, such as the expanding use of credit reports and genetic testing in underwriting and rating, often raise new consumer protection concerns. The increased marketing of usage-based insurance often conflicts with older disclosure laws. Providing a 10-day cancellation notice on a product that only provides coverage for a few days may no longer make sense. Producers that use the internet to provide quotes is another challenge. Often, regulators cannot determine the actual underwriter or producer linked to these websites. Carriers may not be aware of the marketing activities of producers because of all the various marketing channels available.

### 2. Individual Company Concerns

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

* Company showing rapid market share growth;
* Low premium for coverage in comparison to competitors;
* Company making requests for rapid rate increases (in lines of business subject to rate regulation);
* Company implementing severe underwriting restrictions;
* Company implementing new claims payment rules;
* Company experiencing rapid growth in number of producers;
* Company hiring producers with questionable reputation or prior disciplinary history;
* Increase in consumer complaints;
* Producers targeting a specific demographic group;
* Unusual number or occurrences of replacements;
* Major reallocation of agent sales force;
* Company moving from one area of the state to another;
* Introduction of new policy types;
* Company submitting and/or using unusual policy language;
* Excessive prerequisite conditions for claim payment;
* Company getting into long-tail business hoping to build assets while waiting for lag in claims;
* Company increasingly dependent upon one producer or managing general agent (MGA);
* Agencies emphasizing production of business at the expense of sound underwriting;
* Life or health company affiliated with questionable associations or trusts;
* Company not cooperating with states on examinations or other regulatory review activities; and
* Company writing new business funded by old business.
* Company outsourcing claims, plan administration, producer licensing, & rate and form filings to third-party administrators with little oversight.
* Producer websites indicating products that may not be filed in various jurisdictions.

### 3. Global Objectives

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

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

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

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

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

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

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

**Develop data sources and methodologies that serve as triggers for further market conduct review**:The value of hindsight should not be overlooked. A key component of any analytical program is validating the results obtained, and the communication between analysts and examiners needs to run both ways. Once problem companies have been identified, data collected on those companies should be compared with baseline data for the market to see what patterns can be observed and whether these patterns suggest the development of new indicators or second thoughts about indicators currently in use. There are multiple tools available for regulators to sort and review data. Regulators should be comfortable using Microsoft Excel, Access, ACL, Tableau and additional tools that can be used to graph/chart the data.

1. Similarly, the *Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act* (#884)provides that “complaint” shall mean a written communication primarily expressing a grievance. This definition was adopted by the Market Regulation and Consumer Affairs (D) Committee in 2006 after a review of the complaint definition recommended in the NAIC *Consumer Complaints* White Paper adopted June 2000. [↑](#footnote-ref-1)
2. 18 There are 12 life/accident & health ratios, 13 property/casualty ratios and 11 fraternal ratios. [↑](#footnote-ref-2)