

## **MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE**

Market Regulation and Consumer Affairs (D) Committee Apr. 13, 2021, Minutes

Market Conduct Annual Statement Best Practices Guide (Attachment One)

NAIC Market Regulation Handbook (Attachment Two)

Market Analysis Procedures (D) Working Group (Attachment Three)

Market Analysis Procedures (D) Working Group Feb. 25, 2021, Minutes (Attachment Three-A)

Market Analysis Procedures (D) Working Group Jan. 27, 2021, Minutes (Attachment Three-A1)

Market Conduct Annual Statement Blanks (D) Working Group March 23, 2021, Minutes (Attachment Four)

Market Conduct Annual Statement Blanks (D) Working Group Feb. 24, 2021, Minutes (Attachment Four-A)

Market Conduct Examination Guidelines (D) Working Group March 30, 2021 Minutes (Attachment Five)

Privacy Protections (D) Working Group March 29, 2021, Minutes (Attachment Six)

## Draft Pending Adoption

Draft: 4/16/21

Market Regulation and Consumer Affairs (D) Committee  
Virtual 2021 Spring National Meeting  
April 13, 2021

The Market Regulation and Consumer Affairs (D) Committee met April 13, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair (KY); Alan McClain (AR); Evan G. Daniels represented by Maria Ailor (AZ); Trinidad Navarro (DE); John F. King (GA); Dana Popish Severinghaus (IL); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing (MT); Jon Godfread (ND); Chris Nicolopoulos represented by Edwin Pugsley (NH); Carter Lawrence represented by David Combs (TN); Jonathan T. Pike (UT); and Michael S. Pieciak represented by Kevin Gaffney (VT). Also participating were: Russell Toal (NM); Jessica K. Altman (PA); Larry D. Deiter (SD); John Haworth (WA); and Rebecca Rebholz (WI).

### 1. Adopted its 2020 Fall National Meeting Minutes

Commissioner Clark made a motion, seconded by Commissioner Godfread, to adopt the Committee's Dec. 8, 2020, minutes (see *NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

### 2. Heard a Presentation on the Activity of Lead Generators in Health Insurance

Commissioner Navarro said for the past several months, state insurance regulators and officials from federal agencies have met to discuss improper marketing of health plans by various entities. He said prior to this ad hoc group, state insurance regulators in the health, market conduct and fraud areas were investigating these concerns, but not communicating with each other. He said after talking with the NAIC and other state insurance regulators, the states formed an ad hoc group designed to do two things. First, the ad hoc group was created to bring members of the Health Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee together to share information regarding entities that were improperly marketing health insurance products, including the use of lead generators, unsolicited phone calls, internet solicitations, and other marketing methods occurring in each state. Commissioner Navarro said these discussions have identified common practices, themes and actors. He said the group invited members of the federal government to participate, including the Center for Consumer Information and Insurance Oversight (CCIO), the U.S. Department of Labor (DOL), and the Federal Trade Commission (FTC). He said as a result of those discussions, schemes have been identified and administrative actions taken. Second, he said the ad hoc group identified a need to look at and perhaps update or create new model laws to address the aggressive and improper marketing of health plans and the oversight of lead generators. He said the ad hoc group agreed that lead generators, whether by mailers, phone calls or internet solicitations, were part of the insurance sales process, but some states were concerned whether they had jurisdiction over these entities. However, he said all states agreed that there needs to be some oversight. He said the NAIC white paper, *The Marketing of Insurance Over the Internet*, needs to be updated to reflect the changes in how the internet is used today and how some entities use the internet to market plans in ways not contemplated only a few years ago.

Commissioner Navarro said the Antifraud (D) Task Force will be considering a proposal to formalize the ad hoc group into a working group under the Task Force. He said the working group would address two goals. First, it would facilitate continued discussions of state and federal insurance regulators about the improper marketing of health plans. Commissioner Navarro said participation of interested state insurance regulators would encompass state insurance regulators from all areas of expertise, including, but not limited to, health, market conduct, antifraud and legal. He said the working group would meet in regulator-only sessions to continue these ongoing discussions and potential prosecutions. Second, he said the working group would be charged with either modifying existing model laws or creating a model law: to 1) address the usage of lead generators in the sale of insurance products; and 2) update marketing rules to modernize the regulation of those activities.

Superintendent Toal commended the work of Commissioner Navarro and his staff. Superintendent Toal noted that this is a critical problem. There are many misleading and unapproved products being marketed. Additionally, contacting a lead generator can generate hundreds of calls to an individual consumer. Superintendent Toal said he would support the efforts in any way he can. Commissioner Altman said this is a very troubling issue. She noted that after the passage of the federal American Rescue Plan Act of 2021 (ARPA), she received calls soliciting Bidencare products. She said the biggest challenge is with unregulated entities. She said the state insurance regulators need to hold regulated entities responsible for the actions of unregulated entities that market their plans improperly. She said she is unsure if state laws allow that. Katie Keith (Out2Enroll)

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and Harold M. Ting (Healthcare Consumer Advocate) noted that the consumer representatives support the work and are willing to assist.

### 3. Adopted its Task Force and Working Group Reports

Commissioner Richardson said Damion Hughes (CO) will be the new chair of the Market Conduct Examination Guidelines (D) Working Group. She said the Working Group summary report is in the materials. She also noted that the Market Actions (D) Working Group and the Advisory Organization Examination Oversight (D) Working Group met in regulator-only session due to the nature of their discussions focusing on specific company practices. She said there are no written or verbal reports for these working groups.

#### a. Antifraud (D) Task Force

Commissioner Navarro said the Antifraud (D) Task Force met March 24 and adopted its Nov. 16, 2020, minutes.

Commissioner Navarro said the Task Force received an update from the Antifraud Education Enhancement (D) Working Group. He said the Working Group hosted a webinar on Feb. 11 by CARCO regarding the mobile capabilities it can provide to state departments of insurance (DOIs) to assist in fighting insurance fraud. He said the Working Group will host the NAIC Investigator Safety training on June 2.

Commissioner Navarro said the Task Force received an update from the Antifraud Technology (D) Working Group. He said by finalizing the revisions to the *Antifraud Plan Guideline* (#1690), the Working Group completed the first step in its charge to “review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.” He said the Working Group will begin drafting a template for industry to use when creating their antifraud plan.

Commissioner Navarro said the Task Force discussed its 2021 charges and its continued monitoring of insurance fraud related to the COVID-19 pandemic. He said the Task Force will continue to monitor potential trends generated by the pandemic and hold meetings, as necessary, to bring general awareness at the state, industry and consumer levels.

Commissioner Navarro said the Task Force received an update on the NAIC Online Fraud Reporting System (OFRS) redesign. He said beta testing is scheduled to begin in April.

Commissioner Navarro said the Task Force received reports on matters of national interest to insurance fraud bureaus from the National Insurance Crime Bureau (NICB) and the Coalition Against Insurance Fraud (CAIF).

#### b. Market Information Systems (D) Task Force

Commissioner Kreidler said the Market Information Systems (D) Task Force met March 22 and reviewed its 2021 charges. He said the charge to “develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis” was delegated to the Market Information System Research and Development (D) Working Group. This was done because the Working Group has members with expertise in this field, and it meets more frequently than the Task Force. Commissioner Kreidler noted that the Task Force remains responsible for the final product.

Commissioner Kreidler said the Task Force adopted the report of the Market Information System Research and Development (D) Working Group. He said the Working Group reported that it adopted a proposal for coding changes to the Regulatory Information Retrieval Systems (RIRS). He said the proposal will be posted to the Task Force web page and will be considered for adoption by the Task Force during the Summer National Meeting. He said the Working Group also adopted a change to the Uniform System Enhancement Request (USER) form process, which aligns the process to the agile approach used by the NAIC.

Commissioner Kreidler said the Task Force also adopted the Market Information Systems (MIS) Data Analysis Metrics and Recommendations.

Commissioner Kreidler said the Task Force reviewed outstanding USER forms.

#### c. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force met on Mar. 26.

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Director Deiter said during the meeting, the Task Force discussed state implementation of online examinations. He said 32 states have implemented online examinations, and three states are scheduled to implement online examinations by the end of April. Only three states decided not to implement remote online examinations. He said the Producer Licensing Uniformity (D) Working Group will be reviewing the examination standards in the NAIC *State Licensing Handbook* to ensure it is consistent with the state practices for implementing remote examinations.

Director Deiter said the Task Force heard a briefing on the National Association of Registered Agents and Brokers Reform Act of 2015 (NARAB Reform Act), which is a federal law that preempts state nonresident producer licensing laws and will establish nonresident producer licensing qualifications on a multi-state basis. He said the briefing addressed the impact on state producer licensing and included an overview of the NARAB Reform Act's structure and governance and the responsibilities of the NARAB board. He said with the change in administration at the federal level, both the NAIC and the National Insurance Producer Registry (NIPR) leadership are monitoring federal activity that would lead to the appointment of the 13 member NARAB board and formation of NARAB.

Director Deiter said the Task Force received a report from the Producer Licensing Uniformity (D) Working Group. He said the Working Group continues to focus on licensing standards for pet insurance. He said the Task Force also received a report from the Uniform Education (D) Working Group. He said the Working Group continues to focus on state implementation of the 2019 Continuing Education Reciprocity (CER) Agreement, which 44 jurisdictions have signed.

Director Deiter said the Task Force received a report from the NIPR Board of Directors. He said the NIPR Board of Directors approved its 2021–2023 Strategic Plan. He said the plan has the following three pillars: 1) engaged and empowered teams; 2) customer-focused excellence; and 3) high-quality and reliable technology. He noted that NIPR also reported the release of a major upgrade to its Attachment Warehouse application. Finally, NIPR reported \$47.9 million in revenue in 2020, a 5.7% increase from 2019.

Director Deiter said the Task Force discussed procedures for amending NAIC Uniform Producer Licensing Applications, and it will have a revised draft to address the comments submitted by state insurance regulators and interested parties.

Director Deiter said the Task Force received comments from the American Council of Life Insurers (ACLI) on how the NAIC's initiatives on race and insurance relate to insurance producers and the desire to increase the number of minority producers. He said while not discussed by the Task Force, which met before the most recent meeting of the Special (EX) Committee on Race and Insurance, there have been three issues delegated to the Task Force from the Committee. He said the issues are: 1) the availability of producer licensing exams in foreign languages; 2) the steps exam vendors have taken to mitigate cultural bias; and 3) the number and location of producers by company compared to demographics in the same area.

### d. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met Jan. 27, Feb. 25 and March 19.

Mr. Haworth said during these meetings, the Working Group adopted revisions to the *Market Conduct Annual Statement (MCAS) Best Practices Guide* (Best Practices Guide) (Attachment One). He said the Best Practices Guide had not been updated since its original adoption in 2014. He noted that among the revisions included identifying additional best practices, highlighting them in an appendix, and recommending a 14-day extension limitation. He said the Best Practices Guide is available on the Working Group's web page.

Mr. Haworth said the Working Group also adopted revisions to the market analysis chapters of the NAIC *Market Regulation Handbook* (Handbook) (Attachment Two). He said considering the changing technology available to market analysts, the Working Group revised four chapters in the Handbook. He said the revisions will be forwarded to the Market Conduct Examination Guidelines (D) Working Group.

Mr. Haworth said the Working Group also adopted two changes affecting MCAS filings. First, the Working Group adopted a proposal to require companies to complete their attestations by line of business and by state. Second, the Working Group adopted a 14-calendar day limitation on extension requests from companies. He said companies will still be able to request additional extensions, if necessary, but for no longer than 14 days at a stretch.

Mr. Haworth said the Working Group continues its discussions on providing technical market analysis training to state insurance regulators, and it is receiving comments on what training is needed by jurisdictions.

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### e. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met March 23.

Ms. Rebholz said the Working Group has four different subject matter expert (SME) groups currently working to finalize drafts for consideration by the Working Group. She said the SME groups are working on: 1) a new Other Health MCAS blank and data call and definitions; 2) a new Travel MCAS blank and data call and definitions; 3) new accelerated underwriting data elements and definitions for the Life MCAS blank; and 4) new digital claims data elements and definitions for the Private Passenger Auto and Homeowners MCAS blanks. She said the hope is to have these drafts exposed and considered by the Working Group prior to the June 1 deadline for updates to the MCAS for the 2022 data year.

Ms. Rebholz said the Working Group is discussing the placement of complaint and lawsuit data elements within the Homeowners and Private Passenger Auto MCAS blanks and reviewing the MCAS lawsuit definitions.

### f. Privacy Protections (D) Working Group

Lois E. Alexander (NAIC) said the Privacy Protections (D) Working Group met March 29 and adopted its 2020 Fall National Meeting minutes, which included a discussion of the initial draft gap analysis of consumer issues.

Ms. Alexander said the Working Group received NAIC status reports on federal and state privacy legislation. She said the federal report indicated that the U.S. Congress (Congress) believes there is a need for federal data privacy legislation, but differences in approaches have thwarted efforts to enact comprehensive legislation. She said the points of contention include: 1) whether and to what extent federal legislation should preempt state laws; and 2) whether the legislation should include a private right of action. She said the NAIC continues to engage with Congress, oppose preemptive legislative proposals, and inform Congress of the Working Group's efforts to update NAIC model laws. She said the NAIC continues to underscore the importance of not disregarding the existing state regulatory framework or inhibiting ongoing efforts in the states to develop laws and regulations in the best interest of consumers.

Ms. Alexander said the state report indicated that at least 30 states introduced data privacy legislation in 2020. She said many of them were comprehensive and similar to the California Consumer Privacy Act (CCPA). However, very few of them were enacted because the COVID-19 pandemic disrupted legislative sessions. Ms. Alexander said in 2021, bills have been introduced in 23 states that focus on business obligations stemming from consumer rights, but the bills vary in substance. She said many of the bills apply to for-profit businesses that: 1) have global annual gross revenues in excess of \$23 million; 2) annually buy, sell or share the personal information of 50,000 or more consumers for commercial purposes; or 3) derive 50% or more of its global revenues from selling or sharing personal information. She said common issues have emerged, such as: 1) a requirement that covered entities perform a risk assessment; 2) providing for a private right of action; 3) addressing data security and privacy; 4) a resemblance to the General Data Protection Regulation (GDPR); and 5) exempting data collected in compliance with the Gramm-Leach-Bliley Act (GLBA), as well as entities subject to the GLBA. Other exemptions would only exclude the data collected in compliance with the GLBA, while still regulating the entity.

Ms. Alexander said the Working Group reviewed additional guidance through the Market Regulation and Consumer Affairs (D) Committee in the form of the NAIC member-adopted strategy for consumer data privacy protections. She said the strategy charges the Committee with: 1) summarizing consumer data privacy protections found in the *Health Information Privacy Model Act* (#55), the *NAIC Insurance Information and Privacy Protection Model Act* (#670), and the *Privacy of Consumer Financial and Health Information Regulation* (#672); and 2) identifying notice requirements of states, the European Union's (EU's) GDPR, and the CCPA and how insurers may be subject to these requirements. She said the Working Group has completed both charges.

Ms. Alexander said the strategy also charges the Committee with: 1) identifying corresponding consumer rights that attach to notice requirements, such as the right to opt out of data sharing, the right to correct or delete information, the right of data portability, and the right to restrict the use of data and how insurers may be subject to these requirements; 2) setting forth a policy statement on the minimum consumer data privacy protections that are appropriate for the business of insurance; and 3) delivering a report on the charges by the Fall National Meeting.

Ms. Alexander said the strategy additionally charges the Committee to: 1) engage with state attorneys general (AGs), Congress, and federal regulatory agencies on state and federal data privacy laws to minimize preemption provisions and maximize state insurance regulatory authority; and 2) reappoint the Working Group to revise NAIC models, as necessary, to incorporate

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minimum consumer data privacy protections that are appropriate for the business of insurance. She said these last charges are also to be completed by the Fall National Meeting.

Ms. Alexander said the Working Group discussed comments concerning the gap analysis received after its Nov. 20, 2020, meeting. She said comments were received from ACLI, the Coalition of Health Carriers, the National Association of Mutual Insurance Companies (NAMIC), and the American Property Casualty Insurance Association (APCIA).

Ms. Alexander said the Working Group announced that a consumer privacy protections panel will speak at the virtual NAIC Insurance Summit in June.

Commissioner Richardson asked for a motion to adopt the reports of the Market Regulation and Consumer Affairs (D) Committee's task forces and working groups, including the following action items: 1) the MIS data Analysis Metrics and Recommendations adopted by the Market Information Systems (D) Task Force; 2) revisions to the Best Practices Guide adopted by the Market Analysis Procedures (D) Working Group; 3) revisions to the four market analysis chapters of the Handbook adopted by the Market Analysis Procedures (D) Working Group; 4) the 14 calendar-day limitation on MCAS filing extension requests adopted by the Market Analysis Procedures (D) Working Group; and 5) the requirement for companies to identify MCAS filing attestors by both line of business and by state to be implemented for the 2021 data to be reported in 2022, which was adopted by the Market Analysis Procedures (D) Working Group.

Commissioner Clark made a motion, seconded by Commissioner Pike, to adopt the following reports: 1) Antifraud (D) Task Force; 2) Market Information Systems (D) Task Force; 3) Producer Licensing (D) Task Force; 4) Market Analysis Procedures (D) Working Group (Attachment Three); 5) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Four); 6) Market Conduct Examination Guidelines (D) Working Group (Attachment Five); and 7) Privacy Protections (D) Working Group (Attachment Six). The motion passed unanimously.

#### 4. Discussed Other Matters

Birny Birnbaum (Center for Economic Justice—CEJ) encouraged the Committee to become more engaged in the work of the Special (EX) Committee on Race and Insurance. He said the CEJ drafted a proposal for a comprehensive work plan to address systemic racism in insurance. Included within the proposal is the development of tools and resources for regulatory oversight. He said the development of the tools requires market regulation data collection that is sufficient to monitor consumer outcomes by prohibited class characteristics and the identification of gaps in regulatory skills and resources that are necessary for the analysis of disparate impact and proxy discrimination. He said both activities fall within the purview of the Market Regulation and Consumer Affairs (D) Committee.

Mr. Birnbaum said all aspects of insurance operations, such as marketing, claims and antifraud, are subject to racism and disparate impact. He said it is important for market regulators to be well represented in the work of the Special (EX) Committee on Race and Insurance.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.

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# MCAS BEST PRACTICES GUIDE

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## Introduction

The Market Conduct Annual Statement (MCAS) was developed with the input of state insurance regulators and representatives from the insurance industry to provide an analysis tool for certain key market data elements. Some of the states collected private passenger auto data as early as the 1990s. In 2003, the NAIC Market Regulation and Consumer Affairs (D) Committee established an annual statement pilot program for life and annuity and property/casualty companies. Today, 49 the states participate in MCAS and the NAIC collects the data on behalf of the states.

By using common data and analysis, the states have a uniform method of comparing the performance of companies. If a company's performance appears to fall outside of industry norms, the state will want to undertake further review of that company. The purpose of this document is to encourage the use of best practices in the collection and review of MCAS data.

Before moving forward with follow-up activity or continuum actions, the following three principles should be considered:

- Always refer back to the underlying raw data. Is the company following the definitions? Did they leave claims open when actually all payments had been made?
- Before moving on, check the company comments. These comments can save time by directing you to specific data or explaining a market shift.
- Always interpret the MCAS within the context of all other available information. Was there a catastrophic event that caused the spike in number of claims?

Data consists of various market indicators, primarily related to two areas:

- Claims handling – claim denials, processing times and lawsuit activity.
- Underwriting – new issues, policies in force, non-renewals and cancellations.

Other line-specific indicators are used to determine, for example, the number of policy exchanges and resisted claims for life insurance policies.

As of the document revision date, MCAS data are collected for the following lines of business with 49 participating jurisdictions:

- Annuity
- Disability Income
- Health
- Homeowners
- Lender-Placed Home and Auto
- Life
- Long-Term Care
- Private Passenger Auto
- Private Flood (effective for the 2020 data year).



## MCAS Timeline

- September – Call letter review/update
- December 15 - Call letters sent
- January 31 – Portal closes for the prior year plus one data
- March – April – MCAS Training Webinars
- April – Companies submit data and make extension or waiver requests
- April 30 – Data submissions are due\*
- April – June – Data Validation by the NAIC and states
- May – June – data analysis by states and next steps
- May – States contact late filers
- July 1 – Scorecards are published

Please note that some lines of business may have due dates that vary from the standard April 30 filing due date. For the most current information on due dates for all lines of business, please refer to the MCAS webpage's calendar of key MCAS dates ([http://www.naic.org/mcas\\_main.htm](http://www.naic.org/mcas_main.htm)).

### September: Call Letter Review/Update

In September, the NAIC requests that the participating states' MCAS contacts submit any changes to the data call letters. These letters are sent to companies to obtain information for the next year. The data call letter identifies changes to the MCAS submission, as well as the contact person for the state requesting submission.



**Best Practice:** Be sure your MCAS contact is current. You can check/update your state MCAS contact here: Link to [Participating Jurisdiction Contacts](#).

### Mid-December: Call Letters Sent

In December, the data call letters are sent to each company's MCAS contact; companies are expected to keep their contact information current. At the same time, the NAIC updates its submission portal in preparation for the submission of new data.

### January 31: Portal Closes

By January 31, companies may no longer use the MCAS portal to make changes to the prior year's data. Changes to prior year's data will need prior approval from the state(s) affected.

### March to April: Training Webinars

The NAIC provides webinars detailing changes to the MCAS data process. Additional information is also available on the NAIC website. To properly analyze the MCAS data, the analyst needs to stay current on what the ratios and data elements mean and why these elements were chosen.

For companies not familiar with the MCAS process, the NAIC provides training on how to submit filings.

The MCAS webpage ([http://www.naic.org/mcas\\_main.htm](http://www.naic.org/mcas_main.htm)) has the most current training materials for each filing year on the left side of the page under the heading "TRAINING". NAIC Education and Training ([https://content.naic.org/education\\_schedule.htm](https://content.naic.org/education_schedule.htm)) also provides links to training for both MCAS and market analysis (Market Analysis Techniques (MAT) On-line).

## April: Companies Submit Data and Make Extension or Waiver Requests

Several methods are used to address questions by the companies regarding data submissions, including bulletin boards, frequently asked questions (FAQs), training webinars and other resources. The NAIC maintains a webpage dedicated to explaining the MCAS process and any changes expected. These resources are available to assist the states with incoming questions from insurance companies.

MCAS resources are located along the left-hand side on the MCAS webpage ([http://www.naic.org/mcas\\_main.htm](http://www.naic.org/mcas_main.htm)).

### April 30: Data Submissions Due

#### *Late Filings and Revised Filings*

Late or inaccurate filings may impact statewide ratios. Regulators should balance the need for accurate data with company accountability. Companies should be encouraged to file timely and accurately. Changes associated with re-filings are detailed in the "MCAS Audit Trail" report, as are any comments the company may have as to why the data was changed. Companies that submit data late, or with changes, may have internal control issues. It also needs to be determined if a company is re-filing for a small number of states or is re-filing globally.



**Best Practice:** When a company re-files to correct an issue, the analyst should review the filings submitted to other states. If filings in other states have the same issues, then coordination with other states, or the domestic state, should be initiated when contacting the company.

Company re-filings should be kept to a minimum. A significant volume of re-filings can alter overall state ratios and change company rankings. Regulators should develop strategies to ensure data is submitted correctly the first time. Companies that habitually re-file over several years should be identified and contacted to help remediate difficulties. Companies should submit an extension request rather than submit data known to be incorrect with the expectation that it can simply re-file at a later date. If a company does have to re-file, it should provide a complete explanation, in the comments section, of the data errors and steps taken to ensure there is not recurrence.

If an insurer that files in multiple states has more than two filings in error within a five-year period and/or files late (a late filing includes failing to meet an extension due date in two consecutive years), information is available on i-Site+ in a Tableau dashboard available to regulators. If a majority of jurisdictions agree, a referral will be made to include the company in the Market Actions (D) Working Group's National Analysis Program. To ensure that companies are aware of the submission requirements, the NAIC develops training classes for company as well as state representatives.

Companies who have multiple revised filings must provide a risk management or loss control policy that outlines their process to address these control/compliance issues. Companies that have a pattern of submitting late or re-filing may have other internal control issues that require additional analysis.



**Best Practice:** Companies that habitually re-file over several years should be identified using the Tableau dashboard and contacted to help remediate difficulties.

#### *Waiver and Extension Requests*

**Waivers:** Data call letters are sent to each company that exceeds premium thresholds on the financial annual statement (FAS) for each line of business captured by MCAS. Because there are slight definitional discrepancies between the FAS and MCAS, a company may receive a call letter even though they are exempt from filing. For example, antique auto products may be reported in the FAS as private passenger auto business, while such products are excluded from the MCAS. In these situations, the company may request a waiver from each state in which it markets these products.

Please Note: Companies that market regular private passenger auto products and reach the \$50,000 threshold are still required to file even if they also market custom auto products.

It is recommended that the states verify the company's request prior to granting a waiver.

*For example*, there may be situations where the company requests a waiver for a product line that is actually covered under MCAS. This happened in the past when companies stated they only market motorcycle coverages. While there was a time when motorcycle coverages were excluded from MCAS, this was changed for the 2011 submission. As some companies were not aware of the change, waivers were requested.

**Extensions**: There are situations where the company knows it will not be able to submit its MCAS filing on a timely basis. In these situations, the company may request an extension of up to 14 calendar days. Requests should be accompanied by the following:

1. Have you requested an extension within the five previous years?
2. If so, is your current request for the same reason?
  - a. If the answer is yes, please provide the following:
    - i. Any steps your company has taken to prevent this concern moving forward.
    - ii. The progress your company has made toward streamlining MCAS filings so it is not dependent on staffing concerns.
    - iii. Whether your company includes this process/review as part of the risk management plan.
3. If a company asks for an extension *on or after the due date*, additional information must be required of the company.



**Best Practice**: Requests for additional information should be made within the MCAS Extension tool. This allows your jurisdiction and other jurisdictions to view the requests over multiple years.

All extension requests must be processed through i-Site+. If a company's request is not processed in i-Site+, the state analyst will not be able to see if the company has actually filed when reviewing the MCAS Filing Status Report. Analysts should review the responses of other states to the extension request. Coordination among the states is important to maintain consistency. Otherwise, one state may grant a 14-day extension where another might not grant one at all.

For additional reference, please see the *MCAS Industry User Guide* located in the Resources section of the MCAS webpage ([http://www.naic.org/mcas\\_main.htm](http://www.naic.org/mcas_main.htm)). For situations where a company requests more than a two-week extension, it is recommended that such an extension request be coordinated with other MCAS states.

### April to June: Validation of Incoming Data

It is important to review the MCAS Correspondence Tracking link in the Summary Reports Section of i-Site+ when beginning review of a company. The NAIC notifies reporting companies by email if data anomalies are discovered.

In addition, inferences should be based only on statistically credible data. If the company is small and has few claims, a delay in a small number of claims could create a large impact on various ratios. The company should also be aware that its data is outside the norm and provide comments. If the company has made comments, the analyst should review them by going to the MCAS Pick-A-Page Section in i-Site+ and select the Jurat Company Contact Information report, as well as the interrogatories.

## MCAS Data Review

### Tier 1: Validation Review

- Once a company has submitted its MCAS data, the NAIC performs validations to test the data for internal consistency and reasonability. For example, a validation exception is generated if a company's direct written premiums reported on their FAS and those reported on the MCAS vary by +/- 20%. All validation warnings can be viewed on the company's Validation Exception Report, which is available on i-Site+. These tolerances have been established to avoid corresponding with insurers regarding validations that are generated due to small amounts of data provided by the company or small (immaterial) differences.
- The following table provides some examples of MCAS data validation conducted by the NAIC:

Line of Business	Validation Description	Review Tolerance
PPA/HO	claims closed w/o pay > claims closed with pay	(claims closed with pay + claims closed w/o pay) >= 100 claims AND >= 25% more claims closed w/o pay than with pay
PPA/HO	policies in force < new policies issued	policies in force and policies issued each must be >= 500 AND policies in force is three times < new policies issued
HO	FAS direct written premiums (DWP) and MCAS DWP vary by +/- 20%	MCAS > FAS by >= 100% OR FAS > MCAS by >= 20%
Life/Annuity	total claims closed with payment <= claims denied, resisted or compromised	(total claims closed with payment) + (claims denied, resisted or compromised) >= 100
Life/Annuity	replacements applied for < policies issued	(replacements applied for + policies issued) >= 100 AND >= 25% more replacements applied for than policies issued
Life/Annuity	If new policies issued or policies in force > 0 then DWP must be > 0	(new policies issued > 50) OR (policies in force > 100) AND DWP = 0
Life/Annuity	If DWP > 0 then (policies issued + policies in force) must be > 0	DWP > 100,000 AND Policies in force = 0

### Tier 2: Ratio and Indicator Review

- The MCAS published ratios are also reviewed to find any company ratios generated from data entry errors or other data anomalies. The ratio results for a given state are reviewed by sorting them to find extreme high or low values. The data is then further examined to determine if a possible data error exists.
- In addition to the MCAS published ratios, additional ratios and indicators are examined to find potential data errors. Following are examples of additional ratios and indicators that are used by NAIC staff:

PPA/HO	Dwellings or autos to policies in force
PPA/HO	DWP to policies in force
PPA/HO	Claims opened to policies in force
PPA/HO	Suits open during the period to policies in force
PPA/HO	Suits open end of period to (claims/1000)
PPA/HO	Median days as reported compared to calculated median days
LIFE	Denied, resisted or compromised claims to policies in force
LIFE/ANNUITY	Surrenders to policies in force
LIFE/ANNUITY	DWP to policies in force
LIFE	Face amount of policies in force to policies in force

LIFE	Face amount of policies issued to policies issued
LIFE	Death claims to policies in force
ANNUITY	Immediate contracts issued to policies in force
ANNUITY	Deferred contracts issued to policies in force
ANNUITY	Immediate contracts issued to deferred contracts issued

### *Tier 3: Individual Data Element Review*

- Once the previous two tiers of review have been completed, each individual data element, by line of business and state, are reviewed. This review is done to find possible data errors. Where possible, the data elements are compared to the value reported in the previous year to identify significant changes in reporting.

Validation of MCAS filings are performed by NAIC staff as well as the participating jurisdictions. All inquiries sent by the NAIC data analysts to companies are located in the Correspondence Tracking application found in i-Site+. Within Correspondence Tracking, an analyst can review the correspondence between the NAIC and the company, and can see the status of the validation issue—"in progress", "state handling", "resolved", or "no action required".

★ **Best Practice:** It is the responsibility of the states to verify that the data is reasonable. For example, are ratios that are extreme outliers an accurate reflection of company market practices, or are they reporting errors? Before contacting the company, check to see if the company has already been contacted by an NAIC data analyst for the same issue.

## May to June: Analysis

For specifics on ratio formulas, see the MCAS Scorecard Ratio Formulas on the MCAS webpage ([http://www.naic.org/mcas\\_main.htm](http://www.naic.org/mcas_main.htm)).

The core of any MCAS analysis consists of developing ratios that serve as potential indicators of company performance and comparing these ratios to an industry-wide baseline. To assess the degree to which ratios deviate from the baseline, analysis can be done in various ways. One of the easiest is to use the MCAS Market Analysis Prioritization Tool (MAPT) for the respective line of business and determine the average for each ratio. Then, identify companies with ratios substantially above that average. For example, private passenger auto Ratio 3 is the percentage of claims paid beyond 60 days. If the state average for all private passenger auto companies is 25%, then companies with a value of 50% could be considered outliers. Though there may be situations where the focus is on very high ratios, attention should be paid to low ratios, as well. A company with a very low ratio of 5% for Ratio 3 may not be conducting any investigations and simply paying all claims. This could have a future impact for the company if loss ratios suddenly increase.

### *Ranks*

The company's ratio rank is a function of the company's ratio value compared to those of all other filing companies. A ranking of zero indicates the ratio value is zero, null or incalculable. A ranking of 21 indicates the ratio value is greater than 100 or the ratio has the highest value of those being ranked. This may be due to anomalies with the data. It should be noted that private passenger auto and homeowners underwriting ratios cannot be calculated at the coverage level, as underwriting information is collected only at the line of business level.

In addition to the overall ranks, the homeowners and private passenger auto lines of business have a claims rank, an underwriting rank, and a suits rank. These supplemental ranks are calculated at the line of business, state and national levels. Ranks can be used to look at multiple companies simultaneously. Outliers can be identified by finding the mean and then calculating the standard deviation in Microsoft Excel or other spreadsheet programs.

Ranks should be evaluated with an understanding of the data elements and underlying raw data. There may be variations in the raw data that make a company appear normal when looking at the ranking. Also, companies with low ranks may be cause for concern. Very low ranks may indicate problems with the company's data. Analysts should not concentrate only on those companies with higher ranks. On occasion, carriers with low underwriting ranks have failed to report certain underwriting activity; e.g., non-renewals or cancellations. Also note that ranks can be trended; i.e., companies moving up or down in ranks over a three-year period can be identified.

It is important to determine whether the underlying data is statistically credible. Due to what statisticians term the "law of large numbers," valid inferences require a sufficient volume of data points. Ratios for smaller companies may not be meaningful indicators of general business practices but, rather, random fluctuations in the underlying data.

*For example*, if a company has only three claims and two of them were denied, their ratio of denials is 60%, and is very likely well above the industry norm. However, any inferences based on this ratio are likely to be unwarranted.

### *Tools and Reports Available*

When reviewing MCAS filings, the analyst may find it useful to review rate and form filings to see what business is being marketed. The company's Management's Discussion and Analysis (MDA) filing may also assist. The MCAS-MAPT is a great tool to conduct analysis, as additional worksheets can be added for doing sorts or conditional formatting, and columns that are not needed can be hidden.

Review of the interrogatories is also helpful. Companies are to report if they are still actively writing; if there has been a significant event or business strategy change that affects the data; or if the insurer has sold, closed, or moved a block of business to another company. Having this knowledge is extremely helpful when reviewing the company's data, especially when comparing it to prior years.

i-Site+ shows premium changes per year, which may be of assistance, and Microsoft Access can also be used to query several MAPT reports at the same time.

★ **Best Practice:** Make use of the tools available for MCAS analysis including; rate & form filing history, the company's MDA, the MCAS-MAPT and a review of interrogatory responses.

### **Analysis Techniques**

Analysis is an ongoing process, but it should begin as soon as data becomes available. The MCAS-MAPT can be used to review rankings and ratios. The mean of the data can be identified, and data that significantly deviate from the mean can be viewed as outliers. In other situations, depending on the skew of the data, using the median may be more representative of the center point of the data. Whether to use the mean or the median should be based on the analyst's judgment, based upon a particular data set.

Thresholds can also be established in Tableau or using Microsoft Excel. With Microsoft Excel, conditional formatting can be used to quickly identify outliers. The analyst may also use highlighted colors with conditional formatting.

### *Trending*

The MCAS-MAPT provides the availability to trend data. Companies that ranked low in prior years but high in the current year can be quickly identified. Claims payment patterns can also be trended to see if there are any patterns of concern. If a company is just entering a product line, trending can be used to identify the new activity and the company's growth. If a company is leaving a market or

shifting product lines, these activities can also be monitored.

Data needs to be monitored to identify false trends or reporting errors. If the company recently expanded into the state but trending indicates a decline, then additional steps to verify the data must take place. This may require contacting the company or performing market analysis.

### *Comparisons*

Once the data is in a searchable format, such as in Tableau, Excel or Access, additional comparisons can be performed. The data can be viewed by insurer group to identify possible non-standard underwriting companies or outlying companies that are part of the group.

### *Company to Company*

Comparisons to other companies can also be conducted. If the industry is seeing higher claims utilization, is that reflected in the data? Are some companies affected more than others?

Newer companies may behave differently than older ones or may have slightly different policyholder demographics.

### *Standard versus Non-standard Lines*

It is important for the analyst to be familiar with the company being reviewed. There may be value to looking at the rate or form filings to determine if products offered are standard or non-standard. Some companies that offer non-standard lines, such as homeowners or private passenger auto, may rank higher on many ratios than standard or preferred coverage. By understanding the product design before review, the analyst can determine if the non-standard company should be reviewed separately from the other companies. When reviewing private passenger or homeowners' coverages, it is important to look at the interrogatory page that contains information about the amount of business written in the non-standard market. This can be located in the MCAS Pick-A-Page section of i-Site+. It can also be found on MCAS-MAPT.

*For example*, non-standard companies' ratios generated from claims data may deviate from the industry norm because, historically, more claims are filed by non-standard policy owners or insureds are harder to locate.

### *Company to State Ratio*

The company can be viewed in relation to the state-wide ratios. Is the company significantly higher or lower than average compared to other companies? Does a particular ratio appear to be high for a company compared to the state ratio? Is the company still writing in the line of business? Are there any trends over the past several years? These questions need to be considered when looking at company data compared to state ratios.

### *State Ratios to Other State Ratios*

Average ratios or company ratios may differ between the states. If the company is writing the same product in specific states, MCAS data in those states may be relevant. The company may have different claims adjusters in different states. Also, data that should be similar between the states may be vastly different.

The analyst may review neighboring states for comparisons of state ratios or may look for states that have similar premium volumes and demographics. This approach may identify if the company has similar issues in multiple states and allow the analyst to develop strategies to resolve them.

## *Review of Individual Company Data*

The underlying data must always be considered. If a company has very few claims and reports a delay in only one, this might cause the rankings and ratios to spike significantly. Annuity companies that no longer write business may see Ratio 3 spike when a consumer surrenders a policy.

It is important to note that the ratios are based on the underlying data. If the underlying data has inconsistencies, it may not be noticed by looking at the overall ratios.

As stated previously, the analyst needs to know and understand the various companies' markets and how business is conducted in the state. If ratios are outliers, the analyst should look at the underlying data to see if the ratios are skewed for certain types of claims.

*For example*, for private passenger auto claims, the analyst should look at how claims are processed for collision, bodily injury, etc.


Also be careful of "false positives."

*For example*, Ratio 3 for life and annuities measures surrenders to new policies issued. If the company writes little or no new business, but has surrenders, this ratio may be very high. Again, it is important to know what the company writes in the respective state. Where applicable, this can be determined by reviewing filings submitted to the state for review. The company may also use its comments section to provide clarification of outliers.

## *Combining MCAS with Other Market Information Tools*

Analysis should not focus exclusively on MCAS data to make inferences about a company's market behavior. Data from other NAIC systems—such as the Regulatory Information Retrieval System (RIRS), Market Analysis Review System (MARS), Examination Tracking System (ETS) and Market Analysis Prioritization Tool (MAPT)—provide a basis for a much more general overview of a company's market performance. The data may be viewed in conjunction with the MAP-T by a specific line of business; e.g., private passenger, homeowners, life, etc. The state insurance department's complaint database can be a resource, as well. By the time MCAS data is received, there may be five or six months of complaint data available within the department not viewable from the i-Site+ Level 1 screens. In addition, other states may have already performed Level 1 or other analyses, and such actions can be viewed in i-Site+. Just because the MCAS filing is unremarkable and does not reveal any areas of concern, the analyst should not infer that the company does not have other issues.

*For example*, the company could still be marketing unapproved forms through unlicensed producers, or engaging in other behaviors not reflected in the MCAS ratios.

 **Best Practice:** Analysis should not focus exclusively on MCAS data – when there are questions, bring in data from other NAIC systems to gain a fuller understanding of a company's market behavior.

## **Next Steps**

### *When to Contact the Company*

If MCAS data anomalies have no apparent explanation, then the analyst should contact the company's MCAS representative. Every effort should be made to determine whether the data is accurate, and whether the representative can provide an explanation for the anomalies related to a company's market practices. If the company representative appears to lack training or the understanding to adequately address concerns, then additional analysis of the company may be



appropriate.

*For example*, does a high ratio of claims closed without payment reflect the manner in which claims are counted in the production of the MCAS, as opposed to claims handling practices?

### *Integrating MCAS Data into the Market Analysis Framework*

Level 1 analysis incorporates MCAS data for all MCAS lines in the states that require MCAS submissions. It is important to note, however, that there are states that do not require MCAS submissions; in these cases, MCAS data will not be incorporated into Level 1 or Level 2 analysis.

As noted in this document, there may be a variety of reasons a company is an outlier that are unrelated to market practices; in these cases, a Level 1 and/or Level 2 analysis may be revealing.

The analyst may also want to review Level 1 and Level 2 analyses conducted by other states prior to contacting the company about issues or concerns. This will allow the analyst to detect possible data issues, as opposed to contacting the company on a range of issues that may not represent true concerns. There may be other times when the company should be contacted directly.

*For example*, a significant number of lawsuits may require contact with the company for clarification.

### *Integrating Other Data into MCAS*

The intent of market analysis is to understand how companies interact with consumers. Are claims paid timely and correctly? Are the products appropriately marketed for the consumer? If the analyst has an understanding of the products filed and approved, the type of producer marketing the product and the company's claim payment method(s), the analyst will be better able to put the company's MCAS submission into context. If the MCAS data suggests a change in the company's practices, then the analyst can be more proactive in protecting consumers.

## July 1: Scorecards

MCAS scorecards are produced each year to show the jurisdiction-wide ratio and the distribution of ratios for all companies filing an MCAS in a given jurisdiction. Individual company ratio information is available through the online MCAS application. A company can gain a better understanding of where they fit in the insurance marketplace and what opportunities may exist to improve their performance in a jurisdiction by comparing their jurisdiction-specific ratios to the scorecard for that jurisdiction. Each year, the most recent scorecards for all participating MCAS jurisdictions are made available on the NAIC MCAS Web page via a link to the Contacts and Scorecards ([https://content.naic.org/mcas\\_data\\_dashboard.htm](https://content.naic.org/mcas_data_dashboard.htm)).

Scorecards are posted on the MCAS Web page. The scorecard allows companies to compare their specific results to the rest of industry for the particular line of business. Please refer to [https://www.naic.org/mcas\\_main.htm](https://www.naic.org/mcas_main.htm) for key dates.

## Appendix A: MCAS Best Practices

**Best Practice:** Be sure your MCAS contact is current. You can check/update your state MCAS contact here: Link to [Participating Jurisdiction Contacts](#).

**Best Practice:** When a company re-files to correct an issue, the analyst should review the filings submitted to other states. If filings in other states have the same issues, then coordination with other states, or the domestic state, should be initiated when contacting the company.

**Best Practice:** Companies that habitually re-file over several years should be identified on the Tableau dashboard and contacted to help remediate difficulties.

**Best Practice:** Requests for additional information should be made within the MCAS Extension tool. This allows your jurisdiction and other jurisdictions to view the requests over multiple years.

**Best Practice:** It is the responsibility of the states to verify that the data is reasonable. For example, are ratios that are found to be extreme outliers an accurate reflection of company market practices, or are they reporting errors? Before contacting the company, check to see if the company has already been contacted by an NAIC data analyst for the same issue.

**Best Practice:** Make use of the tools available for MCAS analysis including; rate & form filing history, the company's MDA, the MCAS-MAPT and a review of interrogatory responses.

**Best Practice:** Analysis should not focus exclusively on MCAS data – when there are questions, bring in data from other NAIC systems to gain a fuller understanding of a company's market behavior.

- Be sure your state's MCAS contact is current – check here: [https://www.naic.org/mcas\\_data\\_dashboard.htm](https://www.naic.org/mcas_data_dashboard.htm)

### Analysis:

- Always refer back to the underlying raw data
- Review ratio formulas to understand what each ratio is measuring  
[https://www.naic.org/mcas\\_main.htm](https://www.naic.org/mcas_main.htm) found under *Resources > Scorecard Ratio Formulas (PDF)*
- Check interrogatory pages for comments that may explain outliers
- Verify that reported data is reasonable; determine if outliers result from accurate data or are reporting errors
- Determine whether the underlying data is statistically credible
- Compare company data trend to state ratio trend
- Use other Market Information Tools to analyze company behavior in addition to MCAS and MAPT
- Contact the company if data anomalies have no apparent explanation

### Waiver/Extension Requests and Late Filings:

- Check company's history of waiver/extension requests
- Verify that company is entitled to a waiver before granting one
- Review filings submitted to other states to determine if similar issues are present
- Any company filing in multiple jurisdictions with prior history of extension requests, late filings, or incorrect filings will be elevated to discussion in the Market Analysis Bulletin Board.

## Appendix B: Resource List

### For Industry:

NAIC website  
[www.naic.org](http://www.naic.org)

Industry Links with a link to MCAS page:  
[https://content.naic.org/index\\_industry.htm](https://content.naic.org/index_industry.htm)

MCAS History, General Filing Information, Training, Resources  
[http://www.naic.org/mcas\\_main.htm](http://www.naic.org/mcas_main.htm)

The MCAS webpage is data year specific. Along the top of the webpage, underneath the logo, you will see four data years to choose from—the next year, the current year and the two prior years. The resources available on the MCAS Webpage often change from one year to the next as revisions or additions are included for the new year. Be sure you choose the relevant data year before choosing the resource. Descriptions of each resource is included in the main page narrative.

The resources on the MCAS Webpage include:

- The *Participation Requirements*
- Training materials for companies
- The data collection worksheets (blanks) for each line of business
- The *Data Call and Definitions* for each line of business
- A summary of changes for each data year
- The *MCAS User Guide* for each year (includes instructions for companies and a listing of all validations)
- CSV upload instructions and templates for each line of business
- Scorecard ratio formulas
- Data Call Communications—Call letter, authority references, and participating jurisdiction signatures
- FAQ—An FAQ for all lines of business is available near the “log in” button used by companies
- Key Dates—The MCAS Webpage also contains key dates for the data year filings. The key dates include the date of the call letter, training dates, filing due dates, scorecard dates and the last date filings for the prior data year can be submitted.

MCAS Scorecards:  
[https://www.naic.org/mcas\\_data\\_dashboard.htm](https://www.naic.org/mcas_data_dashboard.htm)

### [Market Analysis Procedures Working Group](#) Webpage

The Market Analysis Procedures Working Group (MAP) is responsible choosing which lines of business to include in MCAS and revisions to current data. On its page you can find current comments on information on lines of business under consideration.

Also on the MAP website, under Related Documents, there are links to:

- [Process for Selecting New Lines of Business](#)
- [MCAS Revision Process](#)
- [The MCAS Best Practices Guide](#)

### [Market Conduct Annual Statement Blanks Working Group](#) Webpage

The Market Conduct Annual Statement Blanks Working Groups (MCAS Blanks WG) is responsible for the creation of new line of blanks, and the review and revisions of current MCAS blanks. On the MCAS Blanks WG website you will find discussions and comments on the creation of new blanks and reviews of existing blanks.

Under the Related Documents section there are links to:

- Data Calls and Definitions of recently adopted lines of business that will be collected in a later data year.
- [MCAS Revision Process](#)
- Recently adopted revisions and clarifications of current lines of business

**For Regulators:**

MCAS History, General Filing Information, Training, Resources  
[http://www.naic.org/mcas\\_main.htm](http://www.naic.org/mcas_main.htm)

MCAS Scorecards:  
[https://www.naic.org/mcas\\_data\\_dashboard.htm](https://www.naic.org/mcas_data_dashboard.htm)

NAIC i-Site+ Summary Reports:  
[MCAS Correspondence Tracking](#)  
[MCAS Filing Status Report](#)  
[MCAS-MAPT](#)  
[MCAS Ratio Summary Report](#)  
[MCAS State Ratio Distribution Report](#)  
[MCAS Validation Exception Summary](#)

NAIC i-Site+ Company Reports:  
Enter **Cocode** of Company  
Go to **Company/Firm Reports**

Under **Market Conduct Annual Statement**, the following reports are available:

MCAS Audit Trail  
MCAS Company Specific Report  
MCAS Company Waiver and Extension Report  
MCAS Line Reports  
MCAS Pick a Page  
MCAS Validation Exceptions

## Chapter 6—Basic Analytical Tools

### A. Market Conduct Indicators and Priorities

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

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

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

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

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

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

### B. NAIC iSite+

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

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

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

### **C. Use of Complaint Data in Market Analysis**

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

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

- Complaints are to some degree anecdotal and often are not documented in sufficient numbers to be statistically credible. Although this deficiency can be mitigated to some degree by using multistate data, inconsistencies between different state approaches raise other concerns;
- One reason for the small sample size is that not every problem gives rise to a documented complaint. States need to gauge how informed state consumers are about voicing concerns or complaints regarding insurance;
- Conversely, the customer might not always be right. The presence of a complaint points to the existence of a conflict, but not the nature or the cause. A complaint could be the result of an insurer failing to live up to its obligations or the result of a breakdown in communications, but it could also be the result of unrealistic expectations on the part of the consumer. To address this concern, “confirmed” complaints, meaning complaints that have been confirmed by the the state insurance department as the insurer as being in violation or in error, (Link to definition in chapter 7) should be distinguished from other consumer complaints;
- There are some lines of insurance for which there are no useful complaint records because the nature of the business makes it unlikely that consumers will file complaints or because the insurance department does not have an active complaint resolution program. For example, violations of disclosure requirements might never generate complaints because, in the absence of disclosure, consumers do not know their rights have been violated. Similar problems also arise when premiums or benefits involve complex calculations because of the nature of the product; and

- Some markets are inherently more prone to complaints than others. For example, this is likely to be true for the higher risk or non-standard sector within any line of insurance. Such differences must be taken into account before trying to compare the performance of different companies serving different markets. When there are problems with life insurance products, they are less likely to become visible through the consumer complaint process. Similarly, complaints are more likely in lines of business where consumers have more frequent interactions with their insurer, such as health or private passenger auto, regardless of how serious the potential problems might be.

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

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

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

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

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

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

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

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

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

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

### **Market Conduct Annual Statement**

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

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

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

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

### **Financial Annual Statements and State Pages**

The most comprehensive source of data on the financial aspects of insurers' activity in the marketplace are the annual and quarterly financial statements, which an insurer is required to file with its state of domicile, the NAIC and, in most instances, all jurisdictions in which the insurer is authorized to transact business. These statements include specific schedules and interrogatories that provide detailed information, such as premium volume, losses, and changes in business. The NAIC compiles a wide variety of reports from the filed financial statements and makes them available to state insurance departments at iSite+. Financial statement data has value for market analysis on



several levels and sometimes will allow regulators to identify companies with an increased risk of future compliance problems, allowing regulators to respond proactively before serious problems occur.

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

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

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

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

Claims-related information is of particular relevance to market performance, so one of the key items of financial data for market analysts is claim reserves, which is itemized on the property/casualty Blank as “Direct Losses Unpaid” and “Direct Defense and Cost Containment Expense Unpaid.”<sup>3</sup> A spike in reserves can occur for a number of reasons, some of which might signal market conduct problems. If losses and reserves are both moving in the same direction, there is less concern. A spike in reserves without a corresponding change in losses paid should be investigated. Perhaps a major lawsuit was filed against one of the company’s insureds, or there may be a correction of reserves on pending claims. The insurance regulator should investigate the reason and also check the complaints made against the insurer, trends over time, and reserve activity for comparable companies in the market.

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

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

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

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<sup>3</sup> Although this information may also be of value when studying accident and health insurers, particularly in lines like long-term disability and long-term care, there is no analogous line item on the health or life and health state pages. Because calendar year paid loss data aggregates layers of the losses incurred in many different years, unpaid losses cannot be backed out by comparing calendar year paid and incurred loss data.

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

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

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

## **E. Issues Specific to Particular Types of Companies**

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

### **Health Insurance**

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

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

### **Life Insurance**

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

### **Workers' Compensation Insurance**

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

## **F. Other Useful Information**

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

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

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

**Rating Agencies**

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

**Informational Filings**

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

**Interdepartmental Communication**

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

**Communication with other Regulators**

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

**Enforcement Actions**

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

### **Regulatory Information Retrieval System**

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

### **Market Action Tracking System (MATS)**

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

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

Reports from voluntary examinations of companies provide another potential source of useful market analysis information at any stage of the analysis process. In addition to self-audits conducted by companies, evaluations are also prepared when insurers apply for membership or accreditation to “best practices organizations” or independent standard-setting organizations and when those organizations conduct periodic reviews.<sup>5</sup>

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

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

In some states, self-evaluative privilege statutes provide specific guidance on the regulators’ access rights and confidentiality obligations, whereas regulators in other states must consider a variety of issues related to the protection of proprietary information, attorney work product, trade secrets, and other privileged information.

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<sup>5</sup> Market analysts should refer to the NAIC white paper *Best Practices Organizations* for additional guidance related to the application of such evaluations and standards.

Addressing these concerns and working with companies' voluntary review activities is important, because a full understanding of a company's market activities encompasses the company's policies and the practices that implement the company's policies. An active compliance program at a company often reflects a corporate culture that places a high value on compliance. Since "bottom-up" information on a company's market practices is more accessible to regulators, the "top-down" policy focus often found in insurer peer reviews can be a useful complement to the information that is otherwise available.

### **Consumer Dispute Resolution Processes**

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

### **Matched Pair Testing**

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

### **Rating Territories**

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

### **Miscellaneous**

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

Other information collected by some regulators, though not necessarily available in all states, includes underwriting guidelines, detailed geographic market performance data, surveys of market participants and marketplace testing. Detailed geographic data—such as ZIP code data by company and type coverage—has been used by some regulators to identify underserved markets and investigate redlining allegations. Surveys of market participants—including agents, realtors and consumers—are another source of real-time market performance information. Testing—sending

people to purchase insurance who have similar risk characteristics but different races or other characteristics that may make them targets of unfair discrimination—adapts a tool that has long been used in the fields of housing, lending and employment to verify compliance with fair practices. In addition, a review of recent insurance-related lawsuits can provide insight into consumer perceptions of market abuses, and this information is publicly available.

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



Draft: 3/31/21

Market Analysis Procedures (D) Working Group  
Virtual Meeting (*in lieu of meeting at the 2021 Fall National Meeting*)  
March 19, 2021

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 19, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Teri Mecca (AR); Sarah Borunda (AZ); Don McKinley (CA); Kurt Swan (CT); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Jo LeDuc (MO); Jeannie Keller (MT); Robert McCollough (NE); Edwin Pugsley (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Hermoliva Abejar (NV); Larry Wertel (NY); Landon Hubbard (OK); Jeffrey Arnold (PA); Matt Gendron (RI); Michael Bailes (SC); Shelley Wiseman (UT); Will Felvey (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating was: Sarah Crittenden (GA).

1. Adopted its Feb. 25 Minutes

Mr. Haworth said the Working Group met Feb. 25 and took the following action: 1) adopted its Jan. 27 minutes; 2) discussed a 14-day limitation for Market Conduct Annual Statement (MCAS) extension requests; 3) discussed the MCAS attestation process; and 4) discussed training opportunities for market regulation analysts.

Mr. Pugsley made a motion, seconded by Mr. Boeckman, to adopt the Working Group's Feb. 25 minutes (Attachment Three-A). The motion passed unanimously.

2. Adopted Revisions to the MCAS Best Practices Guide

Ms. Rebholz said during the Working Group's last meeting, it discussed the completion of the *MCAS Best Practices Guide*, and the final draft was posted on the Working Group's web page. She said the most significant changes are: 1) the recommendation to limit initial and subsequent extension requests to two weeks; 2) highlighting "best practices" within the document; and 3) adding an appendix to summarize all the recommended best practices. She said the drafting group also inserted a table of contents for ease of reference. She noted that no comments were received on the draft.

Mr. McKinley made a motion, seconded by Mr. Bailes, to adopt the revisions to the *MCAS Best Practices Guide*. The motion passed unanimously.

3. Adopted a 14-Calendar Day MCAS Extension Limitation

Mr. Haworth said the Working Group has discussed the 14-day extension limitation during its last two Working Group meetings. He said the proposal is to limit extension requests to 14 days but continue to allow companies to ask for additional extensions if needed. He said to accomplish this, the MCAS filing tool, which is used by companies to file their MCAS submissions, would need to be re-coded to limit extension requests to 14 days and allow for multiple requests after the initial extension request. He noted that because of the re-coding, if the Working Group adopted the proposal, the soonest it could take effect is for 2021 data collected in 2022, but considering other market information system priorities, it may be later. He noted, however, that any MCAS jurisdiction can still choose to only allow 14 days for any extension request.

Mr. Haworth said his sense is that state insurance regulators are in favor of limiting extension requests to 14 days. Industry, however, proposed making the proposal 14 business days. Mr. Haworth said the Working Group received one comment from a state that is comfortable with 15 business days, which on the calendar would be three weeks. He said during the February meeting, several members of the Working Group noted that if the final day of an extension fell on a weekend or holiday, the jurisdiction would allow the filing on the following business day.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said companies would like to have the ability to request extensions up to 60 days. She said the reliable filers start the process early, and they usually would not request an extension except in unusual situations where more than 14 days might be required. For reliable filers, extensions are not requested because of bad planning, and 14 days may not be enough time.

Birny Birnbaum (Center for Economic Justice—CEJ) said a company that is diligent in preparing its MCAS submission would not discover that it needs more time in the last days of the filing period and would not need 60 additional days after the due

date. He said he supports the 14-day limitation. Ms. Brown said if the reliable MCAS filers find an issue with their data in the last days before the due date, it generally is not a 14-day fix.

Mr. McKinley asked if companies would be able to request additional extensions if 14 days are not enough. Mr. Haworth said the MCAS submission tool would be re-programmed to allow additional requests.

Mr. Gendron requested that the 14-day extension be referred to as a 14-calendar day extension. He said Rhode Island had no preference for either a 14-calendar day extension limitation or a 15-business day limitation. He said Rhode Island is willing to provide the time required to get accurate data. Mr. Haworth noted that the longer the market analysts must wait for the data, the more often they have to refresh the data they are using for their analysis. Ms. Crittenden said she is in favor of referring to the limitation as “calendar days,” and she said market analysts need accurate data as soon as possible.

Ms. Keller made a motion, seconded by Ms. Rebholz, to limit MCAS extension requests in the MCAS submission tool to 14 calendar days and allow for additional extension requests. The motion passed unanimously.

4. Adopted an MCAS Requirement to Attest by Line of Business and by Jurisdiction

Mr. Haworth said the Health Insurance Interested Parties (HIIPs) made a request to be able to identify a different attester per line of business and per state. This request was supported by representatives of companies in the other lines of business.

Mr. Haworth said currently, a company filing its MCAS submissions must have two attesters—one attester to the accuracy and completeness of the MCAS filings and one attester to the company being able to track the data to its source and re-create the results in MCAS filing. He said these two attesters are the same for all lines of business and all states. This causes concerns for companies that have different responsible people for different states and different lines of business.

Mr. Haworth said NAIC staff support advised the Working Group that this can be accomplished by placing the attestations within the blank itself and removing the separate attestation section. The wording of the attestation would be contained in the Data Call and Definitions for each line of business. No MCAS filing could be submitted without attesters being identified, but failure to provide attesters in one state or line of business would not stop other filings from the same company if those other filings had the attesters properly identified.

Mr. Haworth noted that the Working Group also had a conversation about whether the attesters should be officers of the company. He said he is setting that discussion aside until the Working Group votes on whether to allow for different attesters per line of business and per state.

Samantha Burns (America’s Health Insurance Plans—AHIP) said AHIP supports two attesters per line of business and per state. She also said the company should have the discretion as to who the attesters are.

Ms. Brown said she appreciates the needs of the health insurers, but having to name attesters for every filing would result in more work for national companies that have been filing for a long time with no need to differentiate by line of business or by state. Randy Helder (NAIC) said the change would only result in four additional lines to be completed on a comma-separated-values (CSV) upload. Teresa Cooper (NAIC) said the NAIC provides a CSV Assistant for companies on the MCAS web page to make the creation of the CSV simpler.

Mr. Birnbaum said he supports the change because it makes it more efficient for state insurance regulators to contact the correct people on each filing.

Mr. Schott made a motion, seconded by Mr. Pugsley, to allow companies to identify their attesters by line of business and by jurisdiction.

Ms. Brown asked that the motion be re-phrased to “require” companies to identify their attesters by line of business and by jurisdiction because companies will no longer have the option to use the attestation page.

Mr. Schott and Mr. Pugsley agreed to change the motion to allow companies to identify their attesters by line of business and by jurisdiction. The motion passed unanimously.

5. Adopted Revisions to the NAIC Market Regulation Handbook

Mr. Haworth said the revisions to the market analysis chapters of the NAIC *Market Regulation Handbook* were completed prior to the Working Group's last meeting, and they have been posted in the exposure drafts section of the Working Group's web page. He said no comments have been received on the revisions.

Ms. Rebholz made a motion, seconded by Ms. Abejar, to adopt the revisions to the market analysis chapters of the NAIC *Market Regulation Handbook*. The motion passed unanimously.

#### 6. Discussed Market Analysis Training

Mr. Haworth thanked Tony Dorschner (SD) for his written suggestions. He said those comments and others regarding training are posted on the Working Group's web page. He encouraged others to put their thoughts in writing so they can be compiled. He said there is a study group of at least 40 people to learn how to conduct a level 1 review in the Market Analysis Review System (MARS). He said this is in preparation for the Market Actions (D) Working Group's national analysis program.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 3/10/21

Market Analysis Procedures (D) Working Group  
Virtual Meeting  
February 25, 2021

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 25, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Maria Ailor (AZ); Don McKinley (CA); Damion Hughes (CO); Steve DeAngelis (CT); Cheryl Wade (DC); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Teresa Kroll (MO); Paul Hanson (MN); Jeannie Keller (MT); Reva Vandevoorde (NE); Karen McAllister (NH); Leatrice Geckler (NM); Hermoliva Abejar (NV); Larry Wertel (NY); Landon Hubbart (OK); Jeffrey Arnold (PA); Segun Daramola (RI); Rachel Moore (SC); Tracy Klausmeier (UT); Will Felvey (VA); Christina Rouleau (VT); and Theresa Miller (WV). Also participating were: Sarah Crittenden (GA); and Jo LeDuc (MO).

1. Adopted its Jan. 27 Minutes

Mr. Haworth said the Working Group met Jan. 27 and took the following action: 1) adopted its Nov. 12, 2020, minutes; 2) discussed a 14-day limitation for Market Conduct Annual Statement (MCAS) extension requests; 3) discussed the MCAS attestation process; and 4) discussed training opportunities for market regulation analysts.

Ms. Rebholz made a motion, seconded by Mr. Pyle, to adopt the Working Group's Jan. 27 minutes (Attachment Three-A1). The motion passed unanimously.

2. Discussed Revisions to the MCAS Best Practices Guide

Ms. Rebholz said the group assigned to updating the *MCAS Best Practices Guide* (Best Practices Guide) has completed its work, and the revised version can be viewed in the exposure drafts on the Working Group's web page. She said the version in the exposure drafts can be compared with the current version of the Best Practices Guide, which is in the Related Documents tab. She said the most significant changes are: 1) the recommendation to limit initial and subsequent extension requests to two weeks; 2) the highlighting of "Best Practices" within the document and adding an appendix to summarize all the recommended best practices; and 3) the creation of a table of contents for ease of reference.

Ms. Rebholz said after the changes to the Best Practices Guide, the group also reviewed other MCAS references to ensure consistency. This included the web page, the Frequently Asked Questions (FAQs), the call letter, and participation requirements. Ms. Rebholz said since these are supporting documents, the Working Group will not be voting on the changes to them. She noted that the changes to those documents were all technical.

Ms. Rebholz said the Working Group will keep the revised Best Practices Guide posted in the exposure drafts through the next conference call, and she invited comments through March 17. She said at the Working Group's next meeting prior to the Spring National Meeting, it will vote on the revised Best Practices Guide.

3. Discussed MCAS 14-Day Extension Limitation

Mr. Haworth said the MCAS submission tool currently allows a company to choose up to 60 days for an extension request. The subgroup revising the Best Practices Guide is advising that all states allow no more than a 14-day, or two-week, extension. The drafting group is also asking that the MCAS tool be adjusted to only allow extensions for no more than 14 days at a time.

Mr. Haworth said it is possible that companies may need more than the 14 days. The MCAS tool will also need to be changed to allow companies to submit second or third requests. Mr. Haworth said this will require some programming work by NAIC Information Services. He said if the change is approved, the soonest it would be in effect would be for the 2021 data reported in 2022, but it might be the following year.

Samantha Burns (America's Health Insurance Plans—AHIP) asked the Working Group if the extension could be for 14 business days. Mr. Flott said the Kansas Department of Insurance (DOI) typically only provides 14 days and if the 14th day falls on a Saturday, Sunday or holiday, then the last day would be the following working day. He prefers calendar days rather than business days. Ms. Keller said she also prefers calendar days with weekends assumed to be the following Monday.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said it is important to have the ability to make a second or third request if limited to 14 days. She said the reliable filers start the process early, and they usually would not request an extension except in unusual situations where more than 14 days might be required. For reliable filers, extensions are not requested because of bad planning.

Mr. Haworth said the Working Group will vote on this issue on its next conference call. He asked that comments be sent to Randy Helder (NAIC) by March 17.

#### 4. Discussed MCAS Attestation

Mr. Haworth said a mock-up was created of a solution that will allow companies to identify two attesters per line of business, per state. He said the issue is that currently a company can only submit the same two attesters for all lines of business in all states. This creates issues where companies may have different responsible parties for different lines of business or in different states. Mr. Haworth said the proposed solution is to move the attestation to the reporting blank so different attesters can be identified in every filing. He said the actual wording of the attestation will be in the MCAS Data Call and Definitions for each line of business, and it will be referenced on the blank.

Ms. Burns said the health insurer interested parties (HIIPs) were supportive of the proposed solution. She said it was a positive change, and she would like to see it move forward. Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) agreed, and he said it looked like a feasible solution to allow different attesters for different lines of business and states.

Ms. Crittenden asked if the attester could be required to be an executive of the company. Mr. Haworth said it is important that the attester be someone knowledgeable about the specific data being reported. Mr. Arnold said if the attester is too far removed from the data, they are only attesting to the best of their knowledge. Mr. Haworth said there are lines for two attesters, so it may be possible to require one to be an executive while the other is knowledgeable about the specific data. Mr. Helder said there are two attesters because one of the attesters is attesting to the accuracy and the other is attesting to the source of the data and the ability to re-create it.

Ms. Brown said a large nationwide company may have a significant amount of input if the reporting is done with the reporting blank.

Andrew R. Pauley (National Association of Mutual Insurance Companies—NAMIC) said these seem to be two separate issues: 1) who needs to attest; and 2) how the attestation is done. He asked if the solution is all or nothing. He asked if a company can still choose to attest on the attestation page with one attester responsible for all lines and states. Mr. Helder said the solution anticipates removing the attestation page and replacing it with data elements on the reporting blank.

Mr. Haworth asked for comments to be sent to Mr. Helder by March 17. He said the Working Group will consider adoption of the new attestation process at its next meeting.

#### 5. Discussed the Market Analysis Framework

Mr. Haworth said the small group reviewing and updating the NAIC *Market Regulation Handbook* chapters on market analysis completed its work. He said the exposure draft section of the Working Group web page contains links to the redlined versions of Chapters 6 through 9.

Mr. Haworth asked everyone to review the drafts and send comments to Mr. Helder by March 17.

#### 6. Discussed Market Analysis Training

Mr. Haworth said for the last few meetings, the Working Group has been discussing training suggestions that state insurance regulators would find helpful. He said the Working Group received suggestions from South Carolina, and those are posted in the comments on the Working Group web page.

Ms. Abejar said new analysts and examiners would be helped by training in market conduct risk identification. She said it would be helpful to know what risks are present when certain data is seen. She also suggested a repository to document situations and how they were handled to learn from experiences.

Ms. LeDuc suggested a lunch and learn format that is regularly scheduled but informal. State insurance regulators could bring problems they are encountering to the lunch and learn to discuss solutions and ideas. She noted that it is difficult to find training on problems right when it is needed. The lunch and learn would allow for quicker turnaround.

Ms. Ailor said the timing of training should match with the need (e.g., MCAS training is needed when filings are being received and analyzed).

7. Discussed Other Matters

Mr. Haworth said HIIPs also said in their comment letter that there appears to be a one-megabyte file size limitation when uploading filings in the MCAS. He said NAIC staff were unaware of this, but they have duplicated the issue. He said it will likely be an issue that the Market Information Systems Research & Development (D) Working Group will consider addressing and prioritize if any changes need to be made. He said NAIC staff will submit a Uniform System Enhancement Request (USER) for to the Market Information Systems Research & Development Working Group to begin that review.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 2/4/21

Market Analysis Procedures (D) Working Group  
Virtual Meeting  
January 27, 2021

The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Jan. 27, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Maria Ailor and Sarah Borunda (AZ); Don McKinley (CA); Damion Hughes (CO); Steve DeAngelis (CT); Sharon Shipp (DC); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Jeff Zewe (LA); Mary Lou Moran (MA); Dawna Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Cynthia Amann (MO); Paul Hanson (MN); David Dachs (MT); Reva Vandevoorde (NE); Karen McAllister (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Sharon Ma (NY); Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Shelley Wiseman (UT); Julie Fairbanks (VA); Marcia Violette (VT); and Theresa Miller (WV). Also participating was: Shane Quinlan (NC).

1. Adopted its Nov. 12, 2020, Minutes

Mr. Haworth said the Working Group met Nov. 12, 2020, and took the following action: 1) adopted its Oct. 22, 2020, minutes; 2) discussed the Market Conduct Annual Statement (MCAS) attestation process; and 3) discussed training opportunities for market regulation analysts.

Mr. Flott made a motion, seconded by Ms. Amann, to adopt the Working Group's Nov. 12, 2020, minutes (*see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Five*). The motion passed unanimously.

2. Discussed Revisions to the MCAS Best Practices Guide

Ms. Rebholz said the group revising the *MCAS Best Practices Guide* is reviewing other MCAS documents to ensure that all the MCAS documents are consistent. The other documents to be reviewed are the frequently asked questions (FAQ) document, the *MCAS Industry User Guide*, and the data call letter. Ms. Rebholz said the work should be complete after two more meetings.

3. Discussed MCAS 14-Day Extension Limitation

Mr. Haworth said the review of the *MCAS Best Practices Guide* raised the concern of a consistent response to requests for extensions. He said the MCAS submission tool currently allows a company to choose up to 60 days. This creates inconsistencies when some states allow the entire 60 days, some allow 30 days, and others limit the request to two weeks. Mr. Haworth also noted that companies need to re-log into the MCAS to know how the jurisdictions responded to their request. He said it is possible that a company may assume all states are providing 60 days if they only see one or two of the responses.

Mr. Haworth said the group revising the *MCAS Best Practices Guide* is advising all jurisdictions to allow no more than 14-day extensions. The group is also asking that the MCAS tool be adjusted to only allow extensions for no more than 14 days at a time. Mr. Haworth noted that it is possible that companies may need more than the 14 days, so the MCAS tool will also need to be changed to allow companies to submit second or third requests for extensions. He said this will require some programming work by NAIC's Information Technology Group (ITG). He said if the Working Group approves this change, the soonest it would be in effect would be for the 2021 data reported in 2022, but it might be the following year.

Mr. Flott said he supports a 14-day limit on extension, and he said the Kansas Department of Insurance (DOI) already has a standard of only 14 days. He said if additional time is needed, the company is required to provide more specifics to the request. He said the company will typically not contact the DOI if it fails to submit by the end of the extension. Mr. Arnold said he supports the 14-day limitation. Ms. Ailor said the Arizona DOI has the same concern with companies asking for extensions and still not submitting their MCAS by the end of the extension. She also said certain companies fail to even request an extension. She suggested editing the MCAS data call letter to advise that the company must make an extension request if it cannot submit its data by the due date. Mr. McKinley asked if a company can receive a reminder as the end of extension period nears. He also suggested that the MCAS system could advise the jurisdictions about the extensions that are outstanding with no submission. Mr. Dachs also supported the 14-day limitation.

Mr. Haworth said the Working Group will vote on this issue on the next conference call. He asked that comments be sent to Randy Helder (NAIC) by Feb. 17.

#### 4. Discussed MCAS Attestation

Mr. Haworth said in November, the Working Group heard an industry request to allow for more attesters in the MCAS. Some companies that write multiple lines of business in multiple states have different individuals who can appropriately attest to the data. However, Mr. Haworth said the MCAS currently only allows for one attester per company to attest to the accuracy of the data regardless of the number of lines of business and states being reported in the MCAS. He said there seemed to be support from the Working Group on expanding the ability of companies to have more than one attester to the accuracy of the data. He said during the November meeting, he asked NAIC staff support to investigate possible solutions.

Teresa Cooper (NAIC) said the MCAS interrogatories can quickly be revised to add two lines for each attester. She does not believe this would be a substantive change and could be implemented right away. There would be two lines for the individual attesting to the accuracy and another two lines for the person attesting that the data that can be traced back to its source within the company. The four additional lines would be available for each line of business blank in each state. The first line would be for the name of the attester and the second line for the title of the attester. While the current comment section for the attestation would be lost, the comment boxes in the interrogatories can be used for the attestation. Ms. Cooper said if the attestation is currently not completed, the company is unable to submit its filings. She said validations would need to be added to require the new interrogatories to be completed before the filing can be submitted.

Lisa Brown (American Property Casualty Insurance Association—APCIA) said she needs to speak with APCIA membership about this, but she does not believe there would be any concerns.

Joseph E. Zolecki (Blue Cross Blue Shield Association—BCBSA) asked if there would be a description and example provided. Ms. Cooper said she could draft a mock-up of the suggestion.

Birny Birnbaum (Center for Economic Justice—CEJ) said he agrees that the change is not substantive, but if companies believe they need time to re-program, a requirement could be put in place requiring a cover letter with the names of the attesters for each line of business and each state.

Mr. Haworth asked for comments to be sent to Mr. Helder by Feb. 17.

#### 5. Discussed the Market Analysis Framework

Mr. Haworth said the subgroup revising the market analysis chapters of the *Market Regulation Handbook* has made progress and should be completed by the Spring National Meeting.

#### 6. Discussed Market Analysis Training

Mr. Haworth said in the last Working Group meeting, there was clearly a strong desire to obtain additional training from both the NAIC and peers in other jurisdictions. He said the Working Group only received one response to its request for suggested training ideas and opportunities, and he once again asked for more comments by Feb. 17.

Ms. Phelps said she would appreciate training on the meaning and importance of the variety of different ratios used by market analysts. Ms. Amann said there is a how-to guide that was published by the NAIC that contained information on financial ratios and why they should be considered in market analysis. She said she has a hard copy, but it probably needs updates, even though the underlying concepts are still valuable.

Mr. Quinlan said the only MCAS training class for state insurance regulators is an on-site class in Kansas City that was cancelled in 2020. He asked if MCAS training can be made virtual. Mr. Helder noted that the training discussed at the Working Group should include a variety of delivery methods, including virtual and in-person.

#### 7. Discussed Other Matters

Mr. Birnbaum said the initial premise of the MCAS was that the additional market conduct data obtained by annual reporting would increase the efficiency of analysts to identify and focus on priorities. This would also reduce the burden on companies because they would not have to respond to numerous ad hoc data calls and inquiries. However, Mr. Birnbaum noted that



companies continually resist any additional lines of business or data elements in the MCAS. He said if the MCAS were meeting its initial goals, companies should be cooperative with adding additional lines and data elements. He asked why companies did not take the MCAS as seriously as they do other reporting requirements. He asked whether the MCAS is achieving its initial purpose, and the reason if it is not.

Mr. Zolecki asked if the Working Group has considered a possible extension of MCAS reporting, as was provided in 2020, since the COVID-19 pandemic is continuing. Mr. Haworth said it has not because, by now, companies and state insurance regulators have adapted to the new environment. He said extensions create delays in the market analysis process.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

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Draft: 4/5/21

Market Conduct Annual Statement Blanks (D) Working Group  
Virtual Meeting  
March 23, 2021

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 23, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Crystal Phelps (AR); Sarah Borunda (AZ); Scott Woods (FL); Sarah Crittenden (GA); Erica Weyhenmeyer (IL); Dawna Kokosinski (MD); Jill Huisken (MI); Teresa Kroll (MO); Martin Swanson (NE); Leatrice Geckler (NM); Guy Self (OH); Jeffrey Arnold (PA); Michael Bailes (SC); Maggie Dell (SD); Shelli Isiminger (TN); Tanji J. Northrup (UT); Lichiou Lee (WA); and Letha Tate (WV).

1. Adopted its Feb. 24 Minutes

The Working Group met Feb. 24 and took the following action: 1) adopted its Nov. 16, 2020, minutes; 2) heard an update on the Travel Market Conduct Annual Statement (MCAS); 3) heard an update on the Other Health MCAS; 4) discussed a new MCAS proposal submission form; 5) discussed reporting of complaint and lawsuit data elements within the Home and Auto MCAS reporting blanks; 6) discussed the MCAS lawsuit definitions; and 7) discussed the addition of Accelerated Underwriting data elements to the Life MCAS and Digital Claims data elements to the Home and Auto MCAS lines of business.

Mr. Flott made a motion, seconded by Ms. Kroll to adopt the Working Group's Feb. 24 minutes (Attachment Four-A). The motion passed unanimously.

2. Heard an Update on the Travel MCAS

Ms. Rebholz noted that the Travel MCAS subject matter expert (SME) group met March 3 and March 15. She stated that during those calls, Birny Birnbaum (Center for Economic Justice—CEJ) presented a draft blank for the SME group's review. Discussions continued regarding the appropriate reporting granularity, and decisions were made on the granularity of specific data elements. The SME group is making good progress, and it will move to the definitions work in the next few sessions. Discussions will continue during the next Travel SME call, which is scheduled for March 29. Members of the SME group were advised to review the drafts posted to the Working Group's web page in preparation for the call.

3. Heard an Update on the Other Health MCAS

Randy Helder (NAIC) stated that the Other Health SME group is meeting on a weekly basis through the month of April and concentrating on short-term limited-duration (STLD) insurance products. He stated that the intention of the drafting group is to complete an STLD insurance blank and definitions before the end of April to allow for at least 30 days of exposure prior to a vote on the blank before June 1. He stated that as soon as the group completes the STLD insurance blanks and definitions, it will begin work on the remaining Other Health products. Currently, the group is on iteration 5.2, which is very close to what the final product will look like. This version and two prior versions are on the Working Group's web page in the "Current MCAS Blanks Discussions" box. Mr. Helder stated that the drafting group's next meeting would address producer commissions and the blank definitions.

4. Heard an Update on the Accelerated Underwriting and Digital Claims Discussions

Ms. Rebholz stated that volunteers have agreed to participate in the Accelerated Underwriting and Digital Claims discussion groups. She stated that the first Accelerated Underwriting call is scheduled for March 24, and the first Digital Claims call is scheduled for April 1. Working Group members, interested state insurance regulators, and interested parties that would like to participate in these SME groups were asked to contact Teresa Cooper (NAIC). Leaders for these SME groups are also still needed, and they should contact Ms. Cooper if interested in leading these groups.

5. Discussed the Placement of Complaint and Lawsuit Data Elements within the Home and Auto MCAS Reporting Blanks

Ms. Rebholz noted that Attachment Two in the meeting materials was also provided for the Feb. 24 meeting; it is a grid that summarizes the placement of the complaint and lawsuit data elements within each MCAS blank and whether the complaint and lawsuit data is reported at the line of business coverage level. She stated that the Home and Auto complaint data elements are currently reported within the underwriting section of the blank, and they are reported in total only. During its Feb. 24 call, the

Working Group was asked to consider if this level of reporting is what state insurance regulators need to perform market analysis or if complaint data by coverage type is needed. Ms. Rebholz stated that all other MCAS lines of business that contain complaint data elements require reporting at the coverage type level. Mr. Birnbaum noted in February that separate coverage reporting of complaints makes sense for the Homeowners line of business, but it may be more difficult for the Private Passenger Auto line. Ms. Rebholz noted that the goal for this meeting is to get a couple of options for the Working Group to consider and then make a final decision during the April meeting. Mr. Self stated that he has not found the need to look for a higher level of detail than what is currently available in this complaint area; therefore, he suggested no change here. Ms. Rebholz stated that in the April Working Group meeting, no change here will be considered, but if anyone has additional thoughts on this matter, she suggested that they share them on the next call.

Ms. Rebholz stated that the lawsuit data elements for Home and Auto are reported by coverage type; using the current lawsuit definitions for the Home and Auto lines of business only captures lawsuit data for claim-related suits in the Home and Auto lines of business. During the February meeting, Peter Kochenburger (University of Connecticut School of Law) and Mr. Birnbaum encouraged the collection of data for lawsuits that are not related to claims. Mr. Birnbaum also encouraged consistency in the reporting of lawsuits within the MCAS lines of business. However, as with complaints, he noted that the reporting of lawsuit groups for auto coverage types may not make sense. Ms. Rebholz noted that there are similar issues to review regarding the Lender-Placed Insurance (LPI) Auto and Home line of business; LPI lawsuits are currently reported in the claims section, but the lawsuit definition for LPI is the same as for those MCAS lines where reporting is done in a separate reporting section. She noted that she would like to have some lawsuit reporting options that can be considered during the April meeting. The question for the Working Group to consider is whether only claims-related lawsuit data for the Home and Auto MCAS lines of business is needed or if lawsuit data should include suits not related to claims.

Ms. Rebholz stated that it appears the options are: 1) no change, which means data will continue being collected for only claims-related lawsuits; or 2) collecting data for lawsuits not just related to claims but also related to more broad categories for the insurance product, such as the application and sales processes. Mr. Flott stated that he supports option one, as the reviews he has done have not warranted a change here, but he also has no objections to option two if that information is necessary for others. Ms. Rebholz noted that a draft of these options will be written for consideration on the next Working Group call.

#### 6. Discussed the MCAS Lawsuit Definitions

Ms. Rebholz stated that the Working Group needs to make determinations on the level of lawsuit reporting for Home, Auto and LPI before addressing the lawsuit definitions for those lines of business. However, at this time, the Working Group needs to review the lawsuit definition used for Life, Annuity, Disability Income, Private Flood and Long-Term Care (LTC) to determine if any revisions are needed. The definition was provided in Attachment Three of the meeting materials. Ms. Isiminger stated that in reading the definition of lawsuit and the second bullet listed, it states, “an action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant. For purposes of reporting lawsuits for (MCAS Line of Business) products: include all lawsuits, whether or not a hearing or proceeding before the court occurred.” She asked if this means any kind of filing whether it is the company doing it or the consumer. Lisa Brown (American Property Casualty Insurance Association—APCIA) stated that the first bullet states, “include only lawsuits brought by an applicant for insurance, a policyholder or a beneficiary as a plaintiff against the reporting insurer or its agent as a defendant,” and the way the first and second bullets are stated seems unclear. Ms. Rebholz stated that this would be a good time to review this information and add clarity where needed. Ms. Cooper stated that she will take notes on these comments so that edits to these bullets can be discussed further during the next Working Group meeting.

Mr. Kochenburger asked why information on arbitrations is not included, as bullet number three in the lawsuit definition states, “do not include arbitrations of any sort.” He stated that he understands that the results are confidential, but he believes knowing the number of arbitrations would be useful information for state insurance regulators. Ms. Brown stated that arbitration data is collected on the Auto and Homeowners lines of business. Richard L. Bates (State Farm Insurance) asked what the intent of including “agent as a defendant” in the first bullet discussed earlier is. He explained that it is possible that the insurance company may not be a party to the lawsuit or even know about it. Ms. Isiminger stated that she understands the term agent to mean a conservator or power of attorney. Ms. Brown stated that clarifying that producers are excluded could be helpful in this area. Ms. Rebholz stated that she would like to further review the use of the word “complainants” in bullet five versus potentially using the word “plaintiffs.” Mr. Bates asked for additional clarity on the last bullet, which states, “include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.” Ms. Isiminger suggested that the court case information could be cited here.

Mr. Bates stated that when looking at the lawsuit ratios that were developed for Auto and Homeowners, it compares it against claims closed without payment. He stated that if non-claims lawsuits are added in the aggregate, it could cause misrepresentation of information; he stated that the ratio could become less valuable. He asked that this be considered in the

decisions going forward on whether to add lawsuits not related to claims. Ms. Rebholz stated that this would be considered if there were to be a change made on lawsuit data collected. There were no other concerns raised on the other bullet points in the lawsuit definition, and she stated that the concerns raised will be noted and discussed in further detail on the next call.

#### 7. Discussed Other Matters

Ms. Rebholz stated that during the February meeting, a new MCAS proposal form was introduced to be used anytime a new change is proposed for an MCAS blank or data call and definitions. After introducing it, comments were received, and an updated version was posted to the Working Group's web page. Any comments or questions regarding the new form should be sent to Ms. Rebholz, Mr. Flott or Ms. Cooper.

Ms. Rebholz stated that regarding the Disability Income MCAS, a question has come up that NAIC staff need guidance on. The issue is with the Schedule 3 reporting within the Disability Income blank. Schedule 3 is titled "Disability Income Claims Decisions Processed." This title seems to indicate that all claim decisions, regardless of paid or declined, would be included in the schedule. However, the median day data elements 29 and 34 specifically say to include processing time for claims resulting in payment. Ms. Rebholz noted that Schedule 4 is titled "Disability Income Resulting in Closed Without Payment"; so, it includes only those decisions resulting in closed without payment. The question for the Working Group to consider is whether Schedule 3 should include all claim decisions or only those that result in payment.

Dianne Evans (UnitedHealthcare) stated that UnitedHealthcare uses Schedule 3 to report only claims that were paid. Ms. Rebholz stated that the solution could be adding a note or clarification within the data call and definitions on the blank itself, stating that Schedule 3 is intended to capture data only for claims processing times for those claims decisions that resulted in payment.

Mr. Flott made a motion, seconded by Mr. Self, to add a note in the Disability Income blank clarifying that Schedule 3 is designed to only collect claims information about claims that have payment. The motion passed unanimously.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Draft: 3/11/21

Market Conduct Annual Statement Blanks (D) Working Group  
Virtual Meeting  
February 24, 2021

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Feb. 24, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Maria Ailor (AZ); Scott Woods (FL); Sarah Crittenden (GA); October Nickel (ID); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Erica Bailey (MD); Jill Huisken (MI); Teresa Kroll (MO); Martin Swanson (NE); Jeffrey Arnold and Katie Dzurec (PA); Michael Bailes and Rachel Moore (SC); Maggie Dell (SD); Shelli Isiminger (TN); and Letha Tate (WV).

1. Adopted its Nov. 16, 2020, Minutes

The Working Group met Nov. 16, 2020, and took the following action: 1) adopted its Oct. 28, 2020, minutes; 2) discussed options for collections of transactional level data; 3) adopted the motion to revert the definition of lawsuit for the Home and Auto Market Conduct Annual Statement (MCAS) to the one used in the 2019 data year; and 4) adopted the motion to specify \$50,000 in premiums written as the threshold in the 2021 Disability Income Data Call and Definitions document.

Mr. Flott made a motion, seconded by Mr. Swanson, to adopt the Working Group's Nov. 16, 2020, minutes (*see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Six*). The motion passed unanimously.

2. Heard an Update on the Travel MCAS

Ms. Rebholz noted that the Travel MCAS subject matter expert (SME) group met Jan. 26. She stated that the discussions have been moving forward at a nice pace, but they have been slowed down a bit by discussions related to the appropriate reporting granularity. Breaking the data out by retailer types such as airline, cruise line, websites, etc. was discussed. Discussions will continue during the next Travel SME call, which is scheduled for March 3 at 11:00 a.m. CT.

3. Heard an Update on the Other Health MCAS

Ms. Dzurec stated that last year it was decided to break out two workstreams—one for Short-Term Limited-Duration (STLD) and the second for Other Health. The most recent version of the STLD blank was posted to the MCAS web page in December 2020 for further consideration. A lengthy discussion took place about whether to maintain summary level data in the STLD blank, and that is currently the path being pursued unless different direction is given by the Market Regulation and Consumer Affairs (D) Committee. The next step for the STLD blank is to finalize the definitions and use of terms in the document posted on the MCAS web page. Ms. Dzurec invited others to join the discussion and provide any thoughts or feedback on the document and definitions.

Ms. Ailor asked if the goal is to get the STLD blank finalized and approved this year. Ms. Dzurec confirmed that it was, and she asked that any comments be provided by March 10. She stated that the next SME call for Other Health will be scheduled before the Spring National Meeting, likely in the second or third week of March. Ms. Ailor asked when final comments would need to be approved to be implemented next year. Teresa Cooper (NAIC) stated that approvals by the Working Group are needed by June 1 to be effective in the next data year, so having the information ready for the Working Group to review about one month before that would be best.

4. Discussed a New MCAS Proposal Submission Form

Ms. Rebholz noted that a new MCAS proposal submission form will start being used to eliminate confusion and uncertainty surrounding proposed MCAS updates. The form is posted to the Working Group web page as a fillable Microsoft Word form, along with the instructions for completing the form. It can be found under the Related Documents tab of the web page. Suggestions for the MCAS blanks or data call and definitions can be proposed by completing this form. Ms. Rebholz noted that if there is a current proposal being discussed with anyone, NAIC staff will work with those parties to get the proposal put into the form.

5. Discussed the Reporting of Complaint and Lawsuit Data Elements within the Home and Auto MCAS Reporting Blanks

Ms. Rebholz noted that last year there was discussion regarding the placement of reporting of the complaint and lawsuit data elements within the Home and Auto MCAS reporting blanks, and no changes were made at that time. Attachment Three in the meeting materials is a grid that summarizes the placement of the complaint and lawsuit data elements within each MCAS blank and indicates whether the complaint and lawsuit data is reported at the line of business coverage level. Ms. Rebholz stated that no decisions will be made today, and this will be discussed again in the future. She stated that the focus for this call would be getting feedback on the Home and Auto complaints data, and these data elements are currently reported in the underwriting section as only a total number. The question for the Working Group to think about is if this level of reporting is what state insurance regulators need to perform market analysis or whether they want the complaint data broken out by coverage type. Ms. Rebholz stated that all other lines of business that contain complaint data elements require reporting at the coverage-type level.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that having complaints reported separately for life insurance makes sense because the different coverages represent different products and policies, and for similar reasons, he also believes it makes sense to break out the reporting for Homeowners. He said it might be more difficult for Auto though since there can be multiple coverages within one policy; a company may have difficulty deciding which coverage to report a complaint for on pricing or claim settlement when it might affect a bodily injury claim, property claim, or uninsured motorist claim at the same time. Ms. Rebholz asked call participants to give this agenda item some thought before the next meeting so the Working Group can consider which direction to move in.

Ms. Rebholz stated that the Home and Auto lawsuit data elements are reported by coverage type. Using the current lawsuit definitions for the Home and Auto lines of business, lawsuit information is only collected for claims-related suits. The question for the Working Group to consider is whether state insurance regulators need only claims-related lawsuit data for the Home and Auto lines of business or whether the lawsuit data include suits that are not related to claims.

Peter Kochenburger (University of Connecticut School of Law) stated that he encourages the collection of data for suits not related to claims, as he feels that information would be equally as valuable and important. He stated that there is an increasing ability for anyone who is interested to get access to litigation data for free by going on state dockets for example, so the ability to have a better understanding of what lawsuits are out there and have a better understanding of those lawsuits would be helpful.

Mr. Birnbaum stated that there should be consistency with treatment of lawsuits across the various MCAS lines of business. He stated that the CEJ supports collecting information on all types of lawsuits such as underwriting, pricing and sales, in addition to claims. He stated that on the issue of collecting lawsuit data by coverage, if there are separate products that are clearly distinguishable products like life insurance, then it would make sense to collect it broken out by coverage. However, when separate products are not clearly distinguishable among the coverages like Auto, it would not make sense to ask for reporting lawsuits by coverage.

Lisa Brown (American Property Casualty Insurance Association—APCIA) stated that the lawsuits closed during the period with consideration for the consumer were added for both Home and Private Passenger Auto (PPA) last year, which is consistent across the other lines.

Ms. Rebholz asked the Working Group to give this topic additional thought and to be prepared for further discussion on this matter in the next meeting.

#### 6. Discussed the MCAS Lawsuit Definitions

Ms. Rebholz stated that during the 2020 Fall National Meeting, the Market Regulation and Consumer Affairs (D) Committee approved reverting the 2021 Homeowners and PPA definition of lawsuit back to the definition used in the 2020 Data Call and Definitions. The Committee also approved updating the 2021 definitions of lawsuits closed during the period with consideration for the consumer by replacing the phrase “applicant, policyholder, or beneficiary” with the term “claimant.” Ms. Rebholz noted that the meeting materials include the 2021 data year definitions for lawsuit and lawsuits closed during the period with consideration for the consumer for each of the MCAS lines of business and some additional definitions regarding lawsuits contained in the Disability Income MCAS data call and definitions for comparison. She asked that the Working Group review the materials provided and give thoughts on the definitions and level of granularity needed for lawsuit reporting so that it can be discussed in more detail in the future.

#### 7. Discussed the Addition of Accelerated Underwriting Data Elements to the Life MCAS and Digital Claims Data Elements to the Home and Auto MCAS Lines

4/13/21

Ms. Rebholz stated that last year, the Working Group agreed to move forward with reviewing the proposed definitions and data elements for both accelerated underwriting and digital claims, with the intent to implement reporting on those terms. Discussions on these topics need to be done at a more detailed level, so SME groups will be formed to continue these discussions. Once the SME groups reach consensus, the topics will be brought back to the Working Group for consideration. Ms. Rebholz asked that if anyone would like to be part of the SME groups for either accelerated underwriting or digital claims, they should send an email to Tressa Smith (NAIC) or Ms. Cooper, and they will collect the lists. Leaders for these SME groups will also be needed; anyone with interest should contact Ms. Smith or Ms. Cooper as well.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.

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Draft: 4/5/21

Market Conduct Examination Guidelines (D) Working Group  
Virtual Meeting  
March 30, 2021

The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 30, 2021. The following Working Group members participated: Bruce R. Ramage, Chair, and Laura Arp, Martin Swanson and Reva Vandevoorde (NE); Mel Heaps, Teri Ann Mecca and Crystal Phelps (AR); Eleanor Coe and Damion Hughes (CO); Kurt Swan (CT); Sharon Shipp (DC); Susan Jennette and Frank Pyle (DE); Sarah Crittenden (GA); Lindsay Bates and Daniel Mathis (IA); Erica Weyhenmeyer (IL); Lori Cunningham and Ron Kreiter (KY); Mary Lou Moran (MA); Jill Huisken (MI); Paul Hanson (MN) Jo LeDuc, Win Nickens and Rob Reichart (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman (NJ); Leatrice Geckler (NM); Hermoliva Abejar, Barbara D. Richardson and Peggy Willard-Ross (NV); Sylvia Lawson, Sharon Ma and Elvis Soto (NY); Rodney Beetch and Jana Jarrett (OH); Landon Hubbard (OK); Brian Fordham (OR); Gary Jones (PA); Thomas Morgan and Matthew Tarpley (TX); Julie Fairbanks and Bryan Wachter (VA); Mary Block, Isabelle Turpin Keiser and Christina Rouleau (VT); John Haworth and Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Darcy Paskey, Rebecca Rebholz and Jody Ullman (WI); and Desiree Mauller (WV). Also participating was: Matt Gendron (RI).

1. Heard Opening Remarks and Reviewed its 2021 Charges

Director Ramage welcomed returning Working Group members and a new member state, Texas, represented by Mr. Tarpley. Changes in Working Group member state representation in 2021 include Mr. Kreiter, Joel Bengo (NM) and Ms. Dambach.

Director Ramage said the charges of this Working Group, as adopted by the Market Regulation and Consumer Affairs (D) Committee, are to:

- Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook* (Handbook).
- Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
- Develop updated standardized data requests (SDRs), as necessary, for inclusion in the Handbook.
- Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the Handbook.
- Coordinate with the Innovation and Technology (EX) Task Force to develop market conduct examiner guidance for the oversight of regulated entities' use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
- Discuss the effectiveness of a group's supervision of market conduct risks and develop examination procedural guidance, as necessary.
- Discuss the role of market conduct examiners in reviewing insurers' corporate governance, as outlined in the *Corporate Governance Annual Disclosure Model Act* (#305) and the *Corporate Governance Annual Disclosure Model Regulation* (#306).

2. Discussed its Potential 2021 Tasks

Director Ramage said the Working Group is the successor Working Group to the Market Conduct Examination Standards (D) Working Group. The Working Group will not meet at NAIC national meetings; it will accomplish its assigned tasks via regularly scheduled conference calls, to occur approximately every four to six weeks.

Regarding its adopted 2021 charges, the Working Group identified recently adopted NAIC models for which examination standards/state insurance regulator guidance may need to be updated in the Handbook. Some of the models include: 1) the *Suitability in Annuity Transactions Model Regulation* (#275) and the frequently asked questions (FAQ) document that the Annuity Suitability (A) Working Group is developing, when that document is ultimately adopted by the NAIC; 2) the *Insurance Holding Company System Regulatory Act* (#440); 3) the *Health Maintenance Organization Model Act* (#430); 4) the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651); and 5) the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805). Director Ramage indicated that he had prepared an initial



comprehensive draft of updated examination standards to address Model #275 for the Working Group to use as a starting point as it moves forward with its work this year to develop corresponding exam standards for that model.

Director Ramege asked for state insurance regulators to contact Petra Wallace (NAIC) to indicate their interest in volunteering to: 1) review any of the models on the list of recently adopted models—i.e., Model #275, Model #430, Model #440, Model #651 and Model #805; 2) report to the Working Group regarding whether the Handbook should be updated in these subject areas; and 3) to work together as regulator-only subject matter expert (SME) groups to prepare an initial draft for review and discussion by the Working Group.

Director Ramege made additional suggestions for the Working Group to consider, which include: 1) the Regulatory Framework (B) Task Force's recent adoption of the new Pharmacy Benefit Manager Licensure and Regulation Model Act on March 18; 2) the amendments to the *Unfair Trade Practices Act* (#880) regarding rebating practices, which are currently being considered by the Innovation and Technology (EX) Task Force; 3) coordination with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, since one of its charges is to "provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC *Market Regulation Handbook*"; 4) monitoring the Long-Term Care Insurance Model Update (B) Subgroup, which plans in 2021 to update the *Long-Term Care Insurance Model Act* (#640), the *Long-Term Care Insurance Model Regulation* (#641), the *Limited Long Term Care Insurance Model Act* (#642), and the *Limited Long Term Care Insurance Model Regulation* (#643); 5) the issues being discussed at the Big Data and Artificial Intelligence (EX) Working Group surrounding the regulated entity use of AI in underwriting, claims, marketing and rating (as model laws/regulations are developed to address AI, there should be corresponding changes made to the Handbook); 6) the work that the Accelerated Underwriting (A) Working Group will be doing in 2021; and 7) the federal No Surprises Act whenever the regulations have been finalized at the federal level.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that the Working Group consider making corresponding revisions to the Handbook regarding the Real Property Lender-Placed Insurance Model Act, which was adopted by the Property and Casualty Insurance (C) Committee in December 2020 and will be considered for adoption by the Executive (EX) Committee and Plenary at the Spring National Meeting.

### 3. Discussed New Draft Title SDRs for Inclusion in the Reference Documents of the *Market Regulation Handbook*

Director Ramege said title insurance related SDRs addressing in force policies and claims were developed by state insurance regulator SMEs for the Working Group's review, discussion and consideration of adoption for inclusion as new SDRs in the reference documents of the Handbook. The title insurance SDRs, which were circulated to the Working Group, interested state insurance regulators, and interested parties on March 23, replace the title SDRs that were adopted by the NAIC in 2008. Director Ramege said the SMEs had developed the SDRs under the leadership of Mr. Reichart.

Mr. Reichart said the new title SDRs have substantial changes and updates compared to the existing 2008 title SDRs, which were very basic. Mr. Birnbaum suggested that data fields be added to the title claims SDR to address regulated entity use of arbitration provisions. Ronald J. Blitenthal (Old Republic National Title Insurance Company) said some data fields in the SDRs do not apply to title insurance (e.g., the use of "NPN," "agent first name," "agent middle name," "agent last name," and "CSR"). He said a lot of the information requested in the title SDR exposure drafts may not be collected by regulated entities, and if it would need to be collected, software that is used by the industry would need to be updated.

Director Ramege said just because a data field is on an SDR does not mean it is a new requirement of regulated entities; an SDR is a list of suggested fields for state departments of insurance (DOIs) to consider when requesting data from regulated entities. Ms. Plitt agreed, saying that the fields on an SDR are not a mandate, and not each and every data field needs to be used or run in each and every SDR. Mr. Hanson said the fields on an SDR are not a mandate, but regulated entities need to be aware of the data. He added that the data fields contained in an SDR is an issue that a state DOI works out with a regulated entity's exam coordinator; a state DOI adds fields to an SDR where it feels it is appropriate, and this occurs not only with title SDRs, but also with SDRs related to other lines of business.

Mr. Gendron said all title producers in Rhode Island are licensed with the Insurance Division of the State of Rhode Island Department of Business Regulation. He also indicated that per the information that he recently received from the Rhode Island Producer Licensing Division, while not every state/jurisdiction uses the NPN for title agents, most states do use the National Producer Number (NPN) number as a unique identifier.

Mr. Blitenthal said he would be submitting comments on behalf of the Old Republic National Title Insurance Company, and he mentioned that the American Land Title Association (ALTA) would likely also be submitting comments on the title SDR exposure drafts.

Director Ramage said the comment due date on the new draft title SDRs is April 23.

#### 4. Discussed Other Matters

Director Ramage asked the Working Group members to participate in as many Working Group conference calls as possible this year so the Working Group can accomplish the tasks that are planned in 2021.

Director Ramage said NAIC staff will provide advance email notice of the next Working Group conference call, which is anticipated to occur in April.

With regard to Director Ramage's retirement from the Nebraska DOI on April 9, Ms. LeDuc thanked Director Ramage for his leadership of the Working Group and his contributions to market regulation uniformity. Ms. Wallace added that Director Ramage has been chair of the Working Group's predecessor group, the Market Conduct Examination Standards (D) Working Group since 2008, and substantial improvements to the Handbook and NAIC market conduct regulatory guidance have occurred under his leadership.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

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Draft: 4/12/21

Privacy Protections (D) Working Group  
Virtual Meeting (*in lieu of meeting at the 2021 Spring National Meeting*)  
March 29, 2021

The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 29, 2021. The following Working Group members participated: Cynthia Amann, Chair, (MO); Ron Kreiter, Vice Chair (KY); Erica Weyhenmeyer (IL); LeAnn Crow (KS); T.J. Patton (MN); Chris Aufenthie and Johnny Palsgraaf (ND); Martin Swanson (NE); Raven Collins and Brian Fordham (OR); and Don Beatty and Katie Johnson (VA).

1. Adopted its 2020 Fall National Meeting Minutes

Mr. Kreiter made a motion, seconded by Mr. Aufenthie, to adopt the Working Group's Nov. 20 minutes (*see NAIC Proceedings – Fall 2020, Market Regulation and Consumer Affairs (D) Committee, Attachment Nine*). The motion passed unanimously.

2. Received Status Reports on Federal and State Privacy Legislation

Brooke Stringer (NAIC) said both Republicans and Democrats acknowledge the need for federal data privacy legislation, but the differences in their approach have thwarted efforts to enact comprehensive legislation thus far. She said the key points of contention include: 1) whether, and to what extent, federal legislation should preempt state laws; and 2) whether the legislation should include a private right of action. Ms. Stringer said as momentum builds among the states to enact data privacy laws, so does the pressure on Congress to act at the federal level. She said both sides of the aisle were engaged over the past session of Congress on developing privacy bills and were committed to comprehensive legislation, but the onset of the pandemic stalled out their momentum.

Ms. Stringer said the most likely starting points for federal legislation in 2021 are: 1) U.S. Senate Commerce Committee Chairwoman Maria Cantwell's (D-WA) Consumer Online Privacy Rights Act (COPRA), which contained strict standards, but would have established a preemptive floor and allowed for a private right of action; and 2) Sente Commerce Committee Ranking Member Roger Wicker's (R-MS) SAFE DATA Act, which also had high standards and would have preempted all state data privacy and security laws. However, Ms. Stringer said it also had a federal Gramm-Leach-Bliley Act (GLBA) carve out, which may have protected some of the state consumer data privacy laws. While these two bills differ, Ms. Stringer said both senators remain interested in a bipartisan Senate bill.

She said the House Energy and Commerce Committee developed a bipartisan staff draft bill during the last Congress that would have provided the Federal Trade Commission (FTC) with significant rule-making authority to implement standards, but the committee had not yet determined how to handle preemption. Ms. Stringer said U.S. Rep. Suzan Delbene (D-WA) recently reintroduced the Information Transparency and Personal Data Control Act (H.R.1816), which would create a unified national data privacy standard and preempt conflicting state laws. She said according to Rep. Delbene's press release, this act would allow consumers to opt-in before companies could use the consumer's most sensitive, private information in ways consumers might not expect. Ms. Stringer said the Act increases transparency by requiring companies to disclose: 1) the purpose of sharing personal information; 2) if personal information will be shared; and 3) with whom the personal information will be shared.

Ms. Stringer said NAIC staff continue to engage with Congress, oppose preemptive legislative proposals and inform Congress of the NAIC's Privacy Protections (D) Working Group's efforts to update NAIC models. She said the NAIC continues to underscore the importance of not disregarding the existing state regulatory framework or inhibiting ongoing efforts in the states to develop laws and regulations in the best interest of insurance consumers. Birny Birnbaum (Center for Economic Justice—CEJ) asked if the NAIC had entered a position with Congress on the privacy of consumer data for insurance purposes. Ms. Stringer said this has been communicated via the staff level only at this time, but not in a formal letter to this Congress.

Jennifer Neuerburg (NAIC) provided a recap of what happened with state privacy legislation in 2020: 1) at least 30 states introduced data privacy legislation—many of them comprehensive and similar to the California Consumer Privacy Act (CCPA)—but very few of them were enacted since COVID-19 disrupted everyone's legislative sessions; 2) California residents voted in November 2020 to approve the California Consumer Privacy Rights Act (CPRRA), which modified the CCPA, further expanded consumer privacy rights, and created a statewide privacy agency that will be charged with enforcing privacy laws and will likely lead to increased enforcement actions for privacy violations in California; 3) California also extended its exemption from the CCPA to certain employment information and personal information involved in business-to-business

communications and transactions; 4) Michigan modified requirements for insurers providing privacy policies to customers; and 5) Virginia enacted a law governing driver's license scanning.

Ms. Neuerburg said there has been a lot of activity in state privacy legislation in 2021. She said privacy bills have been introduced in 23 states, including: Colorado, Florida, New York, West Virginia, New Jersey, Oklahoma and Washington. Ms. Neuerburg said these bills focus on business obligations stemming from consumer rights but vary in substance. She said many of these bills indicate to which businesses the bill applies. For example, Florida's bill applies to for-profit businesses in the state that: 1) have global annual gross revenues in excess of \$25 million; 2) annually buy, sell or share for commercial purposes the personal information of 50,000 or more consumers; or 3) derive 50% or more of its global revenues from selling or sharing personal information.

Ms. Neuerburg said no template is emerging yet; however, she said some have the following issues in common: 1) they have a requirement that covered entities perform a risk assessment; 2) they provide for a private right of action; 3) they address data security, as well as data privacy; 4) they resemble the General Data Protection Regulation (GDPR) and would be more expansive than the CCPA. Arizona, Florida and Washington are examples of states with such legislation; and 4) they exempt data collected in compliance with the GLBA, as well as entities subject to the GLBA. Colorado and Virginia, for example, have this exemption. She said these exemptions differ from the CCPA and CPRA, which only exclude the data collected in compliance with the GLBA, while still regulating the entity.

Ms. Neuerburg said the CCPA was amended just this month to make it easier for consumers to opt-out. She said most recently, Virginia passed its Consumer Data Protection Act, which creates consumer rights like the CCPA; imposes security and assessment requirements for businesses; and leaves enforcement entirely up to the attorney general, so there is no private right of action. Ms. Neuerburg said a lot more movement in state legislation is anticipated throughout 2021. Ms. Amann said a lot of legislation being considered this year lumps together data security and data privacy, but this Working Group will continue to focus its efforts on the privacy of insurance-related consumer data.

### 3. Reviewed the 2021 NAIC Member-Adopted Strategy for Consumer Data Privacy Protections

Ms. Amann said since the Working Group completed its work plan in 2020, the Working Group received additional guidance through the Market Regulation and Consumer Affairs (D) Committee in the form of the following NAIC Member-Adopted Strategy for Consumer Data Privacy Protections. She said the Working Group is currently working on item C because item A and item B have already been completed.

#### **NAIC Member-Adopted Strategy for Consumer Data Privacy Protections**

1. Charge the Market Regulation and Consumer Affairs (D) Committee with:
  - a. Summarizing consumer data privacy protections found in existing NAIC models—the *Health Information Privacy Model Act* (#55), the *NAIC Insurance Information and Privacy Protection Model Act* (#670), and the *Privacy of Consumer Financial and Health Information Regulation* (#672).
  - b. Identifying notice requirements of states, the European Union's (EU's) General Data Protection Regulation (GDPR) and the California Consumer Privacy Act (CCPA), and how insurers may be subject to these requirements.
  - c. Identifying corresponding consumer rights that attach to notice requirements, such as the right to opt-out of data sharing, the right to correct or delete information, the right of data portability and the right to restrict the use of data, and how insurers may be subject to these requirements.
  - d. Setting forth a policy statement on the minimum consumer data privacy protections that are appropriate for the business of insurance.
  - e. Delivering a report on items (a– d) above by the NAIC Fall National Meeting.
2. Engage with state attorneys general (AGs), Congress and federal regulatory agencies on state and federal data privacy laws to minimize preemption provisions and maximize state insurance regulatory authority.
3. Reappoint the Privacy Protections (D) Working Group to revise NAIC models, as necessary, to incorporate minimum consumer data privacy protections that are appropriate for the business of insurance. Complete by the NAIC Fall National Meeting.
4. Discussed Comments Received on the 2020 Fall National Meeting Verbal Gap Analysis

Robert Neill (American Council of Life Insurers—ACLI) said he and Shelby Schoensee (ACLI) would be sharing trade opinions on behalf of ACLI members since the retirement of Robbie Meyer (ACLI). He said the ACLI was concerned with the Working Group's strategy being too challenging and that the timeline was too short for the Working Group to accomplish its objectives by the Fall National Meeting. Mr. Neill suggested that the Working Group would be better served to wait to see

where federal and state legislation ended up regarding preemption, which seemed to cover business areas broader than insurance. He also said that the business of insurance would be uniquely affected by general data privacy concerns due to conflicting and overlapping provisions. Ms. Amann said the Working Group would attempt to simplify its discussions surrounding overlapping and conflicting legislation by focusing on actual practices rather than on theory. She said the Working Group would call on trades to assist in this important endeavor.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Insurers, said that health insurance is already subject to the GDPR and CCPA, even though these are not insurance-specific. He said insurance products should be regulated by insurance commissioners and should include a safe harbor for compliant companies. Mr. Petersen said a two-stage approach is encouraged for gap analysis: 1) gaps in NAIC models should be identified; and 2) it should be determined whether gaps need to be filled. For example, he said that portability is not needed in insurance because an employer (not the employee) decides what data is needed for employees while they are employed, but this data is no longer needed after the employee leaves the company. Mr. Petersen said this type of data cannot be purged from employers' systems as the GDPR wants. Ms. Amann said the Working Group welcomes all kinds of input because insurance is unique from technology companies, vendors, data brokers, third parties, etc.

Cate Paulino (National Association of Mutual Insurance Companies—NAMIC) said clarification and workability should be goals of the Working Group. She said notices are covered by Model #672, and if it is revised, she asked that it also: 1) incorporates a safe harbor; 2) has more examples added to Appendix A; 3) continues to allow federal privacy notices to be used; and 4) allows web postings with other alternatives. Ms. Paulino said the frequency of notices should be revisited because it has changed in that the annual notices required starting in 2016 by the GLBA are no longer required if there have been no changes by the company since the prior notice. She said workability is the concern regarding the opt-out versus opt-in data-sharing question, so the insurance industry, other than health insurance, urges the Working Group to continue to use opt-out for continuity of existing practices. Ms. Paulino said there is no real difference in them, except opt-in is a lot more difficult for companies to administer, and the scope of opt-out works much better with business function exemptions such as fraud, liens, underwriting, etc. Ms. Amann said state insurance regulators are ready to learn more about areas of functionality from trades.

Angela Gleason (American Property Casualty Insurance Companies—APCIA) said privacy regulation is not new to insurance, but there is a difference between theory and practice. She said that she appreciates the Working Group not rushing into changes without first considering the risk, uncertainty and conflicts such changes may cause. Ms. Gleason said notices are working well now, have changed over time, and can adapt again given the proper time and consideration. She said the concern with portability is that currently states have the right to regulate insurance in their states and that states should continue to have that right in the future. Ms. Gleason said that partnership and collaboration is needed between industry and state insurance regulators. She said the timeline is challenging and asked if it might be more flexible. She also asked if other committees would be making decisions regarding consumer data privacy together or separately. Ms. Amann said the Working Group process would not be slowed down, but it would be thorough. She asked that additional comments on strategy be sent to her, Mr. Kreiter or Lois E. Alexander (NAIC). Ms. Amann said all comments together will help the Working Group maintain its focus on consumer protections, not coverage inhibitors. She said all NAIC groups working on issues related to consumer data protection would work in tandem and collaboration with one another throughout the year.

Mr. Birnbaum said consumer protections and data privacy have more in common than not and that differences are the exception rather than the rule. He asked why the Working Group did not hear from consumer representatives about data protection gaps. Mr. Birnbaum said the Working Group should reach out to them to get a broader set of perspectives. Ms. Amann said all state insurance regulators and interested parties are always welcome to submit comments to the Working Group at any time.

#### 5. Announced the Consumer Privacy Protections Panel at the NAIC Virtual Insurance Summit

Ms. Amann said there will be a panel on consumer privacy protections at the NAIC virtual Insurance Summit June 21–24, with herself, Mr. Kreiter, Ms. Stringer, Ms. Neuerburg and two NAIC consumer representatives serving as panelists.

Ms. Amann said Ms. Alexander would be sending an email regarding the schedule of meetings every four to six weeks with a road map designed to avoid overlap with other groups working on interrelated issues.

Having no further business, the Privacy Protections (D) Working Group adjourned.

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