



Market Regulation Handbook

VOLUME I

2017

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ISBN: 978-1-59917-968-1

Printed in the United States of America

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Market Regulation Handbook

2017 Edition

Volume I

This guidance is as adopted by the NAIC as of December 2016. Please note that there will be modifications to the chapters that should be included in this handbook from year to year, as such guidance is subject to the maintenance process. To address this, the NAIC has a website dedicated to providing the holder of this manual with the latest information impacting market analysis, market conduct examination and the various continuum of regulatory responses.

The holder of this manual may enter a password-protected NAIC website at www.naic.org to access this information:

- Select Committees.
- Go to the Committees, Task Forces & Working Groups section of the web page and click on the “+” sign next to the Market Regulation and Consumer Affairs (D) Committee section to expand it. Then click on the Market Conduct Examination Standards (D) Working Group link.
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Chapter 1—Introduction

A. Purpose of this Handbook

The NAIC developed the *Market Regulation Handbook* as a successor to the *Market Analysis Handbook* and the *Market Conduct Examiners Handbook*. The *Market Conduct Surveillance Model Law* (#693), which was jointly adopted in 2004 by the NAIC and the National Conference of Insurance Legislators (NCOIL), contemplates that state insurance departments will use this handbook as a resource for developing a baseline understanding of the insurance marketplace, which will serve as a basis for further market surveillance activities.

The purpose of a state insurance department's market regulation program is to assess how well the insurance marketplace as a whole, and the individual insurance companies that make up that market, are in compliance with state regulations, and then to take appropriate action if problems are identified. As insurance departments evaluate market conditions and companies' performance, they have three basic mechanisms for gathering information: examinations and investigations of specific companies; surveys and periodic reporting requirements designed to gather market conduct data; and the analysis of existing information that insurance departments already collect for other purposes.

In order to obtain a complete and accurate picture of the marketplace, it is essential to approach the problem from all three perspectives. This is an evolving process; however the scope of the information reviewed may change in the future as regulatory practices develop.¹

The purpose of this handbook is to assist states in optimizing the use of insurance department resources, eliminating duplicative inquiries and investigations and coordinating efforts with other states. Examinations are valuable in identifying problems after they appear so that they can be remedied, but prevention is even more valuable. Coordination with other state insurance departments is essential not only to make market regulation more efficient, but also because market regulation by nature is different from financial regulation and cannot be conducted in isolation by a single state.

For financial regulation, the other states where an insurance company does business can defer to the domiciliary state, as long as the company's domiciliary regulator is conducting effective solvency oversight, since a company's financial condition is typically characteristic of the company as a whole. An insurance company is either solvent or insolvent; it either does or does not have the surplus required by law. If one line of business or one state or region is profitable while another is not, such variations are only relevant to financial regulation to the extent that they provide insight into the company's present and future financial condition.

By contrast, compliance with state market regulation is not an all-or-nothing proposition like financial solvency. Compliance with state market regulation—with its legal obligations and responsible business practices—is variable and therefore not as easily and uniformly measured. Both a company's own operations and the legal and market environment in which it operates may vary considerably from state to state. If a company's compliance is inadequate in a particular place or a particular line of business, it does not matter how strong the company's performance is in its other operations. Money the company earns in other states is available to pay claims in an individual's state, but a good record of timely payment in other states is no consolation to consumers in an individual's state if their own experiences with the company are not so good.

However, it would be a mistake to overemphasize the notion that "all market conduct is local." Although the impact of a company's market conduct is felt one customer at a time, that impact is hardly a matter of pure chance. A company's compliance, or noncompliance, is largely the systematic result of decisions and policies made at a national or regional level. A company that has demonstrated an outstanding, or outrageous, record of customer service in one market will likely have a comparable record in other markets where it does business. An

¹ For example, some regulators have the capability in place to monitor underwriting guidelines, detailed geographic market performance data, surveys of market participants, reviews of recent insurance litigation and marketplace testing programs.

insurance company as a whole is accountable for its actions, and the managers of a well-run organization take that principle to heart. Even where variations between states do exist, these variations make it all the more important for states to work together in order to conduct effective market regulation, especially when it comes to quantitative market analysis, since many trends and patterns can only be identified by combining or comparing information from the various states in which the company does business.

Information derived from proper market analysis will often indicate the need for additional investigation or for a market conduct response. Proper analysis establishes justification for whatever action (such as a market conduct examination) is taken by a state. Compliance issues may be confined to specific regulated entities, or may be so broad as to necessitate a regulatory response aimed at entire segments of the insurance industry. A regulatory response may be specific to one state or may lend itself to a coordinated multistate endeavor. Regulators may choose one or more appropriate responses from a continuum of market conduct responses to address concerns in a manner that is most effective and appropriate to the specific issue. The continuum of market conduct responses is explained in Chapter 2—Continuum of Regulatory Responses.

This handbook is an evolving document and it is expected that discussion of additional types and sources of data, regulatory processes and techniques will be incorporated on a routine basis. The market regulation capabilities of regulators can therefore become more uniform and effective at focusing examination and enforcement activities on the most serious marketplace problems.

The information and indicators described in this handbook may not provide an automatic trigger for any regulatory action. If used correctly and uniformly, they can assist a state in identifying possible predictors of potential problems, in using state resources better and in developing a more detailed understanding of its marketplace.

B. What is Market Analysis?

A market analysis program is a system of collection and analysis of data and other information.

This handbook provides the fundamental elements of a system for market analysis for all companies and all lines of business. The indicators that result from the analysis suggested in this handbook provide a basis for regulators to initially screen and follow-up with insurers whose results are outside of normal parameters and help focus resources on insurers with potential market conduct problems.

Market analysis can enable a regulator to do the following:

- Provide the fundamental elements of a system for market analysis for all companies and all lines of business;
- Screen and follow-up with insurers whose results are out of the norm and help focus resources on insurers with potential market conduct problems;
- Provide a good approach for monitoring the performance of a newly formed or newly licensed company;
- Identify general market disruptions and important market conduct problems as early as possible and to eliminate, or at least limit, the harm to consumers;
- Better prioritize and coordinate the various market regulation functions of the insurance department and establish an integrated system of proportional responses to market problems; and
- Provide a framework for collaboration among the states and with federal regulators regarding identification of market conduct issues and market regulation.

As the General Accounting Office explained in its September 2003 report on state market regulation:²

Among other things, market analysis can provide information on insurance companies' compliance with applicable laws and regulations, highlight practices that could have a negative effect on consumers and help identify problem companies for examination. The NAIC and some states recognize that market analysis can be a significant regulatory tool and all of the states we visited performed some type of market analysis, but in most cases these efforts were fragmented and lacked a systematic organization and framework. We found that in many states, market analysis consisted largely of monitoring complaints and complaint trends and reacting to significant market issues. Analyzing complaints and complaint trends does provide regulators with useful and important information and should be part of any market analysis program. However, other types of information can also help regulators identify and deal with market conduct issues, including data from financial reports, rate and form filings and other company filings, routine and special requests for company data and information from other federal and state regulators. All this information, consistently and routinely evaluated by well-trained analysts, can help regulators identify companies that examiners need to look at more closely or that merit regulatory actions.

Market analysis will assist a state in its review of existing data. As more techniques are developed and refined by the states, and as more states participate in market analysis and other market oversight activities, this handbook will be updated so that states are constantly learning from each other and relying upon the resources of all of the states. For example, as states become consistent in their consumer complaint reporting as suggested in this handbook, the more useful and meaningful market analysis will become on a countrywide basis. As explained earlier, analysis of existing data is only one component of an effective market regulation program and all of the components must work together. Insights gained from data analysis must be shared and used to improve both the examination and data reporting processes and, likewise, the sharing of insights from market conduct examinations and reports will improve states' understanding of the significance of complaint data, financial data and other external information for market analysis.

C. Role of the Market Actions (D) Working Group

The NAIC Market Actions (D) Working Group is the national forum to identify and address issues of multistate concern and for states to coordinate multistate regulatory actions, including market conduct examinations. States can explore, for example, whether they are targeting the same companies, nationally or regionally. The more states that follow this handbook, the better the Market Actions Working Group will be able to function and the more effective the Working Group's market oversight will become.

The Market Actions (D) Working Group consists of 18 individuals and provides policy oversight and direction to the Collaborative Action Designees (CADs), facilitates interstate communication, recommends appropriate corrective actions, coordinates collaborative state regulatory actions and facilitates the use of a broader continuum of regulatory responses. The Working Group focuses its efforts on those nationally significant insurers that exhibit characteristics indicating current or potential market regulatory issues that impact multiple jurisdictions.

D. The Players and Their Tools

The evolving market regulation process necessitates the need for identification of key players, as well as the need for increased communication. There are many new players that have been identified and many tools have been created to help facilitate this communication.

² *Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation*. No. GAO-03-433, September 30, 2003.

Collaborative Action Designee (CAD)

The Collaborative Action Designee (CAD) is the one contact identified by the director/commissioner of each state/territory to have full responsibility for all communications related to market regulation collaborative efforts. This includes participating, or assigning a designee to participate, in Market Actions (D) Working Group meetings or conference calls. While the Market Analysis Chief (MAC) oversees the internal state process of identifying entities with potential market regulatory issues, the CAD oversees the process of communicating about those entities and collaborating with other CADs, potentially through the Market Actions (D) Working Group. The CAD and MAC are responsible for exchanging information with other state insurance departments via the NAIC Market Regulation and Market Analysis bulletin boards.

Consumer Assistance Bulletin Board

The NAIC Consumer Assistance Bulletin Board is a regulator-only bulletin board designed for state consumer services regulators to communicate global issues, concerns, questions and information about consumer services issues. The bulletin board is available on iSite+ and on StateNet.

Core Competencies

Core competencies were developed by regulators to meet expectations from consumers, the insurance industry and all interested parties for effective state-based regulatory oversight of the insurance marketplace. Core competency standards are uniform standards that measure an individual state insurance department's overall ability to effectively and efficiently regulate the insurance marketplace. The four broad categories of core competency are set forth below. The currently adopted core competency standards are contained within Appendix D of this handbook.

- Resources—Standards regarding a state's regulatory authority, staff and training, and standards relating to a state's utilization of contract examiners;
- Market Analysis—Standards regarding market analysis, data collection, the role and responsibilities of a state insurance department Market Analysis Chief (MAC), and required skills and knowledge of a market analyst;
- Continuum—Standards regarding the use of continuum options, market conduct examinations, investigations and consumer complaints; and
- Interstate Collaboration—Standards regarding the NAIC Collaborative Actions Guide document and the role and responsibilities of a state insurance department Collaborative Action Designee (CAD).

Market Action Tracking System (MATS)

The Market Action Tracking System (MATS) allows market conduct examiners and analysts to communicate schedules and results of examinations and other market actions. MATS allows for the calling of market conduct examinations and non-examination inquiries and market actions, in addition to providing easy access to complete information about the entities involved in the action. Market actions captured in MATS are: comprehensive examinations, targeted examinations, focused inquiries (typically inquiries made of multiple market participants) and other non-examination regulatory interventions.

Market Analysis Bulletin Board

The NAIC Market Analysis Bulletin Board is a regulator-only bulletin board designed for state market analysts to communicate issues, questions, concerns and information about the market analysis process. The bulletin board is available on iSite+ and on StateNet.

Market Analysis Chief (MAC)

The Market Analysis Chief (MAC) is the principal liaison with the NAIC Market Regulation Department and the Market Analysis Procedures (D) Working Group and is responsible for communication with other work units within the department. The CAD and MAC are responsible for communicating with other state insurance departments via the NAIC Market Regulation and Market Analysis bulletin boards.

Market Analysis Prioritization Tool (MAPT)

The Market Analysis Prioritization Tool (MAPT), released in 2006, expanded upon the Market Analysis Company Listings³ by creating a scoring system so companies can more easily be prioritized. MAPT is designed to provide regulators with a web-based tool that serves as a starting point in the analysis process by prioritizing companies for further analysis. This prioritization of companies allows states to better focus their resources and to develop more efficient regulatory policies and practices. MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. Key market regulation components vary by line of business. They include, but are not limited to: losses, expenses and premiums; enrollments, market components, regulatory actions, complaints, examinations and demographics.

Market Analysis Review System (MARS)

The Market Analysis Review System (MARS) is available to specific state regulator users for the purpose of tracking, recording and reviewing Level 1 Analysis and Level 2 Analysis completed by other state regulators.

Market Conduct Annual Statement (MCAS)

The Market Conduct Annual Statement (MCAS) was developed with the input of state regulators and representatives from the insurance industry. It provides an analysis tool for certain key market data elements that help regulators allocate market analysis resources where they can be most effective. States participating in MCAS intend to review their markets and share the results of their respective analyses and work to coordinate any needed responses or examinations.

Market Information Systems (MIS)

The Market Information Systems (MIS) are regulator-only databases containing information related to the iSite+ market applications, which include the Complaints Database System (CDS), Market Action Tracking System (MATS) and the Regulatory Information Retrieval System (RIRS).

Market Regulation Bulletin Board

The Market Regulation Bulletin Board is a regulator-only bulletin board designed for state market conduct regulators to communicate global issues, concerns and information about entities engaged in the business of insurance or the specific rules/laws that help govern the industry. The bulletin board is available on iSite+ and on StateNet.

NAIC Staff/Research Resources

The NAIC offers financial, actuarial, legal, computer, research, market conduct and economic expertise. The NAIC Market Regulation Department supports state insurance regulators in fulfilling the state insurance departments' responsibility of protecting the interests of insurance consumers by helping coordinate state market regulatory functions, such as consumer complaints, market analysis, producer licensing and regulatory interventions.

The NAIC Market Regulation Department offers education and training to regulators and non-regulators in various formats: as instructor-led sessions, web-based educational seminars (webinars), online training and web-based "on-demand" training. Some of the areas/topics in which the Market Regulation Department has provided training include: Baseline Analysis, Market Analysis Techniques, Producer Licensing, Consumer Assistance Training, Market Conduct Examinations and Market Conduct Annual Statement Preparation (Property & Casualty and Life & Health). Other NAIC education and training topics will continue to be added in the future. The NAIC Financial Regulatory Services Department provides technical expertise in areas of financial regulation, solvency regulation, financial reporting, as well as other financial-related expertise.

³ As of December 2009, the Market Analysis Company Listings report is no longer available. The data elements and functionality contained within the Market Analysis Company Listings report were incorporated into the Market Analysis Prioritization Tool as described in Section D of Chapter 4.

The NAIC Research Library supports state insurance department regulators and NAIC staff by providing a free inquiry and reference service and maintaining an extensive archive of NAIC publications. Research librarians answer information requests on a variety of issues, and strive to provide responses to regulators within 24 hours.

The NAIC Help Desk provides technical support and customer service for NAIC applications, products and services to enhance productivity within the insurance regulatory community. Regulators may access NAIC Help Desk services at 816-783-8500 or via email at help@naic.org.

E. Resources Within State Insurance Departments

Many of these resources, such as a state insurance department consumer complaint resolution unit, are discussed in detail in the body of this handbook. Other key resources include:

Market Conduct and Financial Examinations

Market conduct examinations focus on such areas as operations/management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting and rating, and claims. The financial condition examination system focuses on financial and corporate matters. Market conduct compliance issues can have a significant effect on legal and compliance risks, which in turn can create potential solvency issues. Coordination with the financial examination function is an important area for market conduct examiners to understand. Guidance on financial condition examinations is provided in the *Financial Condition Examiner's Handbook* and is available through the Insurance Products and Services Division of the NAIC.

Financial Analysis

Financial reporting and analysis information is shared with the NAIC, which assembles a wide range of data compilations on a multistate basis. An insurance department's financial analysis and examination staff can provide valuable assistance in interpreting this information.

Rates and Forms Information

Tools such as the System for Electronic Rate and Form Filing (SERFF) and the insurance department posting of state filing review requirements provide a wide range of new data in formats that are more readily comparable across state and regional lines. As of March 2017, 53 jurisdictions including the District of Columbia, Puerto Rico, Guam and the Virgin Islands—plus more than 4,300 insurance companies, third-party filers, rating organizations and other companies—are using SERFF to efficiently and effectively speed insurance products to the market. The SERFF system provides an indicator of marketplace trends, such as overall increases in premiums or changes in coverages by the submission of filing of amendatory endorsements and exclusions.

Organized Intra-Department Communication

State insurance departments are organized differently, but all perform a range of market regulation functions, from consumer assistance to producer licensing, from rate and form review to market conduct exams, and from investigations to enforcement. All of these functions, as well as financial regulation functions, generate useful information about market problems. An effective market analysis program must include clear procedures for regularly sharing data and other information among the various divisions of an insurance department. Recommended methods of sharing internal information include holding a monthly update meeting or emailing issues that may be of concern or interest to other sections.

F. myNAIC

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

G. Center for Insurance Policy Research (CIPR)

The mission of the NAIC Center for Insurance Policy and Research (CIPR) is to serve federal and state lawmakers, federal and state regulatory agencies, international regulatory agencies and insurance consumers by enhancing intergovernmental cooperation and awareness, improving consumer protection and promoting legitimate marketplace competition.

The CIPR coordinates the collection and dissemination of insurance data and research for the purpose of enhancing:

- Regulatory cooperation between federal, state and international agencies and functional regulators;
- Comprehension of insurance-related topics and issues by federal policymakers and others;
- Insurance information exchange between the states and the federal government; and
- NAIC and state regulator participation in public policy discussions and decision-making affecting insurance and the broader financial services sector.

The CIPR website http://www.naic.org/cipr_home.htm is organized into four sections: a CIPR home page, a key issues section, a CIPR newsletter section and a CIPR events section. The CIPR key issues section presents a topical listing of key insurance regulatory issues. Topics on the key issues page are organized in alphabetical order; each key issue contains a brief summary, support documents and relevant testimony, presentations and NAIC actions. The CIPR newsletter section provides access to current and previously issued CIPR newsletters, as well as an index to newsletters. The CIPR events section provides links to upcoming CIPR events, as well as presentation and handout information for past CIPR events.

H. The Interstate Insurance Product Regulation Commission (IIPRC)

The Interstate Insurance Product Regulation Compact (Compact) is an agreement, which is enacted by law, amongst member states (“compacting states”) to participate in a multistate regulatory system for the filing, review and approval of asset-based insurance products, including individual and group life, annuities, long-term care and disability income insurance. The Compact established a multistate public entity, the Interstate Insurance Product Regulation Commission (IIPRC). The IIPRC is a member-driven organization that serves as a central point of filing, review and approval for asset-based insurance products under detailed and comprehensive uniform standards.

The IIPRC website is www.insurancecompact.org and includes the Compact legislation, as well as the IIPRC bylaws, annual reports, budgets, uniform standards, operating procedures and other relevant tools, tutorials and information. In June 2007, the IIPRC became operational and received its first product filings. As of December 31, 2016, more than 300 companies have filed one or more product filings with the IIPRC for approval since June 2007. The uniform standards require that all forms submitted for approval to the IIPRC have a form identification number in the lower left-hand corner where the form number must include a prefix of “ICCxx” (where “xx” represents the appropriate year the form was submitted for filing). Within the NAIC System for Electronic Rate and Form Filing (SERFF), compacting states have read-only access to product filings submitted to the IIPRC for approval and use in their respective state (each compacting state administers the roles and access to the IIPRC information stored within SERFF). Regulators may want to refer to the IIPRC map on the IIPRC website, which shows the compacting states in yellow.

Through enactment of the Compact, compacting states agree that the uniform standards apply as their state law to the content requirements of products filed and approved through the IIPRC. In other words, the uniform standards are the applicable content requirements for Compact-approved products rather than state-specific content requirements and laws. When working with an IIPRC-approved product, market regulators should be familiar with the uniform standards as they are the applicable requirements of the provisions and content of the IIPRC-approved forms.

Compacting states work together to develop strong and detailed uniform standards for the content of asset-based products that protect consumers equally across the compacting states. Companies use these uniform standards to submit a set of standard forms in a product filing to the IIPRC. The IIPRC reviews these product filings, working with the filer toward compliance and approval in an average review time of much less than the required 60-day turnaround time.

The IIPRC’s uniform standards development and rulemaking process has continually demonstrated state insurance regulators work collaboratively with their fellow regulators among the compacting states to address concerns about the uniform standards, which generally results in further strengthening the standards. On its rulemaking docket located on the IIPRC website, the IIPRC publishes draft uniform standards in the rulemaking process that are being considered by the compacting states. When uniform standards are adopted, the IIPRC publishes these uniform standards, along with all relevant rulemaking material, on its rulemaking record on the IIPRC website.

The IIPRC includes one member from each of the compacting states, which is generally the state’s chief insurance regulator. The IIPRC operates in an open and transparent manner, holding public hearings and soliciting public comments as a fundamental part of its decision-making process. The IIPRC, its management committee and its other committees regularly request input from a legislative committee, an industry advisory committee, a consumer advisory committee and interested parties.

As of March 2017, the IIPRC has adopted 100 uniform standards covering a wide range of products and benefit features for the four individual asset-based insurance product lines authorized by the Compact as well as for group life and disability income insurance products, specifically for employer/employee groups. As authorized by the Compact, the IIPRC reviews rate filings for individual long-term care and disability income insurance products, as well as admissions associated with IIPRC-approved individual long-term care insurance products.

I. Other Regulatory Sources

Federal Regulators and Databases

Expanded information sharing with federal regulators assists both state and federal regulators in conducting more efficient and effective oversight. States can enhance information sharing by reporting information to federal databases, such as the National Practitioner Data Bank (NPDB), which contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers and suppliers. To eliminate NPDB data reporting/querying overlap with the Healthcare Integrity and Protection Data

Bank (HIPDB), the U.S. Congress passed Section 6403 of the *Affordable Care Act of 2010* (ACA), Public Law 111-148. As a result of the legislation, effective May 6, 2013, NPDB operations were consolidated with those of the former HIPDB. Information previously collected and disclosed by the HIPDB is collected and disclosed by the NPDB. Regulators may also pursue access to other federal databases (for example, the FBI database for producer licensing purposes). Each state should have ongoing arrangements with the various federal financial services regulators to share consumer complaint information arising out of cross-sector market activities.

The U.S. Securities and Exchange Commission (SEC) oversees the key participants in the securities world, including securities exchanges, securities brokers and dealers, investment advisors and mutual funds. The SEC is concerned primarily with promoting the disclosure of important market-related information, maintaining fair dealing and protecting consumers against fraud. The SEC website www.sec.gov provides information on publicly held companies, as well as on entities licensed to sell securities products. The SEC's Electronic Data Gathering, Analysis and Retrieval (EDGAR) database provides free public access to disclosure documents that public companies are required to file with the SEC, allowing the user to research a company's financial information and operations by reviewing registration statements, prospectuses and periodic reports.

Other States

Many states require that insurance companies provide specific filings or reports in response to previously identified issues. An inventory of such filings may produce valuable information. It is helpful to state insurance regulators to have ongoing email and phone communications about companies and issues of common concern with state insurance regulators in other insurance departments. Regulators in neighboring states with specialized expertise on particular issues are especially helpful.

Regulatory Meetings

NAIC meetings and training seminars provide valuable opportunities to share information. The same is true for other forums, such as meetings of the National Conference of Insurance Legislators (NACOL), the Insurance Regulatory Examiners Society (IRES), the Society of Financial Examiners (SOFEX) and insurance trade association meetings.

Other Regulatory Agencies within a State Insurance Department

Regulators who oversee market conduct of insurance companies have areas of common concern with various other state agencies, including the agencies that regulate health care, workers' compensation and consumer protection. These agencies can be valuable sources of information and assistance.

J. Industry Sources

Financial Rating Agencies

There are five major financial rating agencies that review insurance companies. Each has its own unique methodology for assigning ratings. More information can be found for each rating agency at the links provided below.

A.M. Best Company: The A.M. Best Company has been rating insurance companies since 1900. The objective of A.M. Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Ratings are available at www.ambest.com.

Fitch Ratings: Fitch Ratings was founded as the Fitch Publishing Company in 1913. Fitch's rating evaluations are qualitative and quantitative and provide two basic types of ratings—insurer financial strength ratings and issuer and fixed income security ratings. Fitch Ratings are available at www.fitchratings.com.

Moody's Investors Service: Moody's Investors Service was founded in 1900. Moody's insurance financial strength ratings reflect its opinion as to an insurer's ability to meet senior policyholder claims and obligations. Ratings are available at www.moodys.com.

Standard & Poor's: Standard and Poor's (S&P) has been rating bonds since 1923 and insurance companies' claims-paying ability since 1983. Standard & Poor's claims-paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policyholder obligations in accordance with its terms. Ratings are available at www.standardandpoors.com.

Weiss Ratings, LLC (formerly TheStreet.com): In 2006, Weiss Group sold Weiss Ratings to TheStreet.com. In 2010, TheStreet.com sold the insurance and bank ratings back to the Weiss Group. Weiss' financial strength rating indicates its opinion regarding an insurer's ability to meet its commitments to its policyholders under current economic conditions. Ratings are available at www.weissratings.com.

K. Public Information Sources

Center for Economic Justice (CEJ) Data Guide

In 1999, the Center for Economic Justice, a consumer advocacy group based in Austin, Texas, published *A Consumer Advocate's Guide to Getting, Understanding and Using Insurance Data*. As explained in the introduction to the guide: "This handbook provides an introduction to the topic of auto and homeowners insurance data and ratemaking. This handbook attempts to serve as a tool kit for consumer advocates working on insurance issues by discussing the sources, uses and misuses of insurance data."

Legal Actions

Monitoring of litigation may alert regulators to issues that the regulatory system has not yet addressed. There are many class action websites available on the Internet, such as Westlaw and LexisNexis.

Consumer and Community Groups

Regular communication with consumer and community groups can help regulators identify and address issues of consumer concern. Educating consumers on insurance matters and where to report concerns can increase complaints among groups, identifying possible trends.

Trade Press/Research Papers

Trade publications and academic research papers inform regulators about emerging issues and other regulatory concerns.

Consumer Advocacy Organizations

Consumer advocacy organizations represent consumer interests and address issues that impact the well-being of consumers. Some consumer advocacy organizations focus their efforts specifically on insurance-related issues and financial security of consumers. Consumer advocacy organizations typically conduct research, develop public education programs, and provide studies and reports to consumers.

L. Company Self-Audits

Self-audits, when made available to regulators, can provide information about how particular market problems have been addressed by insurers on a voluntary basis. The growing use of self-audits and voluntary accreditation programs, such as the National Council on Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), has the potential of providing regulators important information about companies. Many of these organizations require companies to actively monitor their compliance practices and take appropriate corrective actions when necessary. This information can provide useful insights regarding a company's commitment to establishing and maintaining a culture of compliance designed to continually improve their market conduct and compliance practices.

Chapter 2—Continuum of Regulatory Responses

Insurance regulators can access a broad continuum of regulatory responses when determining the appropriate regulatory response to an identified issue or concern. The continuum can be used to guide the decision-making process when regulators move from analysis to a regulatory response. This chapter will provide considerations for selecting regulatory responses to specific situations, as well as provide lists and descriptions of the categories of continuum actions.

A. Considerations

The substantive nature of regulatory concerns may be clarified by evaluating responses to select questions. Answers to the questions categorized below may help set the stage for prioritizing regulatory projects and for then choosing the most appropriate response.

1. Questions to Evaluate

Consumers

- How immediate is the concern? What is the likelihood or severity of any potential consumer harm?
- What is the nature and potential scope of the harm to consumers?
- How extensive is the issue? Does the concern involve one regulated entity or multiple regulated entities?

Regulators

- Do other state, federal or self-regulating organizations also have responsibility over the concern or an interest in it? Is this an issue that should be resolved by the affected jurisdiction independently, with the combined efforts of a few or multiple affected jurisdictions, or should the concern be referred to another jurisdiction?
- Has the concern already been addressed by another jurisdiction? If so, can that resolution be applied to other impacted jurisdictions?

Regulated Entities

- How do company self-audit or best practices organization reviews speak to the concern?
- What is the regulated entity's history for proactive and responsive market conduct compliance?
- What types of market conduct actions have been effective with this or similar entities in the past?

Actions

- What type and volume of information is needed to evaluate the concern and recommend corrective action?
- If an analyst or examiner discovers information or activities that raise suspicions of fraudulent activity, what steps should be taken?
- Should the regulatory response include an enforcement action, restitution, or process and procedure changes?

2. Scale of Response

When deciding which response is most appropriate for the situation, it is also important to determine toward whom the response should be directed. One common target would be a single insurer, although addressing multiple insurers within a holding company group may be more efficient at times. Some groups are comprised of almost completely autonomous operations, while others function within the same operating system or location and under the same management.

Health groups may have a centralized holding company that dictates policies and practices, while connected with numerous small, state-admitted entities. An insurance company or group should be able to indicate how the specific entity is set up. In some cases, the response is best focused on a regulated entity other than an insurer, such as a third-party administrator or producer entity. Some issues may be industry-wide or nearly industry-wide, calling for an appropriate multi-jurisdictional response.

3. Goals of Response

When determining the most appropriate responses, pursue goals similar to the following:

- Stop practices that are harmful to consumers and prevent future harm to consumers;
- Address the issue as widely as possible, with minimal impact to regulated entities that have not contributed to the problem; and
- Remediate harm to impacted consumers. The form of remediation is generally determined through the administrative/legal process. In many cases, the regulated entity will voluntarily propose corrective measures once a noncompliant or incorrect process has been identified. Gathering information to show specific impact can assist the administrative resolution.

4. Measures of Success

When comparing several options that appear to meet the above goals, consider these measures of success to help guide the final decision. Determine if the response is:

- Appropriate: Does the response correspond appropriately to the identified problem?
- Cost-effective: Is the regulatory response cost-effective for both the department and the regulated entity? Does the regulatory response leverage regulatory resources?
- Timing: Does the proposed response accommodate deadlines or time requirements, if any?
- Least intrusive: Is the response the least intrusive way to effectively resolve the matter of regulatory concern?

5. Assigning Regulatory Staff

Who should be assigned to conduct continuum of regulatory responses such as those discussed below? The answer will differ among insurance departments. Individuals with market conduct examination or consumer affairs investigation backgrounds are among those individuals that would be appropriate.

Skills needed, in addition to an understanding of insurance practices to be reviewed, are good letter and report writing skills, good verbal communication skills, and an understanding of insurance department policies and procedures. Additionally, a thorough understanding of issues surrounding treatment of confidential versus publicly available information is important.

B. Regulatory Responses

The continuum of regulatory responses can be roughly divided into four categories: Contact, Examination, Enforcement and Market Actions (D) Working Group. The continuum is not a “ladder,” whereby one step must be taken prior to advancing to the next. Rather, it should be viewed as a range of decision-making options.

A brief discussion of each category follows. Examples are provided only for clarity and should not be considered the sole use for each type of response. Note: The principles outlined in Section D Confidentiality in Chapter 8—Examination Introduction of this handbook can also be applied to the continuum of regulatory responses.

1. Contact with the Regulated Entity

Contact with the regulated entity will include the following components:

- Regulatory authority for making the request;
- A clear explanation of the concern, along with the specific insurance laws or regulations related to the matter;
- A clear expectation of what action is being requested;

- If requesting information, an explanation of how that information will be used and the statutory protections for confidential information;
- A date by which a reply is expected, along with to whom the response should be sent; and
- A clear explanation of how any billing of investigatory work will be addressed.

The continuum begins with the contact category, dealing with various opportunities to connect directly with the regulated entity, such as:

- Correspondence;
- Interrogatories;
- Interviews with the entity;
- Contact with other stakeholders;
- Targeted information gathering;
- Policy and procedure reviews;
- Review of self-audits and self-review documents; and
- Review of voluntary compliance programs.

This category of continuum actions would be recorded in the appropriate NAIC database to enable regulators to share information about regulatory responses other than examinations and enforcement actions.

Correspondence

Once a potential or fully identified problem has been detected, regardless of any other continuum options chosen, correspondence will typically be the initial response. For some issues, correspondence may be all that is needed. A letter or email may be used to discuss such issues as a perceived negative trend in complaints or a specific problem that needs immediate attention.

A distinct advantage of using correspondence is that the problem can be quickly reviewed and addressed by the insurer. In addition, having documentation of the discussion will also serve as a record in the event the problem is not corrected and is subsequently escalated to another continuum option. However, correspondence may not be the best response if a regulated entity has resisted regulatory communications on the part.

Practical examples of using correspondence include:

- Reminding the regulated entity of a specific regulatory requirement after insurance department consumer affairs staff notes cases of noncompliance; and
- Advising an insurer of increasing complaint ratios noted during a market analysis process.

If correspondence does not satisfactorily address the regulatory concern, further regulatory responses should be considered.

Interrogatories

An interrogatory is simply a set of questions used to evaluate an insurer's handling of compliance or processing issues, and can be tailored to a very specific need for information. Interrogatories are a good option when attempting to determine compliance with a particular rule or law. Surveys, certifications or questionnaires might be included in an interrogatory.

Practical examples of using interrogatories include questionnaires regarding:

- Claim handling practices related to automobile total loss valuation, reimbursement of sales tax and special costs, and branding of salvage titles;
- The company's plan of action to comply with a particular new statute; and
- Compliance with annuity solvability requirements.

Interviews with the Regulated Entity

In the form of a face-to-face meeting or conference call, interviews with the entity are useful when there is a need for open dialogue, discussion or clarification. It provides both the regulator and the regulated entity with an opportunity to ask questions, provide clarification and verbalize each point of view about compliance matters. Interviews with company personnel can be useful to obtain information about specific company divisions or functions.

The most formal method of interview would be taking a statement under oath. Before conducting a statement under oath, review the insurance department's policies and procedures or seek advice from insurance department counsel to become familiar with state-specific requirements. General standards may require that persons examined under oath be permitted representation by counsel and be permitted to have access to a transcript of the proceeding.

Interviews may also be advantageous when the state has determined that the insurer is conducting business outside its standard operating policies and procedures. This option may require specific knowledge of the regulated entity's policies and procedures to understand that the analysis results indicate a deviation from those policies and procedures.

Interviews might also be conducted to resolve questionable market analysis findings. That is, should market analysis findings indicate that the regulated entity might be engaged in problematic practices, interviews may be conducted to give a state a better understanding of these activities. As with the option to correspond with an entity, interviews may not be the best response if a regulated entity has resisted regulatory communications in the past.

Practical examples of performing an interview with the regulated entity include:

- Making a phone call to an insurance company compliance officer to discuss concerns relating to the company's change in marketing strategy;
- Requesting a meeting with a company underwriting manager to learn first-hand how the company uses loss history information; and
- Setting up a recorded statement under oath to ask a claims examiner about company instructions and procedures relating to the handling of problematic claims.

Contact with Other Stakeholders

There may be occasions when the state feels that input is necessary beyond what is gained from talking or corresponding with company officers and decides to contact specified members of the public. The state will need to obtain information from the company to contact its current or past policyholders and claimants, while most states will have current contact information for a company's producers. These contacts can be made by mail or by phone and should be intended to uncover very specific information about the company and the potentially harmful behavior under investigation.

Practical examples of contacting other stakeholders:

- Contacting producers to ask for their perspective about training provided by the company; and
- Contacting consumers who purchased a specific insurance product to ask how the product was presented and sold to them.

Targeted Information Gathering

Targeted information gathering may take the form of a survey or data request. A useful survey should include clear and understandable questions. Where possible, it will be helpful to limit the scope of a survey to one or two insurance company functional areas.

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

Also, if possible, be mindful of time constraints faced by insurance companies. For example, requesting a response date that is near the Market Conduct Annual Statement (MCAS) due date may create an undue workload and unnecessary cost upon an insurer.

Practical examples of targeted information gathering include:

- Requesting a data file from a health insurer to analyze compliance with prompt-pay requirements; and
- Requesting producer mailing lists and mailed materials to assess the company's dissemination of state-required information to its producers.

Policy and Procedure Reviews

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

Practical examples of the use of policy and procedure reviews include:

- Review of a company's written guidelines relating to protecting privacy of consumer financial and health information; and
- Review of a company's written guidelines that address mandatory training of producers who sell policies under the National Flood Insurance Program (NFIP).

Reviews of Self-Audits and Self-Review Documents

One use of self-audits involves a review of an insurer's existing internal market conduct audit programs. Use of this technique will vary by state; if uncertain, regulators should consult their insurance department's legal counsel. Additional discussion may be found in the NAIC white paper *Regulatory Access to Insurer Information: The Issues of Confidentiality and Privilege*. An advantage to reviewing self-audit reports is to prevent duplication in the review of compliance issues already actively managed by the insurer.

A disadvantage to use of these documents is that scrutiny of an insurer's self-audit reports may place a damper on such self-audit practices because of fear that the insurer will be penalized for identifying mistakes and that such mistakes will ultimately subject the insurer to liability. One practice to consider is to learn the scope and structure of a company's self-audit program, rather than conduct a review of the resulting self-audit reports themselves.

Practical examples of the use of self-audits and self-review documents include:

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

Voluntary Compliance Programs Review

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

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

Practical examples of reviewing voluntary compliance program documents include:

- Reviewing the URAC documentation when researching an increase in health insurance-related complaints.

2. Examinations

The examinations category is possibly the most familiar of the continuum categories, and the bulk of the chapters in this handbook are devoted to addressing examination practices in great detail. Unless an examination is required by law in a state, there are often more efficient and cost-effective methods to respond to marketplace issues. However, at times an examination will be the best choice among the continuum options. As stated previously, states should enter any continuum actions into the appropriate NAIC database.

Even within examinations there are many levels and choices available. Decisions need to be made as to:

- Timing of examination;
- Penetration level of examination;
- Location of examination; and
- Participation level of examination.

Timing of Examination

Once the need for an examination has been decided, timing of the examination and notification of the entity will need to be determined. There are three general approaches to timing, and each fits a specific need:

- Statutory examination: Regularly scheduled examination based on state statute;
- Scheduled examination: An examination for cause, providing the entity with prior notice, typically 60-90 days, of when the examination will begin and all pertinent details about what will be reviewed; and
- No-knock examinations: An examination without prior notice being sent to the examined entity. This choice is used when a regulator feels that providing an entity with advance notice of an examination would result in the entity destroying evidence of violations, or creating false information to give the impression of compliance.

Examination Type

It will also need to be determined exactly what will be reviewed. Should the focus be narrow to only the issue that prompted the examination, or wide to encompass all entity functions? There are two recognized divisions:

- Targeted examinations: An examination of one or two areas of business (e.g., an examination of a company's marketing and sales practices); and
- Comprehensive examinations: A review of most, if not all, market conduct areas within an entity (e.g., a five-year statutory required examination of a domestic insurer).

Location of Examination

Once the scope of the examination has been determined, the location of the examination will logically follow based on the examinations needs:

- Desk examinations: A review of specimen copies or electronic documents at a location other than the regulated entity's offices, e.g. a regulator uses the Internet and electronically provided samples to conduct a review of an entity's advertising materials; and
- On-site reviews: A review conducted in the regulated entity's offices, necessary for review of original documents and actual transactions, e.g. a review of mail processing practices or complaints logs.

Often examiners will utilize a combination of desk and on-site reviews to conduct an effective review while reducing the travel time and costs associated with having a regulatory team on-site for prolonged stays.

Participation Level of Examination

When analyzing the scope of an issue, the breadth of the concern across the company and the likelihood of the issue being found in other jurisdictions should also be evaluated. Collaboration with other jurisdictions is discussed in detail in its own chapter later in this handbook; however, it is worth mentioning here:

- **Single State:** A review of a regulated entity's actions limited to the jurisdiction conducting the review (e.g., a review of an entity's compliance with a statute enacted in the preceding year);
- **Joint Effort:** A review conducted by two or more jurisdictions of a single entity or issue (e.g., an examination of a small regional insurer by two bordering states into claims adjustments involving both states; and
- **Multi-jurisdictional:** An examination of one or more regulated entities by multiple jurisdictions (e.g., an investigation led by a few states for the benefit of all 56 jurisdictions into a large national insurer's practices related to sales of life insurance targeting specific ethnic groups).

Multi-jurisdictional examinations can be conducted in all of the different variations mentioned above. For example, a multistate examination might be conducted as a targeted desk examination or might be an on-site investigation. They are increasing in popularity with both regulated entities and regulators because of the resources saved. Due consideration should always be given to referring multijurisdictional endeavors to the Market Actions (D) Working Group. The Working Group is discussed later in this chapter and also in the chapter titled Collaborative Actions.

As mentioned earlier, this handbook has several chapters devoted to the details of how to conduct investigations and examinations. Please see the applicable chapters relating to investigations and examinations for an in-depth discussion of those types of reviews.

3. Enforcements

On occasion, an enforcement action will clearly be the most practical solution for addressing cases of noncompliance. The types and combinations of enforcement actions are virtually unlimited, although a few general types are captured in this list. Any action of this type should be recorded in the appropriate NAIC database:

- Informal agreements;
- Voluntary compliance plans;
- Administrative complaints;
- Cease and desist orders;
- Ongoing monitoring/self-audits;
- Remediation plans;
- Negotiated settlement agreements and consent orders;
- Restitution;
- Administrative fines/penalties;
- Post-investigation or follow-up examinations; and
- Probations/suspensions/revocations of licenses.

Informal Agreements

An informal agreement to change practices or implement procedures can be either written or verbal. Such an agreement would be most appropriate for situations involving noncompliance with technical regulatory issues and where no significant harm has occurred to consumers or other stakeholders. Such an agreement could include such things as amendment of business practices, forms or rating plans.

Voluntary Compliance Plans

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

Administrative Complaints

An administrative complaint is filed when the insurance department has reason to believe that a regulated entity is engaging in noncompliant behavior. The document will allege that a violation of insurance law has occurred or may occur and provide for an administrative hearing where both parties are allowed to present evidence and testimony about the allegations.

Cease and Desist Orders

An order can be issued by the insurance department to a company to prohibit a person or business from continuing all operations or certain targeted operations or violations of law. Such an order could be issued when harm to consumers is considered imminent and quick action is perceived to be necessary. The insurance department then may bring the company in for an administrative hearing to determine future action.

Ongoing Monitoring/Self-Audit

After identification of a systematic compliance error being made by an insurer, regulators may request that the insurer conduct a targeted market conduct self-audit. This permits an insurer to take corrective action and to report its findings to the regulator. Additionally, as part of settlement agreements or after final examination reports, a company may be required to submit regular audits covering the areas of concern. The audits would be submitted to the regulator over a period of one or more years to help ensure continued compliance in the area of concern.

Remediation Plans

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

Negotiated Settlement Agreements and Consent Orders

A negotiated settlement may be used to arrive at a mutually agreeable conclusion to a matter of concern. Such an agreement is typically negotiated and placed into a written consent order by the insurance department's legal counsel. The agreed-upon settlement may include such components as remediation, voluntary forfeitures (fines), agreements to cease and desist, agreements to implement action plans, self-reviews, and possibly reporting back to the regulator after an agreed-upon period of time. The settlement agreement may or may not lack an administrative determination that a specific violation has occurred and may or may not also indicate that the regulated entity neither affirms nor denies the specific allegations. The agreement is made as a means to resolve the conflict. Multiple states may also be involved in negotiated settlements, in which case those regulators involved may wish to consult the Market Actions (D) Working Group-created document *Best Practices for Multistate Settlement Agreements*.

Restitution

When a company's actions or omissions have done harm to policyholders, claimants or the department of insurance, the state may require that compensation is made for that harm. The scope and extent of the harm may be determined through self-reporting, any of the continuum actions, or through single or multistate examinations. Compensation is made for actual loss or damage that was sustained.

Administrative Fines and Penalties

An administrative adjudication should follow insurance department or state guidelines. A typical action would follow the filing of a petition or formal complaint against the regulated entity, setting a time and place for an administrative hearing. The regulated entity would be provided an opportunity to offer testimony and evidence before a hearing officer, who would decide the outcome of the action. Likewise, the regulatory representative

would present evidence and request a finding or determination along with a request for resolution. Occasionally, a voluntary consent agreement may be reached prior to an administrative hearing. A regulated entity could be required to pay both restitution and a penalty so that actual financial harm is repaired and the entity is also punished for the violations that caused the financial harm.

Post-Investigation or Follow-Up Examinations

There may be instances when a regulated entity modifies procedures in order to respond to a state's determination of a violation through an investigation or examination. However, the state may not be assured that the change will stay in effect over a long period of time and is not comfortable with the company self-monitoring. In such cases, the state may elect to schedule a series of targeted examinations to monitor the issue over an extended period of time until a comfort level is reached.

Probations/Suspensions/Revocations of License

Depending on the severity and frequency of specific violations, or the variety of violations, a state may take action against a regulated entity's authority to operate in the state. Probation is often ordered for entities guilty of more minor violations or first offenses, which allows them to continue the business of insurance under supervision. For a more serious charge, the license may be suspended to prohibit any performance of the business of insurance, usually for a specified period of time. If the violations are severe or pervasive in nature, or if probation or suspension has not resulted in a remedy to the issues, the license or authority to conduct the business of insurance may be revoked.

4. Market Actions (D) Working Group

The Market Actions (D) Working Group was created to give regulators a forum for issues found that should be addressed on a national level. The Working Group meets at each NAIC meeting as well as holds periodic conference calls and communicates as needed on issues. Membership is made up of a select number of regulators from across the country selected based on their skills, experience and ability to participate in national level activity.

Information Sharing

Each state commissioner appoints a Collaborative Action Designee (CAD) to handle or coordinate the communication to and from the Market Actions (D) Working Group and with other CADs about multistate issues. Most member jurisdictions of the NAIC have signed the Information Sharing and Confidentiality Agreement; the list of signatory jurisdictions may be found in StateNet. Generally, that agreement can be referenced in any exchange of information rather than requiring states to sign individual confidentiality agreements with each other.

Additionally, regulators should be familiar with their state insurance code provisions to determine the extent of materials that may be shared with other state insurance regulators, other state agencies and federal agencies, as some compliance issues may involve multiple jurisdictions or multiple agencies.

Practical applications of information sharing include:

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

Referral to the Market Actions (D) Working Group

Issues of concern that have been developed through market analysis or by other channels may be referred to the Market Actions (D) Working Group. When there is a likelihood that the issue affects multiple jurisdictions and cannot be readily or simply resolved to answer the concerns of all affected jurisdictions, a Request for Review (RFR) can be submitted to the Market Actions (D) Working Group. The RFR may be initiated by one or more states, by a commissioner or deputy commissioner, by a Collaborative Action Designee (CAD), by NAIC staff or self-reported by an entity. The RFR asks the referring state(s) not only for the particulars of the issue and the entity (ies), but also for recommendations for continuum-based regulatory responses.

Practical applications of submitting an RFR to the Market Actions (D) Working Group include:

- Several states identify a company with the same issue, and they believe a united request for voluntary compliance will resolve the issue for all impacted states; and
- One state has completed a continuum action with a company for an issue that potentially impacts many states and believes the same resolution can be applied to those states with an action initiated through the Market Actions (D) Working Group.

National Analysis

In addition to responding to issues brought before the group, the Market Actions (D) Working Group annually coordinates a national analysis project using Market Conduct Annual Statement Data that proactively looks at the country's insurers for signs of developing issues. When issues are found, a volunteer jurisdiction will investigate the concern and report back to the group, completing an official referral if necessary.

C. Closure

No matter which continuum of regulatory response option is used to address a situation, regulators will be faced with the decision of how to bring closure to an issue.

A discussion of some of the most common methods of closure, listed below, follows:

- Determining that no further action is necessary;
- Communicating the insurance department's position;
- Providing information to producers;
- Referral to other agencies, fraud prevention divisions or law enforcement;
- Initiating consumer outreach or education initiatives;
- Ongoing, nonstructured monitoring; and
- Requesting legislative or regulatory rule change.

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

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

Determining That No Further Action Is Necessary

Justification for taking no further action might include such reasons as: (1) determination that company actions were handled in accordance with insurance laws or statutes; (2) there was no violation of insurance law; or (3) that a single problematic issue resulting from a miscommunication was acknowledged and addressed. Additionally, a regulatory response could produce findings that ease concerns raised by market analysis. If an initial entry was recorded in the appropriate NAIC database at the beginning of the issue, notes would be added to the entry, and it would then be closed.

Communicating the Insurance Department's Position

A written communication expressing the insurance department's position on a matter can serve not only as clarification, but also as a potential warning or admonishment. It can place the regulated entity on notice that future occurrences may be dealt with in a stricter fashion. This outcome would be finalized in the appropriate NAIC database, and the entry closed. Any such communication should be clear and specific to the issue at hand. For examinations, this generally takes place in the form of a report of examination. For other types of regulatory responses, a closing letter to management may be appropriate.

Alternatively, the issue may be of wider concern than a specific company, and the insurance department will want to convey its position more broadly. The use of targeted mailings, newsletter articles, bulletins and website notices may allow regulators to widely address a concern or provide information relative to new issues, interpretations, relevant case law, implementation policies for new laws, or discussion of new industry practices or technologies. Education is an effective regulatory tool that can be used to provide information to the insurance industry. Two primary forms of education are insurance department communication and proactive outreach.

Practical examples of insurance department communications include:

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

Providing Information to Producers

The insurance department may also wish to convey information to producers, agencies and brokers. In addition to the possible use of mailings and notices, the department may choose a more proactive type of outreach. Outreach mediums include speaking engagements, insurance department-sponsored seminars and training events, press releases, interviews with the media, articles for publication, billboards and advertisements, brochures, and radio spots. Identifying the target audience and tailoring the delivery to that audience are keys to a successful outreach campaign.

Practical examples of producer outreach include:

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

Referral to Other Agencies, Fraud Prevention Divisions or Law Enforcement

Occasionally, regulatory issues or concerns may cross agency boundaries within the state. Common examples include securities, banking, motor vehicle registration and financial responsibility, health and human services, consumer protection functions of attorneys general, and senior protection agencies. It is helpful to know who within the state insurance department may have established channels of communication with other applicable agencies. It is also helpful to have a general understanding of the functions within those agencies and how they might apply to insurance.

Any indication of insurance fraud, whether directed against an insurer by an outside person or implemented from within the insurance organization, should immediately be reported to the applicable fraud prevention division. Referrals to law enforcement may be warranted when infractions such as theft by deception or forgery are noted.

Initiating Consumer Outreach or Education

Insurance departments have a unique opportunity for determining which insurance-related issues are confusing or unclear to consumers. It is important to use the insurance department's established guidelines for media contact and generally best to coordinate any media outreach with the department's public information officer. Newspaper and magazine articles, press releases, outreach at public events, and speaking engagements can help provide consumers with tips on how to be more "savvy" about insurance. Publishing a brochure explaining a certain confusing insurance product and requiring its distribution at point of sale can help prevent abusive sales techniques and unsuitable sales.

Practical examples of consumer outreach or education initiatives include:

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

Ongoing, Nonstructured Monitoring

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

Requesting Legislative or Regulatory Rule Changes

A market conduct issue may be discovered for which no regulatory authority exists to address the concern or when the law has not kept pace with changing market conditions. Sometimes a practice is identified that is perfectly legal, but is causing harm to consumers or disrupting the marketplace. If the issue is approached correctly, insurers are willing to change the practice in question as long as they can be assured of a level playing field. At other times, these situations are identified when new types of insurance, new marketing mechanisms or industry use of emerging technology and tools are introduced and problems need to be addressed on a broader basis through rulemaking, legislative changes and the development of NAIC model laws.

Most insurance departments will have an established protocol for discussion and proposal of new statutes and regulations, generally requiring that all such proposals be channeled directly to the insurance department commissioner. When evaluating the need for change, it is helpful to review existing NAIC model laws and regulations and to request feedback from other states to see if anyone has already addressed the concern. The NAIC, consumer advocacy groups and insurance trade organizations can also be valuable sources of information.

Practical examples of requesting legislative or regulatory rule changes include:

- Addressing the need for advertising regulations in Internet sales; and
- Addressing the need to amend existing insurance statutes to address new types of insurance or marketing arrangements.

Chapter 3—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 a change is 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, an essential information resource for state insurance regulators, and then discusses a few key items of information that are most likely to be indicators of market conduct problems; consumer complaint data and state-by-state data from insurers' financial statements. 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 on the health care market of the problems many states have been experiencing with their medical malpractice insurance markets and by the broad-ranging consequences of the property insurance market's response to Sept. 11, 2001.

B. NAIC iSite+

The iSite+ suite of applications are used to report financial, market regulation and producer information housed in the NAIC database. 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.

The iSite+ web page provides state insurance department regulators with access to applications used by regulators. Regulators may access iSite+ via the myNAIC link on the NAIC website or directly at <https://i-site.naic.org>. In order to log into myNAIC, regulators must have an active NAIC Oracle account and password login. Regulators who do not have myNAIC login credentials or do not remember their user ID and password should contact their insurance department IT Liaison.

iSite+ reports are standardized reports that provide regulators with a variety of financial and market regulation information. Most of these reports provide information related to a group of entities with similar attributes (e.g. companies that write business in a particular state) rather than individual entities. A comprehensive listing and description of available iSite+ reports is located in the Help file on iSite+.

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 state 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 of 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 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 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 high-risk 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 problems appear with life insurance, 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 personal 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 referrals 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 analysis 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 should be available at the offices of the insurer. Information from this register can be obtained during field examinations of the company or on request from the home office of the company. The register 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

The first Market Conduct Annual Statement (MCAS) was adopted by the NAIC in 1991. It was designed as an aid in targeting examinations, as well as an alternative to examinations. The MCAS was initially designed to capture private passenger automobile claim payment information. On an annual basis, companies writing private passenger automobile coverage submitted a diskette containing a Microsoft Access® database populated with specified claim information. Included in the report were the number of claims opened and closed with and without payment during the period; the median number of days to pay first-party and third-party liability and property damage claims; the median number of days from the date of loss to the date a claim is reported and the number of first- and third-party suits filed during the reporting period. This reporting was intended to assist in the detection of insurers that exhibited results outside the industry normal ranges.

During 2003, the Market Regulation and Consumer Affairs (D) Committee took a proactive approach to market regulation and began implementing various market reform initiatives. As a result, an MCAS pilot program for life and property/casualty companies was implemented to assess the long-term viability of an annual statement approach to identifying market problems. Following a successful pilot, the project was adopted as an additional market analysis tool. Data collected through MCAS can be used to review the market activity of the entire insurance marketplace in a consistent manner and identify companies whose practices are outside normal ranges.

At the 2008 Fall National Meeting, the NAIC Executive (EX) Committee adopted a proposal to determine the best possible way to collect MCAS data according to a two-part plan:

Short-Term:

The first part of the plan provided for the transfer of MCAS data collected in 2009 by the 29 participating states to the NAIC for storage, aggregation and analysis in the existing Microsoft Access® database format. The proposal also provided direction for NAIC staff to analyze the aggregated data and identify strengths and weaknesses in the data currently being collected.

Long-Term:

The second part of the plan focused on the long-term commitment of the NAIC to centralize collection of market conduct data. As a result, the 2010 MCAS data was collected and stored centrally by the NAIC through an online submission tool.

For the 2010 and 2011 data years, sixteen new states collected MCAS data using the new centralized collection process. This brought the total number of states participating in the MCAS to 45. Currently, there are 49 participating jurisdictions. An overview of the participating jurisdictions is available on the NAIC MCAS web page.

Currently, MCAS data is collected on individual life cash and non-cash value products, individual fixed and variable annuities, individual stand-alone and hybrid long-term care policies, private passenger automobile policies and homeowners policies.

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 http://www.naic.org/industry_market_conduct_statement.htm at or by contacting NAIC Market Regulation Department staff.

Financial Annual Statements

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.”⁴ 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 calculation of “reverse market share” information—since companies report premium written by state, it is apparent 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.

⁴ 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.

For property/casualty companies, market share information is readily available on iSite+ in the NAIC’s financial market share summary report titled, “Market Share—By Line of Business,” which can be calculated for any line of business as reported on the annual statement Blank or for any combination of up to 10 lines of business. This report indicates the market share by company, by line of business, as well as relative loss ratio.⁵ This report is based on three columns from the State Page: Direct Premiums Written, Direct Premiums Earned and Direct Losses Incurred. Market share for each company is calculated by dividing Direct Premiums Written for that company by total Direct Premiums Written. Data for Property and Health companies is included in this report.

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.

For life and health companies, there are four market share reports on iSite+: “Market Share—Life & Annuity,” “Market Share—Credit Life,” “Market Share—A&H” and “Market Share—Credit A&H.” For the Market Share—A&H report, data can be included for one business type or for all Property, Life and Health companies. For the Market Share—Credit A&H report, data can be included for Property companies only or for both Property and Life companies.

The Insurance Regulatory Information System (IRIS) tool, based on financial statement data, should also be noted. 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.

⁵ The paid loss ratio—paid losses to written premiums—is another loss ratio measure in common usage. Each has its advantages and disadvantages. The incurred loss ratio is a more meaningful measure of profitability as long as the underlying data are accurate, but incurred loss estimates are inherently subjective. Paid loss information is precise and objective, but the paid loss and written premium reports for a given year reflect different blocks of policies.

Property/Casualty Insurance

Personal lines property/casualty coverage is another key focus of consumer assistance and complaint resolution programs. Because a high proportion of consumer concerns in these lines of business relate to claims and to policy termination; often the two go together. This is a dynamic market with many emerging issues, such as the use of credit scoring in underwriting and rating. Other issues include concerns raised by consumer advocates that some companies may be using underwriting guidelines that have the effect of limiting the availability or quality of insurance to certain groups. There are 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 rest of the story. 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 implicating certain companies. Even routine activities, such as increases or decreases in new licenses or appointments or changes in lines of authority, can be indicative of market trends which might warrant further inquiry to evaluate whether the effects are positive, negative or mixed. The information contained in this handbook provides additional resources for assisting with the analysis of a company. This handbook contains information about matched pair testing, rating territories and underwriting guidelines, which may be helpful if the initial analysis has indicated a potential area of concern.

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). 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 toward specialized information, such as claims activity, that is also of particular interest to market regulators. Surveys and reports on particular topics by research institutions, consumer groups and trade organizations may also yield valuable data.

Rating Agencies

There are five principal rating firms that measure insurance companies' financial strength: A.M. Best Company, Moody's Investor Service, Fitch Ratings, Standard & Poor's 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 complete 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.

Communication Between Work Units

As mentioned above in the discussion of complaint information, anecdotal information of various kinds can also be valuable even when it cannot be measured and reduced to numbers. The rewards of quantitative analysis can bring with them the risk of "not seeing the forest for the trees." Thus, a continuous dialogue with regulators in other areas with 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.

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.

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.⁶

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. Addressing these concerns and working with companies’ voluntary review activities is important, because a full

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

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 who 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 resumes 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 clipping digests—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.

Not for Distribution

Chapter 4—Putting It All Together: Market Analysis

State insurance departments already have at their disposal the information needed to develop some key baseline indicators of market conduct concerns. This section of the handbook will provide a step-by-step outline for establishing a market analysis program, identifying companies for analysis, how to perform baseline analysis and guidelines for conducting basic market analysis in three core areas: consumer complaint data, State Page data and market share data, as well as a section regarding coordination with the Market Actions (D) Working Group.

Excerpts from the NAIC Framework for Market Analysis document, which provides an overview of the basic principles and structure of market analysis, have been reproduced in Section A. The Framework for Market Analysis document was adopted by the Market Analysis Priorities (D) Working Group at the NAIC 2006 Winter National Meeting.

A. Framework for Market Analysis

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

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

Market analysis should be conducted on a regular basis, but no less frequently than annually. The data analyzed for a given market analysis year includes the prior calendar year financial and market conduct annual statement data. Companies must report all of their financial and market conduct annual statement data for a given calendar year by April 30.

To accomplish its purposes, market analysis has an array of tools for states to use. The first of these is the Company Listing Spreadsheet available from the NAIC. This tool is designed to provide states a quick overall look at their marketplace for a particular line of business. The Market Analysis Prioritization Tool (MAPT), released in 2006, expands upon the Company Listings⁷ by creating a weighting system so companies can more easily be prioritized. Using the information from the Company Listing Spreadsheet, the Market Analysis Prioritization Tool will provide the analyst a high level comparison of companies for a particular line of business based on financial, complaint and regulatory activity information available from NAIC databases. States should use this tool to identify companies that need further, more detailed analysis and elevate these companies to a Level 1 Review. The information obtained from this tool is merely an indicator of a potential regulatory problem. Normally, no final conclusions about actual behaviors can be drawn at this level of analysis.

⁷ As of December 2009, the Market Analysis Company Listings report is no longer available. The data elements and functionality contained within the Market Analysis Company Listings report were fully incorporated into the Market Analysis Prioritization Tool, as described in Section D of this chapter.

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

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

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

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

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

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

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

B. Developing a Market Analysis Program

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

Step 1—Appoint a Market Analysis Chief (MAC)

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

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

Step 2—Establish a Systematic Procedure for Interdivisional Communication

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

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

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

- Significant changes in the ratio of consumer complaints against the insurer or significant numbers of complaints in a relatively short period of time;
- Dramatic growth (> +33 percent) or decline (< -10 percent) in one or more lines of business;
- Significant changes in the company's book of business;
- Rapid expansion into new states and significant premium volume in new states;
- Significant concentrations of risk—geographically, by line of business or exposure—or significant changes in the concentrations of risk;
- Significant changes in expense levels (such as defense costs or commissions);
- Recent change of the state of domicile of a major writer in an insurer group;
- Recent changes in ownership or senior management;
- A high degree of reliance on third parties to perform company functions, such as managing general agents (MGAs) or third-party administrators (TPAs);

- Significant problems with electronic data processing systems such that the integrity of data underlying claims, underwriting and financial systems is questionable; and
- Reports listed in the Regulatory Information Retrieval System (RIRS);

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

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

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

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

Step 5—Identify Potential Problems from Complaint Ratios

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

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

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

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

Step 7—Market Conduct Annual Statement

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

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

On a coordinated basis, states should conduct baseline analysis as outlined in the Framework for Market Analysis document, reproduced in Section A of this chapter. All states should analyze the various data elements and indicators within the same general time frame to assist in the coordination of possible collaborative actions. Results should be compiled and reviewed quarterly. If state Market Analysis Chiefs (MACs) find an issue with a particular company, they can share information with their state Collaborative Action Designees (CADs). CADs can then contact other state CADs to compare the most current information, and determine if a collaborative action or a Request for Review (RFR) to the Market Actions (D) Working Group is in order.

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

The Market Analysis Procedures (D) Working Group is responsible for the MARS Level 1 areas of review and questions. Level 1 Analysis questions have been reproduced in Appendix B of this handbook. Level 1 Analysis questions are subject to annual review by the Market Analysis Procedures (D) Working Group and state insurance regulators.

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

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

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

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

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

C. Identifying Markets and Companies for Analysis

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

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

Additional Uses for Market Share Information

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

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

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

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

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

D. Baseline Analysis

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

Tools Available for Conducting Baseline Analysis

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

MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. MAPT can provide reports against market and financial data or Market Conduct Annual Statement (MCAS) data. Market and financial MAPT reports provide an overall prioritization ranking, a national prioritization ranking and a state prioritization ranking for companies by line of business, which allows market analysts to compare companies writing premiums in a specified line of business on a national and state basis using a uniform data set.

In 2009, the data elements and functionality contained within the NAIC Market Analysis Company Listings report were incorporated into MAPT and as of December 2009, the Market Analysis Company Listings report was no longer available. Key market regulation components used in MAPT vary by line of business. They include, but are not limited to: losses, expenses and premiums, enrollments, regulatory actions, complaints, examinations and demographics.

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

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

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

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

How to Conduct Baseline Analysis

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

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

After the reports are downloaded, an analyst may:

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

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

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

Other Methods Used to Conduct Baseline

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

- Utilizing the MAPT to focus on the companies with the highest score for each line, then applying the below listed criteria to the companies chosen:
 1. Does the applicable state have an open exam;
 2. Is the last exam the applicable state performed less than one year old;
 3. Does the company have less than \$100,000 in written premium; and
 4. Has the company notified the insurance department that it is ceasing to write business in the state.

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

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

E. How to Analyze Consumer Complaint Data

In order to conduct a systematic and focused analysis, it is necessary to develop meaningful numerical indicators which will allow regulators to make comparisons between companies and track the activities over time of each company and of market averages. Outliers—companies whose complaint activity significantly exceed industry norms, historical conditions or established best practice guidelines—can be singled out for individualized attention.⁸

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

Basic Complaint Ratio Analysis

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

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

⁸ Of course, the identification of a company as an outlier may be the result of factors entirely unrelated to the company's actual performance in the market. For example, a report once identified a company as having a complaint index of 2,189,763.36700—that is, a complaint frequency more than two million times higher than “expected,” based on the company's premium volume. However, this statistic was based on \$1 in reported premium and a single consumer complaint.

Definition of “Complaint”

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

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

Definition of “Confirmed Complaint”

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

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

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

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

Revisions to Complaints Database System (CDS) Complaint Coding and Complaint Mapping

In December 2008, the NAIC membership adopted a new coding plan for the Complaints Database System (CDS) and a recommended implementation plan. The primary objective of creating a new CDS coding plan was to improve complaint data quality through uniform complaint handling and reporting by all state insurance departments.

Key revisions to CDS complaint coding and mapping included:

- Changes to existing reason and disposition codes;
- Creation of new coverage, reason, disposition and subject codes;
- Modifications to the mapping of some reason codes and disposition codes to new or existing codes;
- Revisions to the CDS standard complaint data form (creation of a new subject field and confirmed field); and
- Revisions to the CDS Definitions and Basics Manual.

Implementation called for each state to convert to the new coding plan, with the assistance of NAIC staff, over a five-year conversion period (2009-2015). Following conversion, states reported complaints to CDS using the new coding plan. Prior to converting to the new coding plan, states reported complaints to CDS using the previous coding plan. The NAIC converted these complaints, upon receipt, to the new coding plan. As of December 13, 2010, all historical complaint data in CDS was converted to the new coding plan.

All reports created in iSite+ and the Consumer Information System (CIS) reflect the new coding plan, and as of April 2016, all states have converted to the new coding plan. Additional detail and guidance regarding the revised CDS complaint coding and mapping—as well as the revised CDS standard complaint data form and the CDS Definitions and Basics Manual, are available to regulators via myNAIC on StateNet, at the link to the Market Data Team (MIS).

Although total complaints are useful for many purposes, the baseline complaint index should be based on confirmed complaints, both because these are a more meaningful indicator of company-specific shortcomings and because this enables consistent comparisons from state to state and between states and the Consumer Information Source (CIS). States should be tracking consumer complaints in a format consistent with the Complaints Database System (CDS) format and reporting complaints to the CDS. Confirmed complaints are complaints in which one of the complaint resolution codes used by the state, also known as “complaint disposition,” upheld the consumer’s complaint position. Complaint disposition codes in which a consumer’s complaint position was upheld include the following:*

- 1208 Compromise Settlement/Resolution;
- 1225 Claim Reopened;
- 1230 Claim Settled;
- 1257 Fine Assessed;
- 1280 Referred to Other Division for Possible Disciplinary Action; and
- 1311 Company Position Overturned.

*Note: Once a state has implemented the new complaint coding plan, the state no longer uses the above-referenced complaint disposition codes to determine if a complaint is confirmed; upon implementation of the new coding plan, states submit a “confirmed” status, indicating if a complaint is confirmed or not, based upon the state’s analysis of the consumer complaint.

Complaint Ratios

A company’s complaint ratio is defined as:

$$\frac{\text{(number of confirmed complaints)}}{\text{(gross premium written [in thousands of dollars])}}$$

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

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

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

Complaint Indices

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

Complaint Index

A complaint index is defined as:

$$\frac{\text{(complaint ratio for the company)}}{\text{(complaint ratio for the aggregate market)}}$$

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

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

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

$$\frac{(\text{company's complaint share})}{(\text{company's market share})}$$

The “complaint share” is defined in the same manner as a company’s market share, i.e., by dividing the company’s complaints by the aggregate number of complaints in the relevant market.⁹ This is the format in which the NAIC CDS compilations are presented on iSite+.¹⁰ When doing the actual numerical calculations, in order to minimize rounding errors, the relevant data should be input directly, so that the complaint ratio is calculated as:

$$\frac{(\text{number of complaints against company}) \times (\text{market aggregate written premium})}{(\text{market aggregate complaints}) \times (\text{company written premium})}$$

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

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

$$670 \text{ confirmed complaints} / \$61 \text{ million in premium} = 670 / 61000 = 0.011$$

This corresponds to complaint indices for the three insurers (rounded to two decimal places) of:¹¹

Insurer A	0.010/0.011	0.91
Insurer B	0.015/0.011	1.37 ¹²
Insurer C	0.020/0.011	1.82

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

⁹ This formula demonstrates why the complaint index will be the same whether the original complaint ratios are expressed in terms of complaints per dollar, complaints per thousand dollars or complaints per million dollars.

¹⁰ However, at this writing, those reports are based on raw complaint data, not confirmed complaints. The NAIC is developing a report framework based on confirmed complaints.

¹¹ Additional precision, although readily available, is inappropriate because it would not reflect any meaningful distinction between companies. Indeed, even the two decimal place calculation will generally overstate the significance of the underlying data.

¹² The careful reader might note that the approximation 15/11 actually rounds to 1.36. See *supra* note 9.

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

- Although complaint indices should be calculated by line of business if possible, their accuracy depends on the availability (and the use) of accurate confirmed complaint counts by line of business. Complaint ratios and complaint indices draw a misleading picture if the complaint count and the gross premium figure are based on different sets of policies;
- Premium volume may not be the best measure of market activity in many lines of business, particularly annuities and life insurance. States should give strong consideration to supplementing their basic complaint analysis with an alternative complaint index calculation based on policy count, when that information is available. For life insurers, the number of policies and group certificates in force is reported on the State Page, itemized by the type of coverage;
- Complaint indices can be misleading for companies with small market presence. In particular, it is not appropriate for published tables or rankings to include (at least without a conspicuous disclaimer) companies whose complaint indices would be significantly different with one or two more or fewer confirmed complaints;¹³
- Using more states and/or more years provides a larger sample size, but this will only give more accurate results if the information from other states or earlier years is comparable. Inaccuracies may result from changes in company behavior over time, different company practices or market conditions in other states or inconsistencies in the ways different states gather or report complaint data. For example, all other things being equal, if the average policy in a given state is half as expensive as in a neighboring state, then complaint ratios, calculated by premium volume, will be twice as high in that state as the same level of complaint activity would generate in a neighboring state; and
- A CDS Closed Complaint Summary Index Report can be run, using complaint information from one year and premium information from a different year, allowing multiple complaint years to be compared to a common baseline. This corrects for the effects of general economic conditions, such as inflation on premium growth, but will create other distortions when premium volume changes for other reasons.

Reports from the NAIC Complaints Database System

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

¹³ A company which earned more premium than it wrote will actually appear in computer-generated tables with a negative complaint ratio, which on its face is absurd and should be seen as a clear indication that the company had too little activity in that market to generate a credible report. On the other hand, if several complaints were filed against such a company, regulatory follow-up is clearly warranted.

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

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

The NAIC also publishes complaint index information for the general public through its Consumer Information Source (CIS). These reports calculate complaint indices on a nationwide basis, based only on confirmed complaints, and rebalanced so that a score of 1.0 represents the median company for a particular line of business¹⁴—half the companies in that line of business had better complaint ratios for that year, while the other half had worse, rather than the mean complaint ratio overall. To illustrate the difference, the median complaint index for group health insurers in 2002 was 1.28. This indicates that most companies in this line of business had complaint indices noticeably greater than 1.00—the most likely explanation for such a result is that those companies with high complaint indices tended to be smaller companies (or companies for which group health was not a major line of business), while the larger group health writers tended, on average, to have fewer complaints relative to premium volume.¹⁵ This brings down the average, so that a company could have a better complaint record than most of its competitors, but still have a complaint index of 1.1.

Therefore, the CIS would report such a company's complaint score as $1.1/1.28 = 0.86$, highlighting its performance relative to other companies rather than its proportionate share of the nationwide complaint total.¹⁶

¹⁴ The CIS report refers to the rebalanced complaint index as a “complaint ratio,” but that is different from the way that term is used in this guide.

¹⁵ Another possibility would be a bimodal (“camel hump”) distribution curve in which there are really two distinct market sectors being compared here, the larger of which (on average) has measurably higher complaint ratios.

¹⁶ The underlying question is which figure can most fairly be called “normal” market behavior. The use of the median is based on the premise that the market-wide complaint ratio (i.e., the mean complaint ratio) is disproportionately influenced by the behavior of a few large companies. Conversely, however, it can be argued that the median complaint ratio is disproportionately influenced by very small companies whose behavior affects relatively few consumers.

F. Market Conduct Annual Statement Data

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

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

G. How to Analyze State Page Data

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

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

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

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

Review Data for Significant Changes in Premium Volume

The list of licensed companies and changes in premium volume needs to be examined to find the companies with significant fluctuations in premium volume since the prior year. The initial analysis of premium volume should aim at focusing state insurance department resources on companies with the most significant changes. Every insurer's premium volume changes every year, so the analyst should be looking for dramatic growth (33 percent or more) or decline (10 percent or more) in one or more lines of business in the state. Since most changes are increases, the normal range for increases is broader than the normal range for decreases.¹⁷ Schedule T, on all three types of statement blanks, provides a state-by-state breakdown of premium activity; and it may be useful to check this schedule to compare activity in other states and identify regional or national trends.

Market analysis of the State Page data when it is filed in March provides a good opportunity to double-check whether all state insurance department staff are aware of and are alerting the department's MAC of the warning signs noted above. The March annual statement filings should rarely be the first notice that the department

¹⁷ It should also be noted that, when a company is one of the dominant insurers in the market, there is less room to grow in the normal course of business, so a lower threshold for "significant" premium growth should be considered for those companies.

receives if an insurer has had significant premium fluctuations or other unusual financial results in the prior year. Usually, some preliminary indication was already present in the quarterly reports or some other source of current information.

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

- Does the change correlate with complaints filed against the insurer?
- How many rate, rule and form filings has the company made? Does the number, compared to the change in the company's writings, suggest that the company is using a rate structure that is not filed or not approved, if required for that line of business?
- Is the increase in premium volume due largely to an increase in the number of risks assumed or due largely to rate increases?¹⁸
- If there are significant rate increases, do they reflect trends in the overall market or is the company an outlier?
- If the company's writings have changed, have the numbers of agents changed accordingly?
- How many agent appointments and terminations has the company made?
- For what lines are they licensed?
- If the company's writings have changed, have the number of adjusters changed? (If relevant to the line of business in question and the state requires a license for adjusters, or this information is otherwise available.)

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

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

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

Review Data for Changes in Reserves

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

¹⁸ Lines of business where rates are not filed, this will be more difficult to ascertain.

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

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

Review Loss Ratio Data

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

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

Review Data on Defense Costs

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

Not for Distribution

Chapter 5—Enhancing State Market Analysis

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

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

Below are some examples of possible approaches.

A. Improving Consumer Complaint Analysis

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

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

Having uniform definitions and standards applicable in all states results in an accurate exchange of information, allows for the systematic analysis of that information, allows complaint information to be used effectively in the market surveillance process and allows accurate complaint summaries to be compiled for public distribution. As noted in Chapter 4—Putting It All Together: Market Analysis, readers do not have to switch gears unnecessarily; there is value in standardization even for non-substantive formatting conventions, such as whether complaint indices are expressed as percentages, with 100 as the norm, or as ratios, with 1.00 as the norm.

1. Key Elements of Best Practices

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

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

A complaint is “any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose.”¹⁹

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

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

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

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

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

- Insured;
- Service provider; and
- Other.

¹⁹ Similarly, the *Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act* (#884) provides that “complaint” shall mean a written communication primarily expressing a grievance. This definition was adopted by the Market Regulation and Consumer Affairs (D) Committee in 2006 after a review of the complaint definition recommended in the NAIC *Consumer Complaints White Paper* adopted June 2000.

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

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

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

2. More Detailed Information on Complaints and Regulatory Actions

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

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

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

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

3. Calculating Complaint Ratios by Number of Policies

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

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

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

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

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

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

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

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

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

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

5. Publishing Complaint Information

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

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

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

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

6. Confirmed Complaints

The definition of a confirmed complaint, as adopted by NAIC member states:

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

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

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

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

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

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

B. Use of myNAIC and iSite+ in Market Analysis

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

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

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

The market regulation tools on iSite+ can be used after a Level 1 Analysis or Level 2 Analysis, in which a regulator may want to monitor a company or when a regulator has a potential or on-going examination of a company. iSite+ users are able to personalize applications to assist with analyzing and monitoring specific companies. iSite+ provides a quick high-level snapshot of a company's overall activities, including market share, complaint indices, Level 1 Analysis reviews, state market regulation initiatives and market conduct examinations. Users are able to select a customized listing of insurers and lines of business to display in iSite+. While the default display is to show state level information, users can add national data once a company has been selected. National data is helpful information which can be used to monitor the activity of insurance companies when analysts believe there is potential for further regulatory analysis or action.

C. Use of IRIS Ratios in Market Analysis

As discussed more fully on the NAIC website, the Insurance Regulatory Information System (IRIS) is a tool designed to assist state insurance departments in monitoring the industry's financial condition. A key component of IRIS is a series of financial ratios based on annual statement information, developed for the purpose of identifying companies with potential financial difficulties. There is a separate series of IRIS ratios for property/casualty companies and for life/health companies.²⁰ IRIS ratios are a preliminary screening tool and IRIS ratios outside the pre-established norm do not necessarily indicate an adverse financial condition, let alone constitute evidence of market conduct problems. The IRIS ratio merely provides a signal for the regulator to follow-up to determine the cause of the changes in the company measured by the ratio or ratios in question. Bearing in mind these limitations, the eight IRIS ratios that are most likely to be of value as market conduct indicators are:

- **Property/Casualty—Gross Premiums Written to Policyholders' Surplus (P/C Overall Ratio 1)**
This ratio tests the adequacy of the company's surplus, without the effects of reinsurance. The higher the ratio, the more risk the company bears in relation to the surplus available to absorb loss variations, without the benefit of reinsurance.

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

- **Property/Casualty—Net Premiums Written to Policyholders' Surplus (P/C Overall Ratio 2)**
This ratio is similar to the Gross Premiums Written to Policyholders' Surplus ratio, but it considers the effects of reinsurance. The higher this ratio, the more risk the company retains in relation to available surplus.

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

²⁰ There are 12 life/accident & health ratios, 13 property/casualty ratios and 11 fraternal ratios.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. The Use of Underwriting Guidelines in Market Analysis

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

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

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

1. The Significance of Underwriting Guidelines

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

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

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

2. Reviewing Underwriting Guidelines

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

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

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

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

3. Use of Information Obtained from Underwriting Guidelines

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

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

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

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

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

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

Example of Compilation of Underwriting Guidelines for Private Passenger Auto

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

Conclusion

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

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

E. Modes of Analysis

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

1. Analysis of General Market Conditions

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

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

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

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

2. Individual Company Concerns

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

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

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

3. Global Objectives

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

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

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

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

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

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

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

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

Not for Distribution

Chapter 6—Collaborative Actions

This chapter offers guidelines and techniques that may assist states in determining the need to collaborate on regulatory response when an issue impacting multiple jurisdictions is detected. Additionally, the chapter explains how a Request for Review (RFR) can result in regulatory responses coordinated through the Market Actions (D) Working Group and identifies key players in a Market Actions (D) Working Group collaborative action. Although a variety of approaches among the continuum of regulatory responses may be appropriate and should be considered, the final portion of the chapter offers guidelines for conducting the collaborative regulatory response of multistate examinations.

A. Collaborative Action Guidelines

1. Goal

By collaborating, states that identify issues or concerns with regulated entities can respond in a more effective, efficient and expedient manner. By implementing market analysis techniques and sharing pertinent information with other states and the Market Actions (D) Working Group, states can identify those regulated entities where there is a shared concern regarding the regulated entities' market practices. The goal of this chapter is to establish procedures and guidelines for state Collaborative Action Designees (CADs) to use in facilitating the communication and coordination of regulatory responses between and among the states. Moreover, this chapter is designed to identify alternatives to performing a single state market conduct examination and assist the states in effectively addressing problem insurers or other regulated entities whose business crosses jurisdictional boundaries. Coordinated, collaborative regulation will benefit both regulated entities and the state.

Examples of some of the benefits of collaborating efforts instead of pursuing individual state responses include the following:

- States may address specific regulatory issues that cross jurisdictional boundaries more efficiently;
- States will benefit from sharing techniques, skills, resources and experience;
- States may achieve greater regulatory leverage to resolve multistate market regulatory issues or concerns;
- Fewer individual state market conduct examinations will result in less expensive market regulation oversight and will reduce the amount of regulatory intervention needed to resolve regulatory concerns;
- Corrective action may be enforced on a multistate or national basis rather than a state-by-state basis; and
- Greater consistency among state regulatory responses.

2. Definitions

Collaborative Action Designee (CAD): The one person appointed by the commissioner or each state to be their representative in market conduct collaborative matters.

Final Report: A final document prepared by the Managing Lead State in conjunction with the other Lead States in accordance with this handbook and issued by the Participating States upon completion of the response. Any recommendations for continued review or state-specific addenda should also be included in this document, if appropriate.

Initiating State: The state insurance department that determines the need for a response and brings it to the attention of other states, the regulated entity's domestic state, or to the Market Actions (D) Working Group.

Interested State: A state insurance department that expresses an interest in the concern or problem with said regulated entity.

Lead State: One or more states that assist in leading the collaborative regulatory response.

Managing Lead State (MLS): The state insurance department identified by the Market Actions (D) Working Group or the Lead States to coordinate the collaborative regulatory response.

Market Actions (D) Working Group: A group of regulators chosen for their market conduct expertise to act as a forum and resource for states on issues suitable for collaboration.

Market Analysis: The process by which a state reviews data and information to determine whether specific areas of regulatory concern are occurring in the marketplace.

Non-Participating State: A state that decides not to assume any role in regulatory response or does not have an interest in the area of review.

Participating State: An interested state that decides to participate in a regulatory response but does not necessarily take an active role in the action.

Referring State: The state that submits a Request for Review (RFR) to the Market Actions (D) Working Group.

Regulated Entity: Any person, firm or company engaging in, proposing or attempting to engage in any transaction, kind of insurance or surety business; and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of a state insurance commissioner.

Regulatory Review Trigger: An event or identified concern that prompts a regulatory review.

State Addendum: A document containing state-specific findings and recommendations based on that state's statutes and regulations.

3. Assumptions

These guidelines are based on several assumptions defined and agreed upon by the members of the NAIC:

- a. Collaborative actions will be considered when there is an issue or area of concern that impacts multiple jurisdictions. Collaboration would not be appropriate when the issue involves compliance with a state-specific law if other states do not have similar statutes;
- b. Collaborative actions can be conducted for both nationally significant and non-nationally significant regulated entities;
- c. All impacted states will be encouraged to participate in the collaborative regulatory response when possible;
- d. The collaborative action, depending on the severity of the problem and the level of the response taken, can be handled by one designated state that reports to the other states, or by a group of Lead States, where one state is designated as the Managing Lead State (MLS), others are designated as additional Lead States and together the "Lead States" work collaboratively while other states may passively participate in the process;
- e. States retain the ability to choose not to participate in a collaborative action and may designate another state to review the information on its behalf. However, if a Participating State does designate another state to review information on its behalf, it is the Participating State's responsibility to outline its interpretation of its own laws it would like included in the review;
- f. Participating states retain their authority to initiate their own regulatory response if a collaborative action does not cover the scope of an area of concern to that state;
- g. The collaborative review will follow the guidelines and standards outlined in this handbook. Lead States should agree on the appropriate standards to be applied during the review;
- h. Each Participating State will determine if state-specific recommendations and actions are needed at the end of the collaborative action process, based on the findings by the Lead States;
- i. Verification that the regulated entity has complied with findings and recommendations of a final report is a separate administrative function that may or may not occur through either a collaborative or individual state follow-up effort, continuum response, examination or re-examination;
- j. Regulator resources responsible for completing the work to review data and information will be available for any follow-up proceedings required. Each state participating in the collaborative action is responsible for any expenses associated with the appearance of regulators at a proceeding arising out of the regulatory effort;

- k. If an examination is the collaborative action selected, Lead States will determine, and agree to use, computer software programs that will be employed in conjunction with the examination;
- l. Whenever a regulatory response is taken collaboratively, the Managing Lead State will provide a final report to Participating States and the Market Actions (D) Working Group; and
- m. In the case of Market Actions (D) Working Group actions, when selecting Lead States and Managing Lead States, the Market Actions (D) Working Group chair will consider at least the following criteria:
 - The domestic regulator of the regulated entity;
 - The top five premium volume and/or market share states;
 - The referring states requested participation level;
 - A state in which the identified issue appears to be more problematic;
 - Geographic balance between zones;
 - Specialized experience of a state's staff members;
 - A state's experience in managing complex investigations or collaborative actions; and
 - The ability to perform the duties and responsibilities of a Lead State and/or Managing Lead State.

4. Determinations

States should gather information from data currently available, including any state surveys and required state reports, information collected by the NAIC, information shared on NAIC regulatory forums, a variety of sources in both the public and private sectors, and information from within and outside of the insurance industry. Such information should be analyzed in order to develop a baseline understanding of the marketplace and to identify practices that deviate from the norm or that may pose a potential risk to insurance consumers in their state. States should refer to this handbook as one resource on how to perform analysis of a regulated entity's market activities.

When further inquiry into a particular insurer or practice is determined necessary, the states' Collaborative Action Designees (CADs) should consider collaboration as part of the continuum of regulatory response. If the regulated entity is a small regional insurer, then collaboration with one or more states may be beneficial. If the regulated entity is one of national significance, CADs should report their findings to the Market Actions (D) Working Group. Through the Market Actions (D) Working Group, CADs will be able to identify all other states that may have similar issues or concerns with the market practices of a regulated entity. In this way, the Market Actions (D) Working Group helps to eliminate duplicative inquiries and ensure more consistent consumer protection.

a. Determining Need for Collaboration

The following questions are designed to assist state Collaborative Action Designees (CADs) in determining whether an issue is appropriate for collaboration. CADs are encouraged to review these questions when an issue of concern is raised that involves a regulated entity that does business in more than one state.

1. Is your state's concern something that would be of concern to other states?
 Yes No

General issues such as the timely payment of claims or inappropriate marketing and sales practices could be an issue of concern to multiple states. If the issue is based on a specific state statute, such as the suitability of life insurance product sales or a specific state-mandated benefit for health plans, the CAD should determine how many other states have similar statutes. The NAIC research librarians can provide a compendium or model adoption chart to assist the CAD with this determination.

2. Is this a high-profile issue that has the potential to impact multiple jurisdictions?
 Yes No

3. Does the regulated entity have written premiums reported in two or more states for the previous calendar year?
 Yes No

If “Yes,” the CAD should contact all states where there is a new, open or called examination listed in the Market Action Tracking System (MATS) and discuss whether there are common issues or the ability for the other state to assist with the review of your area of concern. Note: All new, open or called examinations should be reviewed and the calling state’s CAD contacted to consider collaborations, even if the examination is a financial examination or appears to be unrelated to the topic of concern.

4. Are there any entries in the NAIC Market Information Systems or the Market Regulation electronic bulletin boards?
 Yes No

If there are, the CAD should contact CADs in states that appear to have common concerns and/or where there is a new, open or called examination status. The CADs can discuss whether there are common issues and the interest of other states to assist with regulatory responses to the area(s) of concern. Note: All new, open or called examinations, Level 1 or Level 2 Market Analysis reviews and initiatives should be reviewed and the state CAD contacted to consider collaborations, even if the examination is a financial examination or appears to be unrelated to the topic of concern.

5. Is this regulated entity already on the Market Actions (D) Working Group agenda?
 Yes No
6. Was the regulated entity selected by any other states for Level 1 or Level 2 Analysis reviews, and did at least one review recommend further analysis or referral to the Market Actions (D) Working Group?
 Yes No

If the answer to each of the above questions is “No,” this is probably not a good candidate for collaboration. If one or more responses are “Yes,” the CAD should consider collaboration and answer the questions in the next section to determine if the issue should be referred to the Market Actions (D) Working Group.

b. Determining Level of Collaboration

Once the need for collaborative has been determined, the questions below can assist in determining if the issue should be referred to the Market Actions (D) Working Group or addressed on a regional level.

1. Is the regulated entity nationally significant?
 Yes No

Note: It is not necessary that a regulated entity be nationally significant for Market Actions (D) Working Group referrals. However, if a regulated entity is nationally significant, it is more likely that other states are interested in the regulated entity’s activities or engaged in contact with the regulated entity for other or related issues.

2. Has the regulated entity previously been included on the Market Actions (D) Working Group agenda for this issue or any other issue?
 Yes No

If this information is unknown, NAIC staff may be able to provide some assistance. If available, the CAD should review the closing report, final report or other documentation created from previous Market Actions (D) Working Group action. If this is a related or similar issue that should have been resolved based on a prior collaborative effort, the CAD should submit the Request for Review (RFR) to the Market Actions (D) Working Group.

3. Has the regulated entity been chosen as part of the Market Actions (D) Working Group's National Analysis Project?
 Yes No
4. Does the issue involve a significant amount of consumer harm?
 Yes No
5. Does the issue lend itself to a multistate resolution?
 Yes No

If the answer to any of these questions is "Yes," the CAD should consider submitting a referral to the Market Actions (D) Working Group. If the answer to all of these questions is "No," follow the Multistate Examination Process outlined later in this chapter.

B. Responsibilities of Key Players in a Collaborative Action

The different roles played within a collaborative action are often driven by the domestic, the state that brought the issue forward and top premium states. In the case of the Market Actions (D) Working Group, once members agree to a collaborative response, the Working Group chair will determine Lead States and the Managing Lead State (MLS). The Lead States will also issue an invitation for additional states to participate. Below are the responsibilities that different individuals assume as part of their role in a collaborative action.

1. Managing Lead State (MLS) Responsibilities

The MLS bears the overall responsibility to facilitate communication and coordinate activities in an efficient manner. The MLS is the key contact with the regulated entity under review. If necessary, the MLS will directly contract with and supervise any vendors hired. The MLS will carry out the collaborative action from the continuum of regulatory options as it is collectively determined by the Lead States. In addition to general Lead State responsibilities (see Section C2 below), MLS duties include:

- Determining the number of Lead States needed and recruiting additional Lead States, if needed, in collaboration with the Market Actions (D) Working Group chair if applicable;
- Convening the Lead States for initial strategy planning to determine the appropriate course of action and scope of issues to be addressed;
- Considering all options in the Continuum of Regulatory Responses and determining an effective course of action. An examination is only to be conducted if other regulatory options in the continuum are not considered sufficient;
- Organizing an initial meeting with the regulated entity to review collaboration or Market Actions (D) Working Group processes and discuss issues. Sample initial meeting notice letters are available to regulators through NAIC staff;
- Entering and updating the action in the Market Action Tracking System (MATS);
- Scheduling regular meetings and calls with the regulated entity to ensure that the process continues to be efficient and effective;
- Keeping the domestic state apprised of the status of the collaborative action and requesting any assistance from the domestic state as necessary if the MLS is not the domestic state;
- Scheduling regular meetings with all Lead States, vendors and/or independent contractors;
- Closely monitoring all vendors and/or contractors for appropriate billing practices;
- If state staff are to be used as part of the collaborative action, communicating with CADs to obtain resources and schedule activities; and

- If the issue is a Market Actions (D) Working Group action:
 - Providing a presentation to the Market Actions (D) Working Group outlining the general scope of the collaborative action prior to the initiation of the effort. The presentation shall include a preliminary timeline for various stages and completion of the regulatory effort;
 - Providing an update and revised timeline to the Market Actions (D) Working Group within 30 days of the Lead States' decision to change the plan, if the MLS determines that circumstances require a substantial change in the planned course of action;
 - Providing an update on the progress of the action to the Market Actions (D) Working Group at each NAIC national meeting and, upon request, on the Market Actions (D) Working Group conference calls. Providing details on action findings when they are available, and terms of proposed resolutions/settlements; and
 - Completing the Market Actions (D) Working Group Managing Lead State Post-Mortem Report Form.

2. Lead State Responsibilities

The Lead States commit to serve as team members who share an equal responsibility to make all key decisions in the collaborative action. The Lead States shall work collaboratively to determine the following:

- If violations occurred and the extent of any violations found;
- An appropriate corrective action by the regulated entity that will help prevent further, similar violations;
- A plan of remediation, if necessary, and its scope;
- Post-collaborative action reporting by the regulated entity, if any;
- The scope of post-collaborative action monitoring necessary by the Lead States;
- An administrative sanction, as necessary, its scope, and
- Applicable use of the Market Actions (D) Working Group *Best Practices for Multistate Settlement Agreements*, as needed.

In general, a Lead State should be prepared to do the following:

- Attend conference calls and in-person meetings to discuss the collaborative action;
- Carry out assignments related to the collaborative action in a timely manner; and
- Review all materials prior to meetings.

3. Replacement of a Lead State

In the event that a Lead State or Managing Lead State is unable to continue to serve, the Managing Lead State or other Lead States by agreement will appoint a replacement. In the case of a Market Actions (D) Working Group action, the Working Group chair will appoint a new Managing Lead State, and if a team fails to make efficient progress to conduct or finalize the collaborative action, the chair has discretion to relieve any of the Lead States of their duties and appoint new Lead States. If any one of the Lead States believes that the conduct of a Lead State is detrimental to the collaborative action, that state should contact the Managing Lead State, or the Market Actions (D) Working Group chair if applicable, to discuss these concerns. The Working Group chair has discretion to remove and replace a Lead State at any time during a Market Actions (D) Working Group collaborative action.

4. Participating State Responsibilities

Any state may need to participate in a collaborative action by executing the participation agreement form sent by the Managing Lead State at initiation of the action. The invitation and form will outline the major issues found and, in most cases, briefly outline the scope of the action. All Participating States will have access to confidential and privileged information, provided that the state has signed the NAIC Information Sharing and Confidentiality Agreement.

Participating States do not take an active role in the action; however, they should contact the Managing Lead State to discuss any new issues of consideration for inclusion in the collaborative action. Participating States agree to provide interpretation of the Participating State's laws if requested and respond to any requests for information. If the Managing Lead State finds that the state issue is not an appropriate part of the collaborative action, the state may then initiate a separate regulatory effort.

In some cases, only Participating States may be eligible to receive a portion of any monetary sanction imposed on the regulated entity. A Participating State is not required to accept the proposed resolution presented by the Lead States; however, a Participating State does agree to consider the proposed resolution.

C. Market Actions (D) Working Group

The Market Actions (D) Working Group is the forum for identifying and addressing issues of multistate concern. Members of the Market Actions (D) Working Group are chosen for their experience and qualifications within the market conduct arena. Members meet at each NAIC national meeting and hold periodic conference calls in the interim. Each state's CAD is invited to attend calls and NAIC national meetings, and is able to participate but not vote on acceptance of actions.

In addition to referring issues to the Market Actions (D) Working Group and participating in its activities, CADs should remain cognizant of the issues that the Working Group addresses by attending meetings and calls to determine their importance in the market in a regulator's state.

The Market Actions (D) Working Group has an interest in monitoring all multistate enforcement efforts and will work to assist collaboration and communication on all such efforts. However, the Working Group must focus its efforts on projects and entities that will impact a significant number of NAIC members and consumers. Issues that impact only a few states will be monitored and, should a small group of states decide to conduct collaborative action independent of the Market Actions (D) Working Group, the Working Group or NAIC staff will provide assistance upon request with communications, general information or other, similar resources.

1. National Analysis Project

This annual project coordinated by the Market Actions (D) Working Group members uses market conduct and financial annual statement information to identify companies that are exhibiting indications of current or potential concerns and then coordinates analysis of the identified entities. Issues found through the process may be handled on an individual state basis or eventually be referred to the Working Group through the Request for Review process. The goal is to uncover issues sooner, decreasing consumer harm and reducing the number of duplicative actions.

2. Request for Review (RFR)

When a Market Analysis Chief (MAC) discovers an issue that impacts multiple jurisdictions, the MAC should consult with their state Collaborative Action Designee (CAD). Working together and answering the questions in Subsection 4a and 4b of this chapter, the CAD and MAC may determine that a referral should be made to the Market Actions (D) Working Group. The referral form is available to regulators and once completed, it should be submitted to the Working Group's designated NAIC staff support. The RFR should include the results of Level 1 and Level 2 Analysis reviews, if available, as well as any supporting documentation. NAIC staff will assist state regulators to ensure proper RFR procedures are followed.

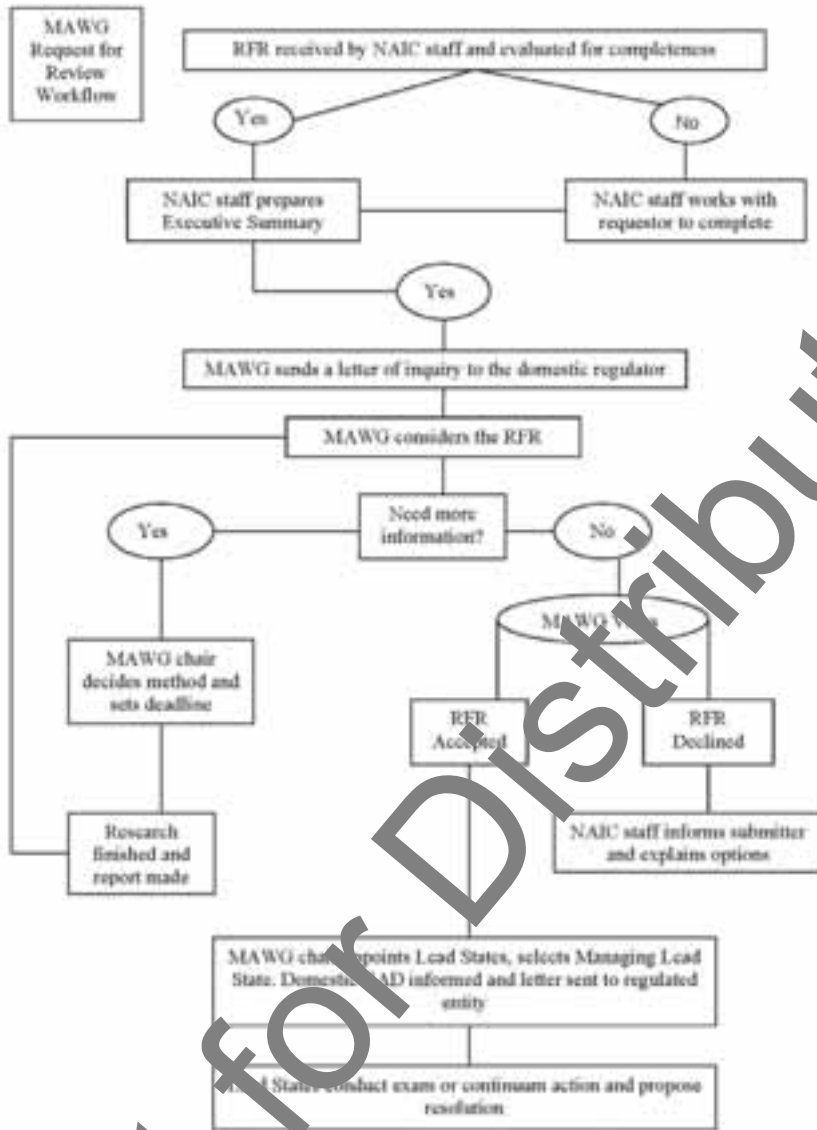
The Market Actions (D) Working Group will consider each RFR and determine whether to pursue the matter as a Working Group collaborative action. Among other criteria, Working Group members consider whether a material issue or pattern of conduct exists that demonstrates a systemic failure of the internal control systems of an entity that affects multiple jurisdictions. The Working Group will also consider whether consumers are at risk of not receiving contracted benefits or of suffering other serious harm.

Prior to the Market Actions (D) Working Group's vote on acceptance, if the referring regulator is not the domestic, or has not previously contacted the domestic, the Working Group chair will contact the domiciliary state insurance department and request information concerning the RFR. The letter may include questions about the regulator's awareness of and actions related to the alleged problem and whether the state has any plan of action or monitoring in place.

Once the Market Actions (D) Working Group chair determines there is sufficient information to make a decision, if there is a quorum, a vote is taken. A three-fourths majority is required to accept the RFR for a Working Group collaborative action. If an RFR is declined, NAIC staff will contact the CAD of the referring state and provide guidance and suggestions as to other steps that may be taken.

The steps in the RFR process are outlined in the flowchart on the following page.

Not for Distribution



Not for Distribution

D. Multistate Examination Process

This section contains the steps to determine the need for, and how to best conduct a multistate market conduct examination. For purposes of this discussion, the proposed deliverable is assumed to have been met/achieved before moving on to the next section.

1. Document the Need for an Examination

The state Collaborative Action Designee (CAD) will work with the Market Analysis Chief (MAC) to determine which entities should be the focus of attention for the state. Through internal decision-making processes, the CAD and other state staff should ascertain that other choices from the continuum of regulatory responses are not adequate or appropriate. At the point of determining the need for an examination, the CAD should take the following steps:

Steps:

- a. Document the need for an examination based upon identified triggers;
- b. Prepare a justification memo; and
- c. Obtain necessary approvals and support from the commissioner and legal department.

Deliverable:

A justification memo, which documents the need for an examination.

2. Determine if Multistate Examination is Appropriate

Several jurisdictions may have a joint interest in the market performance of a company, and their collective concerns may be best met through a multistate examination of that company. In determining appropriateness of a multistate examination, the state CAD should consider the similarity of product(s) across jurisdictions, differences in state regulations of product(s) and location of the offices of the insurer, and any other factors that may apply. Multistate examinations are not appropriate when company behaviors are specific to one jurisdiction.

Steps:

- a. Follow Steps 1 through 6 in Subsection 4a of Section A of this chapter to determine if a collaborative action is appropriate;
- b. Follow Steps 1 through 5 in Subsection 4b of Section A of this chapter to determine if a Market Actions (D) Working Group Request for Review (RFR) is appropriate; and
 - If yes, confirm commissioner support for a potential Working Group collaborative action, complete and submit the RFR to the Working Group.
 - If no, the issue is not appropriate for the Working Group but is appropriate for collaboration.
- c. In either case, the collaborative action itself will typically follow the path outlined below.

Deliverable:

A possible Market Actions (D) Working Group RFR recommending a collaborative examination based on documented triggers.

3. Work with Domiciliary State

At this point, the CAD of the initiating state (if not the domiciliary state) will contact the CAD of the domiciliary state to determine what that department of insurance may have done previously to uncover or address the issue.

Steps:

- a. The initiating state CAD notifies the domiciliary state of concerns and interest, and receives and reviews any response/input from domiciliary state; and
- b. The initiating state CAD and domiciliary state determine the scope of the problem and draft notification to all states.

Deliverable:

A listing of all potentially affected states and description of the issues of concern, including magnitude. A clear understanding of the role of the domiciliary state and which state will lead the examination.

4. Initiate Collaborative Examination

The CAD of the Lead State, whether the initiating state or domiciliary state (if different) will still want to use the Market Actions (D) Working Group's forum to provide information on the action and solicit other potentially impacted states.

Steps:

- a. Notify the Market Actions (D) Working Group and each state's CAD of the intended collaborative action. Include at least the following:
 - A brief description of the issue;
 - A list of possibly affected states;
 - An invitation for any interested states to join the action;
 - A request for information from any other states that have addressed the issue; and
 - Possible assistance desired from the Working Group or NAIC staff.
- b. Interested states submit participation responses, including the following:
 - Whether the state intends a passive or lead role;
 - If the state wishes to take a lead role:
 - Number of staff that will be dedicated by that state; and
 - Staff availability dates;
 - The state's statutory authority to examine company records;* and
 - An authorization to review records.
- c. Review invitation responses to determine:
 - Any state-specific concerns of Participating States;
 - If other states have addressed the problem(s), collect information on findings; and
 - Which states wish to be named a Lead State.
- d. Enter the examination call in the Market Action Tracking System (MATS), noting that it is a multistate action.

*The domiciliary state has authority to look at all records of their domiciled companies. Most states can authorize another state to review their own records.

Deliverable:

A list of Participating States with desired participation level, resources available and authorization to review records. (All information is entered into NAIC systems as the examination proceeds.)

5. Plan the Examination

The Managing Lead State Coordinator assumes the role of coordinating and planning the examination. This function may be part of the state CAD's responsibility, or another staff member may be designated. The CAD may still be responsible for any communications with the Market Actions (D) Working Group or NAIC staff to request advice or assistance.

Steps:

- a. The Managing Lead State (MLS) assigns the Examiner-in-Charge (EIC). Criteria for selecting an EIC include:
 - Minimum qualifications;
 - Expense based on scope of the examination; and
 - A representative from the Lead State (recommended).

- b. The MLS and EIC plan the examination in coordination with other Lead States, addressing:
 - Scope statement (market conduct areas to be covered);
 - Number of examiners and other resource requirements;
 - List of runs or records needed based on period of review;
 - Role Participating States will play;
 - Tasks that go into the plan;
 - Tentative schedule (time frame and sequence of examination events); and
 - Location(s);

Note: The MLS should consider input from Participating States to prepare the examination plan.

- c. The MLS and EIC set the start date and date of pre-examination conference;
- d. The MLS and EIC develop a confidentiality clause for the examination;
- e. The MLS finalizes the examination plan. The examination plan, including confidentiality clause, should be distributed to and signed by all Participating State CADs; and
- f. The MLS updates the Market Action Tracking System (MATS).

Deliverable:

A formal examination plan that has been agreed to by all Lead States. The plan should include details regarding:

- Statutory authority of Participating States;
- Roles of Lead and Participating States;
- Estimated number of examiners;
- Expected resources required;
- Resources available;
- Identity of the EIC;
- Scope statement;
- Examination start date and estimated completion date; and
- List of runs, records and information required.

6. Notify Company

Let the company or companies know that an examination has been called.

Steps:

- a. The Managing Lead State (MLS) sends examination notification to the company. Timing and content follow guidelines for regular examinations;
- b. The MLS receives the company's response, including identification of the company's examination coordinator;
- c. The EIC assembles the company's response information:
 - Coordinator/contact name;
 - Location of documents; and
 - Other requested information.

Deliverable:

Examination notification is sent to the company.

7. Perform Pre-Examination Activities

Pre-examination activities for a multistate examination follow the guidelines outlined in this handbook. It is the responsibility of the Managing Lead State to coordinate pre-examination activities and the responsibility of the Lead State CAD to ensure adequate communication activities among all Participating States.

8. Conduct Examination

Conduct the examination following the guidelines outlined in this handbook. It is the responsibility of the EIC to coordinate and conduct the examination and the responsibility of the Managing Lead State (MLS) to ensure adequate communication among all Participating States.

Steps:

- a. The EIC is responsible for conducting the examination;
- b. The EIC is responsible for on site coordination;
- c. The EIC is responsible for addressing state-specific concerns of Participating States during the examination;
- d. The EIC is responsible for communication with company management;
- e. The Lead State CAD is responsible for communication with the Participating States;
- f. The MLS and EIC coordinate a wrap-up session with the company; and
- g. All Participating States should continue to maintain applicable confidentiality until the conclusion of the examination and/or settlement.

9. Write the Multistate Examination Summary

Upon conclusion of the examination, a multistate examination summary is drafted by the EIC. The Managing Lead State (MLS) will help coordinate the communication of comments on the summary by Participating States.

No state-specific examination findings or recommendations are included in the multistate examination summary. These will be handled with state-specific addendum and will incorporate conclusions based on individual state statutes and regulations.

Steps:

- a. The EIC coordinates the drafting of the multistate examination summary and state-specific findings (which are not included in the summary itself);
- b. The Lead State CAD exposes a draft of the multistate examination summary.
 - Distribute to all Participating States;
 - Gather Participating State responses; and
 - Resolve discrepancies.
- c. The EIC finalizes the multistate examination summary and obtains a sign-off from Participating States;
- d. The MLS or EIC distributes the approved multistate examination summary to the company, and the Lead State CAD distributes the final copy to all Participating State CADs; and
- e. The Lead State CAD updates the Market Action Tracking System (MATS).

10. Finalize the Examination Report

Final Examination Report = Multistate Examination Summary + State Addendum

Each Participating State may issue an examination report or choose to adopt the Lead State report that consists of the multistate examination summary. Alternatively, each Participating State may issue an optional state addendum, taken from the EIC's report on findings related to state-specific issues.

Examination Report

The state addendum details the state-specific examination findings and recommendations, based on that state's own statutes and regulations.

Steps:

- a. Each Participating State CAD sends the state's final examination report to the company:
 - Receive and evaluate the company response; and
 - Include the company response as part of the report.
- b. Each state CAD finalizes its state's examination report; and
- c. Each Participating State should record the applicable administrative resolution for its state in the state NAC database.

E. Conclusion of Collaborative Enforcement Actions

When a collaborative effort produces findings for which a regulatory penalty or sanction is contemplated, such action should be memorialized in a written consent order, voluntary settlement agreement or similarly titled settlement document. States may contemplate a collaborative enforcement action at the same time as a pending civil court action concerning similar issues, such as a class action lawsuit. Such an enforcement action may or may not occur simultaneously with a settlement of the civil action. Negotiations for coordinated regulatory and civil settlement should be the responsibility of the Lead State(s).

In the event a collaborative effort is challenged, or Lead States cannot reach a settlement, they should develop a resolution strategy. Lead States should outline their strategy and recommendations to ensure violations are appropriately addressed in the correct jurisdictions. Examiners from Participating States must be made available for follow-up proceedings, if required. Expenses associated with the appearance of any examiners at a proceeding arising out of the examination must be borne by the states conducting the action.

1. *Best Practices for Multistate Settlement Agreements*

The purpose of this document is to outline best practices that will meet the needs of multiple jurisdictions affected by the business practices of regulated persons/entities. It is important to recognize that although state departments of insurance have the authority to perform multistate examinations and investigations of potential violations of insurance law, the states cannot require regulated persons/entities to participate in a multistate settlement agreement. Thus, multistate settlement agreements are commonly entered into by way of mutual agreement with the applicable regulated entity as a way to uniformly and efficiently resolve regulatory matters.

The *Best Practices for Multistate Settlement Agreements* document is intended to provide guidance to regulators with respect to engaging in multistate settlement negotiations and drafting multistate settlement agreements. It is recognized that the terms of the agreement may vary depending on the subject matter of the examination/investigation, the nature of the violation, the duration of noncompliance, the number of consumers affected, and the number of states in which the regulated entity is doing business, among other considerations. However, agreements should be negotiated and drafted in a manner that is intended to promote participation by regulators and effectively address the issues of concern to regulators. With this in mind, best practices have been developed to effectuate the greatest amount of participation among the states in multistate settlement agreements. A complete copy of the *Best Practices for Multistate Settlement Agreements*, adopted by the Market Actions (D) Working Group, is available to regulators.

Chapter 7—Market Regulation Investigation Guidelines

A. Background and Introduction

The NAIC Resources (D) Working Group was charged with developing an inventory of resources and guidelines for market regulators in the following areas: consumer services, rates and forms, producer licensing, market conduct examinations, residual markets, antifraud, senior issues, investigations, enforcement, market analysis, consumer education and special issues. An extensive inventory of resources was developed in all of the aforementioned areas with the exception of investigations and enforcement. The Working Group was unable to locate resources in those two areas. The Market Regulation and Consumer Affairs (D) Committee at the NAIC 2002 Spring National Meeting appointed the Investigation Standards Subgroup of the Uniformity (D) Working Group. The goal of the Subgroup was to develop market regulation investigation standards. This chapter contains the standards compiled by the Subgroup.

The market regulation function of an insurance department serves as an early indicator of market problems that may lead to large-scale problems and may eventually affect solvency. These investigative standards were developed to provide an additional resource in the area of market regulation. These investigations are not an examination. Based on an analysis of the problem, a determination has to be made after reviewing a number of indicators—such as frequency of violation, whether it was intentional, number of consumers involved, severity of the violation, amount of money involved, etc.—as to whether an investigation is the most efficient means to address that problem. The investigative method decided upon should provide a concise and cost-effective means with which to deal with the problem(s).

The purpose of this chapter is to provide market regulators with guidelines for the use of various market regulation tools. These tools are not intended to replace effective procedures or hinder or limit the processes currently in place, but are suggested for use when appropriate. This guide provides an explanation, descriptions, suggestions, options and samples regarding an investigative process when it has been determined that this is a viable way to deal with a problem.

As a means of improving this sharing of information among the states, at the conclusion of an investigation, all states are encouraged to contact the state's market analysis coordinator in an affected state and inform them of the results of the investigation. States are also reminded to share with the Market Actions (D) Working Group, as well as the other states, any investigation procedures that they found to be particularly useful and/or productive, and any other significant issue(s) that arose during the process of the investigation.

State insurance regulators have many different tools at their disposal to deal with potential violations of state insurance statutes and regulations, as well as potential market conduct violations alleged of any licensee, whether they are a producer, a company or other regulated entity. There are occasions where state regulators find it necessary to conduct specific and/or targeted examinations of companies and/or producers due to specific allegations of misconduct or noncompliance with statutes and regulations. The following information contains procedures for those instances where a market regulation investigation is warranted.

These guidelines have been created to assist states with development of their own market regulation investigation procedures. These procedures are not intended to be an all-inclusive document with regard to investigation procedures; and states may wish to utilize other procedures than those incorporated.

B. Guidelines for Conducting Market Regulation Investigations

Suggested Statutory Authority

Individual states may have broader and/or more comprehensive authority. The following, which is excerpted from (Alabama Code §27-2-26) is an example of statutory authority.

- As to the subject of any examination, investigation, or hearing being conducted by him, the commissioner may subpoena witnesses and administer oaths or affirmations and examine any individual under oath or take depositions and, by subpoena duces tecum, may require and compel the production of records, books, files, documents, and other evidence;
- Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a circuit court. Witness fees, mileage and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized and shall be paid by the person being examined or in the proceedings in which such witness is called such person is found to have been in violation of the law or by the person, if other than the commissioner, at whose request the hearing is held;
- Subpoenas of witnesses shall be served in the same manner and at the same cost as if issued by a circuit court. If any individual fails to obey a subpoena issued and served under this section with respect to any matter concerning which he may be lawfully interrogated or required to produce for examination, on application of the commissioner, the circuit court of the county in which is pending the proceeding at which such individual was so required to appear or the circuit court of the county in which such individual resides may issue an order requiring such individual to comply with the subpoena and to testify or produce the evidence subpoenaed. Any failure to obey such order of the court may be punished by the court as a contempt thereof; and
- Any person willfully testifying falsely under oath as to any matter material to any such examination, investigation, or hearing shall, upon conviction thereof, be guilty of perjury and punished accordingly.

Conducting an Investigation

An investigation may be conducted by an insurance department's examiners or investigators either at the offices of the insurance commissioner or wherever the person being investigated is located, as well as at such other places as may be required for determination of matters under investigation.

Every person being investigated, as officers, attorneys, employees, agents and representatives shall make freely available to the commissioner or his/her representatives the accounts, records, documents, files, information and matters in his/her possession or control relating to the subject of the investigation.

Neither an insurance department nor any examiner or investigator shall remove, destroy or deface any record, account, document, file or other property of the person being examined from the offices of such person except with written consent given in advance of such removal or pursuant to a court order.

Some states may have specific statutory authority that addresses the issues of electronic/computer records and may want to add those provisions to these procedures.

Pre-Investigation Planning

Internal planning should be conducted by an insurance department's examiners and/or investigators with regard to the company or individual selected for investigation. Information that should be gathered includes, but is not limited to, the following:

- Information from internal databases regarding the subject of the investigation. This includes filings such as annual reports, policy and form filings, etc. All information maintained in internal databases should be reviewed and analyzed as soon as possible during the investigation;

- Information concerning the subject of the investigation from applicable NAIC databases. The NAIC maintains several databases which contain information, which may be of assistance to the investigator. Those databases consist of the following:
 - Regulatory Information Retrieval System (RIRS);
RIRS contains regulatory actions taken by participating state insurance departments against producers, companies and other entities engaged in the business of insurance. Note that the absence of information on a particular entity should not be taken as conclusive, that no disciplinary action has been taken. Not every state participates actively and fully in RIRS.
 - Other NAIC Databases; and
There are other NAIC databases which also may be of assistance to the investigator. These are the Complaints Database System (CDS), the Market Action Tracking System (MATS) and the State Producer Licensing Database (SPLD). Information found in these databases includes regulatory actions, closed complaints, financial and market conduct examinations, relationships between entities, and suspicious or fraudulent activity. Information contained in the SPLD also contains licensing and appointment information on insurance producers.
 - IIPRC product filings (via SERFF).
The uniform standards, rather than state-specific content requirements/laws, are applicable to products approved by the Interstate Insurance Product Regulation Commission (IIPRC). Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective jurisdiction and may wish to view the approved forms, filing correspondence, notes from reviewers, checklists and supporting documentation. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product or advertisement constitutes a violation of the provisions, standards or requirements of the compact (including the uniform standards).
- Discussions with other insurance department personnel;
- Any departmental records, such as financial examinations and/or producer licensing and investigation files;
- Information received from other states;
- Any information received from law enforcement and/or other state or federal regulatory agencies. Other federal and state regulatory agencies have databases that may assist the investigator, for example, the Federal Trade Commission (FTC) and Financial Industry Regulatory Authority (FINRA); and
- If possible, any information that can be requested from the entity being investigated should be gathered before a field investigation is commenced. The information requested may be broad or very specific depending on the type of investigation being conducted. Reviewing and analyzing all available information concerning the subject of the investigation prior to the start of a field investigation will allow the investigation to be conducted in a more comprehensive and expedited manner.

The pre-investigation planning stage should address the following issues:

- The justification for the investigation;
- The scope of the investigation;
- A time and cost estimate; and
- What costs, if any, can be billed to other sources.

Investigative Reports

The insurance department's examiners and/or investigators should prepare a written report at the conclusion of each investigation. This report should combine the appropriate features of an examination report and possibly include some of the data and format of a more traditional law enforcement report, specifically if criminal violations are uncovered during the investigation. The report is considered confidential until such time as the insurance department has reviewed it and its distribution may either be permitted by the commissioner or required by law.

The investigator should document all tasks and facts discovered, both inculpatory and exculpatory in the investigative file. This documentation should include:

- Written notes of calls/interviews;
- Written statements;
- Summary and organization of relevant documents;
- Preservation of original evidence; and
- Written findings and recommendations.

Investigative Options

There are several options available to an insurance department once a market conduct investigation has been concluded. These options include, but are not limited to, the following:

- Prepare and finalize an investigative report and determine whether or not sufficient evidence exists to proceed, or if additional information is needed to complete;
- Filing of an investigative report, which may be an internal confidential document or provided to the subject of the investigation;
- Call a market conduct examination if warranted, and
- Filing an examination report. This option gives the subject of the examination an opportunity to respond and/or object to the examination report and to have a hearing concerning those objections. Once the examination report becomes final, it may be a public document.

Enforcement Options

There are several enforcement options available to an insurance department. These options include, but are not limited to, the following:

- An administrative complaint may be filed against the licensed entity or individual who is the subject or target of the investigation. As with other administrative complaints, the respondent has 30 days to respond to the allegations and, in most cases, a hearing will then be scheduled.
 - Cease and desist order: In certain circumstances, it may be appropriate to issue a cease and desist order against the subject of an investigation;
 - The insurance department has the authority to enter into settlement agreements and/or issue a consent order with regard to violations of a state's insurance code which are uncovered during an investigation. A settlement agreement may be entered into after or before the filing of an administrative complaint, and the same is true for a consent order. It is important to remember that it is not necessary to file a formal complaint against the target of an investigation before a settlement agreement or consent order can be entered into to resolve any outstanding issues and violations;
- Suspension or revocation of licenses;

- Corrective action plan;
- Referral to appropriate law enforcement or other regulatory agencies, if warranted and/or required by law;
- Restitution; and
- Information-sharing with other states.
All states should report any significant findings to other affected states, through their Collaborative Action Designee (CAD) and through the Market Actions (D) Working Group. Since an investigation is a separate and distinct process from an examination, the existence of an investigation may not be reported to MATS, nor are the findings of an investigation always reported to RIRS.
- Some entities will request that a department of insurance enter into what may be referred to as a confidential settlement to resolve any violations found during an investigation. Confidential settlements are not allowed under many state public record laws. Fellow regulators expect NAIC databases to maintain accurate information. All violations and monetary payments should be reported to the appropriate NAIC databases unless prohibited by law.

The investigative and enforcement options are merely a list of options. No order or priority was given to any option. Regulators must choose whichever option or options best address the circumstances.

Monetary Penalty or Fine

A state's insurance code may provide limited fining authority for specific instances of violation of the insurance code. Consistent with the insurance department's authority stated above to enter into settlement agreements and consent orders, the insurance department does have the authority to enter into agreements which provide reimbursement to the insurance department for its administrative costs in settling matters related to a market regulation investigation.

The enforcement options listed above are not mutually exclusive and it may be appropriate in many cases to pursue more than one option and/or restitution, if warranted.

C. Standards for Conducting a Field Investigation

The following are general guidelines to be used by market regulation examiners and investigators in conducting market conduct field investigations on behalf of an insurance department:

Investigation Activities

Activities such as interviews, record reviews and report preparation—for the investigation should be planned in advance in order to efficiently utilize departmental resources.

Disposition of Investigation

Investigators are responsible for conducting investigations which identify and document their findings. Investigators should only make a recommendation on disposition after the investigation has been concluded. Appropriate disposition of the case will be determined by the supervisor of the investigator, in consultation with the insurance department's legal division, after the investigation activities have been completed. The commissioner of insurance ultimately decides the disposition of all cases investigated by an insurance department.

Scope of Investigation

The investigator conducting the investigation should conduct activities and tasks directly related to the alleged violations which were originally referred. If the investigator believes there are additional alleged violations or that the investigation should broaden its scope, the investigator should discuss this matter with his/her supervisor before proceeding further.

Authorization and Entry into NAIC Databases

Investigators should only investigate cases that have been properly assigned to them and have a file number. All investigative cases must be authorized and approved by the supervisor who oversees the investigator's department/division. If possible, all investigations should be entered into the appropriate NAIC databases.

Timeliness of Investigation Activities

Investigators are responsible for planning their schedule of activities on assigned investigative cases to ensure that activities and tasks are completed in a timely manner. Written updates to files should be made on at least a monthly basis.

Documentation of Investigation Activities

All activities, tasks and discussions occurring on an investigative case should be properly recorded in the investigative reports within five working days from their occurrence. It is important this rule be adhered to in all cases.

Investigative Files

All materials and documents gathered as a part of an investigation shall remain part of the investigative file, regardless of whether they are used as evidence. A copy of the complete investigative file should be forwarded to the insurance department's legal division when and if a request is made for administrative action to be taken against an entity or individual.

Confidentiality of Investigative Files

No information in an investigative file should be provided to anyone outside the insurance department without the express permission of the investigation supervisor, legal division or the agency records officer. Investigators should become familiar with the confidentiality provisions of the insurance code, as well as the insurance department's rules for sharing confidential information with law enforcement and other regulatory agencies. It should be the policy of any insurance department to cooperate fully, to the extent allowed by law, with all federal and state law enforcement and regulatory agencies. Many states have signed the Master Information Sharing and Confidentiality Agreement (commonly referred to as the Global Confidentiality Agreement) drafted by the NAIC. The provisions of this agreement should allow for the sharing of information between various state insurance departments.

D. Guidelines for Conducting an Interview

Prior to conducting interviews during an investigation, it should be determined beforehand whether the person being interviewed is a witness, victim or the subject of the investigation. A written record should be made of every interview that is conducted. In most cases, notes will be taken during an interview and will later be transcribed or dictated by the investigator at a later date. It is very important that the preparation of a final report of an interview be completed as soon as possible after the interview has taken place. Most law enforcement agencies require this to be completed within five days of the date of the interview. The insurance department should have established guidelines as to whether an investigator's original notes should be maintained after the interview has been formally transcribed. Once a specific policy has been adopted regarding this issue, it should not be deviated from under any circumstances. It is recommended that the investigator preserve the original notes from each and every interview and that the investigator strives to make sure those notes are as accurate as possible.

Investigators should check insurance department rules and regulations, as well as applicable state law, concerning the use of informants. Some state laws may allow for the protection of an informant's identity. The investigator should always tell an informant that, although the department will attempt to keep their information confidential to the full extent allowed by law, there are no guarantees that the information could not be discovered at a later date. Investigators should make sure that they have a full and complete understanding of their department's policy concerning confidentiality of informants, as well as any state or federal laws which may apply to the matter they are investigating.

Individuals who are considered to be possible subjects and/or targets of the investigation should normally be interviewed toward the end or at the conclusion of the investigative process. More often than not, individuals who are the subject or target of an investigation may in fact, contact the investigator and/or the insurance department during the course of the investigation once they learn of its existence. Interviews conducted of individuals who are subjects/targets of an investigation should be among the most thorough interviews conducted during the investigation. If at all possible, every statement and detail provided by a subject/target of an investigation should be recorded. The primary reason for this is often a subject/target will be deceptive and/or provide misleading information to the investigator. The more detail that is gathered, the more useful it may be in proving a deception has occurred. Furthermore, the subject/target is obviously in the best position to provide information to the investigator concerning the alleged offense.

The issue may arise as to whether or not investigators for a state insurance department are required to advise a subject/target of their Miranda rights under the criminal law. Each state should formulate a policy that reflects their specific laws in conformity with the protections provided by the U.S. Constitution. Some state investigators have police powers and may be required to advise subjects/targets of their rights under certain circumstances. Many states' investigators do not have such police powers and, thus, may not be under any obligation to do so.

Interviews of witnesses are normally conducted differently than those of a subject/target. A witness is normally cooperative and usually possesses less than complete knowledge of the matter being investigated. Witnesses should obviously be questioned extensively concerning their specific knowledge of the matter under investigation. It is important, however, for the investigator—when making a written record of the interview—to try and summarize as much as possible the information provided by the cooperative witness. By summarizing the information provided by a witness, the investigator does not put the witness into the position of possibly having their credibility attacked over confusion or a mistake over a minor detail in their statement. The investigator should always keep in mind that any and all statements obtained during an interview may, in fact, be used in an administrative and/or court proceeding and, thus, be available for review by a subject/target of an investigation and their attorney.

Investigators should make it a standard practice and procedure to record interviews conducted with custodians of records and/or anyone from whom they receive documentary evidence. For example, when contacting a custodian of records at a bank to serve a subpoena for financial records, a properly written record should be created documenting the identity of the person contacted, the purpose and the results of the interview—even if all that was carried out was the delivery of a request for information and the information was provided. This procedure not only helps document all steps taken during the investigation, but also may help with establishing the chain of custody for documentary evidence to be used during the investigation.

Investigators should always use caution when interviewing either a hostile subject, witness, victim or anyone of the opposite sex. It is advisable to have another investigator present any time a hostile witness or the subject/target of the investigation is interviewed. If another person is unable to be present, do not conduct the interview behind closed doors. It is preferred that male investigators always have another person present when they interview female subjects/targets.

An investigator should at all times be courteous and professional during an interview, no matter who is the subject of the interview, be it a subject/target or a witness. Furthermore, investigators should never provide information nor make statements to a subject/target or a witness that cannot be substantiated by the evidence the investigator already has. An investigator should never make promises to an individual and should always remember that he or

she does not have the authority to resolve or settle the matter being investigated, and that it is up to the department head or other higher legal authority to determine when and how the matter will be resolved. This does not mean that an investigator cannot tell a subject/target that they may make a favorable recommendation to the department head and/or higher legal authority should cooperation be granted, but the investigator should clearly point out at all times that this is merely a recommendation and does not have to be followed. It is more advisable, when asked by a subject/target or even a witness, if favorable treatment can be provided, for the investigator to merely state that he or she will report all of the facts gathered during the investigation, including cooperation, to his or her superiors to take into consideration.

There may be occasions where it is desirable to record an interview either electronically or by a stenographer or court reporter. A state's insurance code may allow for the taking of statements under oath. This is best accomplished with a court reporter or stenographer present who can also administer the oath to the person being examined. It may be preferable to electronically record an interview. If electronic recordings are used, the investigator should be aware that voice tone and inflection, as well as individual comments, could be misconstrued and interpreted differently by different individuals. More importantly, individuals interviewed under oath or being recorded electronically may be inhibited as to what they tell the investigator. Insurance departments should review federal, state and even local laws with regard to the possible restriction of the use of electronic recordings. Investigators should be instructed to conduct themselves at all times as if their conversations with witnesses and/or subjects/targets of an investigation are being recorded. This is especially true if interviews are conducted over the telephone.

The investigator must always remember that they control the interview, and not the person being interviewed. Investigators should always be polite and courteous when conducting interviews and should be respectful of the interviewee's time. While it is necessary and often preferable to engage in small talk to establish rapport with the witness, investigators should keep such talk to a minimum. Furthermore, investigators should always remember their job in conducting an interview is to gather information, and not provide information. Inadvertent or purposeful disclosure of information gathered during an investigation which is not necessary to be disclosed can result in complications for the investigator and the insurance department. In fact, there may be legal prohibitions against the disclosure of such information; frequently, subjects/targets of investigations will make allegations regarding impropriety on the part of the investigator, not accusing the investigator of spreading lies or slandering the reputation of the subject/target or entity being investigated. To avoid these types of situations, the investigator should always focus on gathering information and disclosing only that information which is necessary to conduct the investigation. This type of conduct will withstand any allegations of impropriety raised by subjects/targets.

Persons professing to have information regarding a fraudulent act may contact insurance department personnel or become known to investigators. Many times these individuals will request that their identities be concealed. These types of individuals, sometimes referred to as informants, often provide valuable information that may lead, and often do lead, to the establishment of an act of fraud or an attempt to commit a fraudulent act. Informants provide information for many different reasons, and it often takes a professional to be able to determine an informant's motive and the true value of information provided. Investigators should consider the following when using informants:

- Never insist that an informant identify him or herself;
- Do not agree to compensate an informant, unless previously approved by a supervisor; and
- Always corroborate information provided by the informant to the fullest extent possible.

E. Preparation of the Interview Form

Each insurance department should consider adopting a standard form to record the results of any interviews conducted during an investigation. The purpose of using a standard form is to provide an accurate and complete record of all evidence developed during an investigation. The form should be filled in using paragraph form, adhering to the rules of basic English and limited to one investigative act (one search, one interview, etc.). It should consist of the following sections:

Preamble

The preamble informs the reader of the background and nature of the investigation.

Body

The body sets forth the results of the investigation while adhering to the following:

- The date;
- Using all capital letters when writing names of persons and businesses;
- Using third person, past tense and complete sentences (concise ones are best);
- Avoid phrases such as, “he stated” and “he advised.” The preamble should preclude the need for these types of phrases;
- Do not use slang, jargon or abbreviations; avoid using “subject” or “target”;
- Make sure terms used in the report are easily understood by laymen and clearly defined;
- Stick to the relevant facts. Record what was heard, seen, done, or what the interviewee heard, saw or did. Omit opinions;
- Arrange in a logical (usually chronological) order; and
- For second and subsequent interview pages, use an additional white sheet of paper, which should be clearly marked as an attachment to the original interview form.

Descriptive Data of Relevant Individuals

The investigator should obtain from each person being interviewed their full name, place of employment and phone number(s). Physical descriptive data is usually not necessary with regard to witnesses. The investigator, however, should not overlook the fact that often, physical descriptive data of a subject/target of an investigation is necessary. This is best accomplished by providing a photograph of the subject/target to the witness if physical identification is necessary. If a photograph is not available, the investigator should be careful to not pin the witness down to an exact physical description, as the physical appearance of the subject/target may, in fact, be different or may have changed since their contact with the witness. Any discrepancies in the physical description may be exploited later by the subject/target and/or their attorney.

Blanks

The blanks at the bottom of the interview form should be completed by the investigator. A series of sample subject interview forms are included at the end of this chapter.

F. Procedures for Closing a Market Regulation Investigation

At the conclusion of an investigation, after evaluation and submission of all case-related documentation, evidence, etc., a case may be closed for any of the following reasons:

- The allegations are unfounded or the investigator is unable to make a determination due to lack of information, etc.;
- All investigative efforts have been pursued to their logical conclusion without proving or disproving the allegations;
- All investigative efforts have been completed, subjects have been administratively, civilly or criminally charged and all aspects of the case have been resolved;
- All investigative activity has been completed, a complaint and/or warrant has been issued and all efforts to locate the subject(s) have been expended;
- The case is exceptionally cleared (i.e., subject dies, subject is arrested and out of jurisdiction, entity goes out of business, etc.);
- Assistance is no longer required;
- Inactive status; and
- An entry should be made in the appropriate NAIC database(s).

G. Procedures for the Completion of Case Summary Reports

The case summary report is designed to provide a brief overview of the specific information and documentation obtained during an investigation. These reports assist supervisors and insurance departmental counsel in expeditiously identifying the pertinent facts of a case so that an informed decision can be made regarding the final disposition of the case. The case summary report should contain the following information:

- The identity of the person or entity to be cited in the report. This section contains the name, business address and phone, residential address, and home phone for the individual or entity to be cited and prior regulatory history, if any, of the entity;
- The investigator should indicate all current licensure of the person or entity to be cited;
- The investigator should provide a brief narrative description of the allegations, including the number of violations;
- The investigator should provide a brief and concise representation of the information obtained during the investigation, including what the respondent did, how the violation occurred, how often the violation occurred, what further action needs to be taken, an identification of consumers who are due restitution and a description of any special circumstances or mitigating or aggravating factors;
- Witness list; and
- Source of the complaint.

H. Guidelines for Conducting a Photographic Lineup

Although it is not the standard practice and procedure of many regulatory agencies to maintain photographs of their licensees, there are occasions where it is possible to obtain such a photograph. Investigators should always attempt to obtain a photograph of an individual when that individual is the subject/target of their investigation. Even though a regulatory licensing agency may not have or require photographs of its licensees, there are other regulatory agencies, which may possess photographs and may be able to share them with the investigator. The first and most obvious is the Motor Vehicle Licensing Unit of the state in which the subject/target resides. Also, there may be other regulatory agencies that use photographs, such as a State Securities Licensing Agency.

If a photographic lineup is necessary and photographs can be obtained, the following guidelines should be closely adhered to before using this technique. If at all possible, use an original photograph. Good copies are adequate.

If at all possible, obtain at least five additional photos of the same size and, most importantly, the individuals in the additional photos must somewhat resemble the subject, with all photos being black and white, or in color. Different jurisdictions may have different requirements for the number of photos to be used in a lineup.

Under no circumstances should color photos be mixed with black and white photos. All photos must be original or they all must be copies.

Once the photos needed for the lineup are available, they should be identified on the back with a letter. They should not be identified in any other manner that would cause the person viewing the lineup to select the subject's photo because of some special mark or characteristic.

The investigator must never show any facial or body movements that would indicate that the individual viewing the photographic lineup did or did not select the subject/target of the investigation. In the event that the witness did not identify the subject/target in the photo lineup, the investigator must never point out or identify in any manner whatsoever that the witness failed to select the correct photo.

The photograph lineup should be preserved as evidence and the witness should identify the photograph identified in the lineup. A separate copy of the lineup should be used for each witness.

I. Forensic Examinations—Expert Witnesses

Investigators should keep in mind that during an investigation it may be helpful and, in fact, necessary to use outside experts in the field of forensic examination. For example, accident reconstruction, medical examiners and physicians, computer experts and forensic accountants may provide needed assistance to the investigator during an investigation.

Handwriting Investigation

Every person develops his or her own handwriting, which is a habitual act or subconscious habit. While signatures may recognizably belong to us, no two of our signatures are exactly alike. It is impossible to exactly and free-handedly replicate a previous specimen of our signature and neither can anyone else.

The identification of the writer of the signature, or any other body of writing, is a comparative study based on the use of known or authenticated writings, which are commonly referred to as standards or exemplars. The standards form the basis of any comparison. There are two classes of known writings, collected standards and requested standards:

- Writings, which are produced in the normal course of business, such as cancelled checks, correspondence, loan applications, etc. (collected standards); and
- Writings which are produced for the purposes of investigation (requested standards).

Either type of standard must be comparable to the writing in the questioned material (i.e., cursive to cursive, printing to printing, similar words, letters and letter combinations).

Given that the act of handwriting is one of free will, a person can try to alter and disguise their writing. Therefore, when obtaining requested writings, it must be done in a manner which makes success at such attempts to disguise handwriting very difficult.

Some important general guidelines are as follows:

- The subject should never be allowed to see the questioned material;
- If possible, use a format similar to that of the questioned material (i.e., same amount of writing space horizontally and vertically, lined paper/unlined paper, similar type of writing instrument, etc.);
- Dictate, verbatim, the questioned material;
- After each repetition, remove it from view prior to execution of the next specimen;
- Obtain a sufficient sample of known source writing (i.e., 15 to 25 repetitions of full text);
- If there are multiple-question items, sporadically interchange them to further frustrate disguise;
- Ensure that the writer provides comparable writing (i.e., cursive or printing); and
- If available, submit collected specimens along with requested writing so as to demonstrate normal writing. Collected writings may be all that are available. In such instances, as many writings as possible should be obtained to maximize comparability.

With regard to questioned writings, it is imperative that the original copy of the questioned document be made available for examination. Copies tend to hinder the investigation to varied degrees. The following list is a descending order of preference of desirability for use in questioned documents, and also applies to collected specimens:

- The original document;
- Photograph of the document;
- Photocopy of the document;
- Microfiche/microfilm; and
- Facsimile/carbon copy.

As a final note, it is vitally important to protect and preserve evidence which contains a forged signature or may in fact, be a questionable document itself in the same manner as other physical evidence is preserved. Any questioned documents should not be folded or handled in such a way as to possibly distort or alter their contents or the ability of a document examiner to properly examine them, or a latent fingerprint examiner to detect fingerprints. Contact the document laboratory whenever there is any question or any uncertainty.

J. Form of Investigative Report

General

- **Objectivity**
An investigative report should reflect, in its wording, the same objectivity that was used in the fact-finding and information-gathering process of the investigation. The report must be a factual recording of the findings. Use of words such as “some,” “many,” “several” and “few” must be minimized. The use of superlatives should be avoided in writing the report. The most important questions that must be answered in an investigative report are: who, what, when, where, why and how.
- **Privacy**
The investigator should be aware that although investigative reports are privileged and confidential, they may, in fact, be used in administrative, civil and possibly criminal proceedings. Accordingly, steps should be taken, when possible, to protect the confidentiality of individual policyholders or consumers. For example, when listing Social Security numbers, the investigator may want to list only the last four digits of the number.
- **Use of Jargon**
The needs of various individuals who will review and utilize the investigative report should be kept in mind during the preparation of the report. Whenever possible, the use of insurance industry jargon within the report should either be avoided or explained.
- **Writing Style**
The writing style of an investigative report should tell the story of the investigation. The story is simple, direct and factual and should always be told in chronological sequence.
- **Main Objectives of an Investigative Report**
An investigative report should inform the reader of the investigator's findings, including information and the source of information. The report should facilitate the understanding of the investigation and foreshadow the uncompleted portion of the investigation. The report should also fulfill the duties of the assignment.

Content of the Report

- **Title Page**
 - Type of investigation;
 - Subject and address of investigation. If the investigation location is different, include that address also;
 - Identifying numbers (e.g., agent number, Social Security number, etc.);
 - Dates of investigation;
 - Period covered by the investigation; and
 - List of jurisdictions and agencies participating.
- **Table of Contents**

- Case Summary Page (see Exhibit B in this chapter)

The case summary report is designed to provide a brief overview of the specific information and documentation obtained during the investigation. These reports assist insurance department supervisors and legal counsel in expeditiously identifying the pertinent facts of a case so that an informative decision can be made regarding the final disposition of the case. The case summary page should contain the following:

 - Identity of person or entity—including any available addresses or phone numbers;
 - Current licenses—all license powers of the person or entity to be cited;
 - Allegations—brief description of the allegations, including number of violations; and
 - Summary of the case—brief, concise information obtained during investigation including:
 - What the respondent did;
 - How the violation occurred;
 - How often violations occurred;
 - What further action needs to be taken; and
 - Identifications of consumers due restitution.
- Detail of Report
 - Scope of the Investigation
 - Cite specific statutory authority for the investigation; and
 - Briefly outline the investigation purpose.
 - Body of the Report
 - Detail of the investigation;
 - Summary of interviews; and
 - Summary of documentary evidence.
 - Appendices
 - Copies of interviews;
 - Copies of documentary evidence;
 - Copies of sworn statements and affidavits;
 - Copies of all licensing records; and
 - Flow chart.

K. Indicators of Fraud

Listed below are certain activities which, if discovered, are indicators of fraud and should be reported in any investigative report and should be forwarded to appropriate insurance department personnel for further action:

- Any misuse of a consumer's premium money for a purpose other than providing the insurance or benefit the consumer wanted to purchase;
- False claims against insurance coverage;
- Doing the business of insurance without a license;
- Making a false statement in a document that is required to be filed with the insurance department;
- Paying money or giving any benefit of value to a non-licensed person in return for that person's influence in placing insurance business;
- Making key alterations in written documents, forging signatures and creating false records;
- Any conduct in the business of insurance that has the effect of deceiving, fooling or tricking another person or any entity;
- Reluctance or willful delay in providing information during an investigation; and
- Suppression of information.

L. Investigative Priorities

It may be beneficial after reviewing the marketplace and insurance department resources to discuss establishing priorities for investigations to more efficiently address problems in a regulator's state insurance marketplace. Prioritizing these identified problems should maximize an insurance department's investigative resources.

Some considerations in establishing priorities for enforcement investigations are: low, medium and high. Each level has a time frame during which the investigator should attempt to complete the investigation. These priority levels are as follows:

- High priority (complete in 60 days or as supervisor designates): Multiple victims, elderly victims, high-dollar losses, felony convictions and high risk of continuing harm, publicity or media attention;
- Medium priority (complete in 120 days): Single or few victims, relatively lower dollar amounts involved, low risk of continuing harm; and
- Low priority (complete in 270 days): Little or no harm to consumers (e.g., advertising, rebating).

Develop a list of factors that could be used in evaluating complaints involving producers:

- A producer who has had three or more complaints filed against them in the previous two years;
- Three or more complaints involving marketing and sales or policyholder service in the previous five years; and
- Complaints where there are serious allegations of consumer harm, particularly harm to the elderly.

M. Exhibits

All of the following exhibits are samples provided by various states. These examples are neither recommendations nor conclusions of any state regulatory office.

Exhibit A Sample Interviews

SAMPLE SUBJECT INTERVIEW

John T. Crook, born October 15, 1937, Social Security Number XXX-XX-XXXX, was interviewed at his place of business, The Crook Insurance Agency, 1111 North Main Street, Anytown, USA. Crook resides at 1234 City Main Street, Anytown, USA. His telephone number is 555-555-5555. After being advised of the identity of the investigator and the nature of the interview, Crook provided the following information:

Crook has been in the insurance business for almost 20 years. He worked for a national insurer as an adjuster for many years before becoming an agent. He has been an independent agent in Montgomery, Alabama for almost 10 years. He has two employees and some summer part-time help. He is aware that there have been some complaints by customers. The complaints allege that he has charged fees for placing insurance and/or he has placed insurance with a different insurer than where he told the policyholder he was going to place the insurance.

Crook was asked to produce the files of John Doe, Mary Doe and Fred Doe. When questioned, Crook stated affirmatively that he had in fact taken money from these three individuals and had done his best to secure insurance for them. To the best of his knowledge, insurance coverage was secured through Unlimited Risk Insurance Company. Crook has had a relationship with Unlimited Risk Insurance Company for many years.

John Doe, Mary Doe and Fred Doe each paid by check and those checks were deposited into Crook's business account. Crook then wrote checks to Unlimited Risk Insurance Company to pay for their premium. Crook does not know that some of his checks have been returned for insufficient funds at his bank but was not aware that his check for insurance on John Doe, Mary Doe and Fred Doe had in fact been returned for insufficient funds. Crook was not aware that Unlimited Risk Insurance Company had no record of policies being issued for John Doe, Mary Doe and Fred Doe. Nor did the company have any record of any application being submitted on their behalf.

Crook was asked about the power being cut off in his building last week and he stated it was a mistake by the power company, that he had paid his bill on time, and that he was not undergoing any financial difficulty. Crook blamed the insufficient checks on a bank error and said he was doing his best to maintain his business and service his customers. Crook agreed to provide the insurance department's investigators with all of his policyholder records and copies of his bank statements. Crook asked the investigator if he could surrender his property and casualty insurance license but maintain a life insurance license. He stated he believed that as a life agent, he would not be in receipt of policyholder funds. Crook was advised this decision was not up to the investigator and Crook would be notified of the insurance department's decision.

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Investigation on John T. Crook at Anytown, USA

File Number P-2003-12345JD Date of Interview August 5, 2003

By Investigator George Goodguy and Investigator Fred Fearless

SAMPLE CUSTODIAN OF RECORDS INTERVIEW

Paul Papershuffler was interviewed at his place of employment, the National Bank of Anytown, 22222 Northwest New Street, Anytown, USA. His telephone number is 555-555-5555. After being advised of the identity of the investigator and the nature of the interview, he was served with an administrative subpoena requiring production of any and all bank records pertaining to the Crook Insurance Agency and John T. Crook, Inc. for the period of June 1, 1999 to the present.

Papershuffler, after reviewing the subpoena, indicated he would have no problem obtaining the records and would produce them at the offices of the insurance commissioner as ordered at the time and date indicated.

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Investigation on John T. Crook at Anytown, USA
File Number P-2003-12345JD Date of Interview August 7, 2003
By Investigator George Goodguy

Not for Distribution

SAMPLE INTERVIEW OF COOPERATIVE WITNESS

Mati Hari, who resides at 333 Long Way Drive, Anytown, USA, 12345, telephone number 555-555-5555 was interviewed at her place of employment, The Rightway Insurance Agency, 100 Tree Street, Anytown, USA 55555. After being advised of the identity of the investigator and the nature of the interview, she provided the following information:

Hari was employed by John T. Crook for 18 months from 2000 to 2001. She worked as a receptionist and dealt with customers both in person and over the telephone. She also attempted to maintain Crook's financial and business records for him. Crook was not a good record keeper and did not come into the office until late in the morning and left early in the afternoon. She had great difficulty in getting him to pay attention to his work. Crook received many telephone calls from individuals who appeared to be bill collectors and Hari noticed numerous envelopes from the bank in the daily mail, which appeared to be insufficient funds notices.

Hari brought to Crook's attention six months into her employment that many customers were complaining that although they had documents indicating that they had insurance, they had been told they did not have coverage with Unlimited Risk Insurance Company as represented by Crook. Crook told Hari basically to mind her own business and that he would take care of the matter.

Crook got a divorce in 1998 and Hari suspected that he actually lived at the office, sleeping on a cot during the night. She did not think Crook was intentionally a dishonest person but that he had great difficulty in his personal life and this may have affected his ability to run the insurance agency. Hari stated that Crook fired her because she questioned the status of clients' payments and accounts and whether or not insureds had insurance coverage. Hari has worked at the Rightway Insurance Company since leaving Mr. Crook's employment.

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Investigation on John T. Crook at Anytown, USA

File Number P-2003-12345JD Date of interview August 15, 2003

By Investigator Fred Fearless

SAMPLE VICTIM INTERVIEW

John Doe, born June 24, 1940, Social Security Number XXX-XX-XXXX, was interviewed at his place of employment, Cheese & Such Company, 333 Old Wooden Bridge Road, Anytown, USA. Doe resides at 5555 Royalty Lane, Anytown, USA and his telephone number is 555-555-5555. After being advised of the identity of the investigator and the nature of the interview, Doe provided the following information:

In August of 2000, Doe began looking for a new insurance company after his rates were increased by Big Guy Insurance Company. His secretary recommended Mr. John Crook and the Crook Insurance Agency as he had once been her neighbor and she had insurance with him in the past. Doe visited Crook sometime in August of 2000 at his office and got quotes from him on both of his vehicles and his residence. Crook called him a few days later and informed him he could provide Doe with insurance on the vehicles and his residence with Unlimited Risk Insurance Company for around \$150.00 per month. This was much less than Doe was currently paying to Big Guy Insurance Company and the very next day Doe delivered a check to Crook and signed some forms.

Doe never received a copy of a policy and contacted Crook's office sometime around Christmas of 2000 inquiring about the same. He spoke briefly with Crook who advised him that he did have insurance with Unlimited Risk. A few days later he received what appeared to be a computer printout and a policy table in the mail from Crook Insurance Agency.

In June of 2001, Doe's son, John, ran into the back of a van on Interstate 85. The next day, Doe notified Crook Insurance Agency who instructed him to contact Unlimited Risk Insurance Company directly. Doe contacted Unlimited Risk Insurance Company and was informed they had no record of Doe having any insurance with them for either his vehicle or his residence. Doe contacted Crook the next afternoon. Crook said he had sent in the funds for the insurance premium, he had received proof of receipt of the same and that Unlimited Risk had once again made another mistake with regard to a policyholder. Crook said he would straighten the matter out.

Doe contacted Unlimited Risk Insurance Company, who has repeatedly denied his claim as he had no insurance in effect. Doe has turned this matter over to a local attorney, as Doe has paid for the damage caused by his son's wreck out of his pocket. Doe has not had any contact with Crook for the past year and understands that he has gone through some serious difficulties and may have in fact been evicted from his office and/or had the power cut off at various times. Doe provided this investigator with a copy of his cancelled check as well as correspondence that he has sent and received in this matter.

This document contains neither recommendations nor conclusions of the XXXXX Insurance Department. It is the property of the XXXXX Insurance Department and is loaned to your agency; it and its contents are not to be distributed outside your agency.

Investigation on John T. Crook at Anytown, USA

File Number P-2003-12345JD Date of Interview August 27, 2003

By Investigator George Goodguy

SAMPLE ARREST INTERVIEW

Pursuant to an authorized arrest warrant signed by the Honorable Lynn Clardy Bright, District Judge for the County of Montgomery, Alabama, Investigator George Goodguy of the Anytown Department of Insurance accompanied Investigators Gary Gungho and Tom Tough of the Anytown Bureau of Investigation to the offices of the Crook Insurance Agency in Anytown, Alabama. After identifying themselves, the investigators took John T. Crook into custody without incident. He was transported to the Anytown County Detention Facility where he was fingerprinted and photographed.

This document contains neither recommendations nor conclusions of the XXXXX Insurance Department. It is the property of the XXXXX Insurance Department and is loaned to your agency; it and its contents are not to be distributed outside your agency.

Investigation on John T. Crook at Anytown, USA

File Number P-2003-12345JD Date Interviewed September 1, 2003

By Investigator George Goodguy

Not for Distribution

Exhibit B Case Summary Page

CASE SUMMARY PAGE

Identity

Current Licenses

Allegations

Summary

Not for Distribution

Not for Distribution

Chapter 8—Examination Introduction

A. Background

History

The market conduct examination process began in 1969 as a new form of examination, first in Illinois, followed in 1972 by Missouri and New Hampshire. The McKinsey report, funded in 1973 by the NAIC, pointed out that financial examinations were too lengthy and too infrequent to prevent insolvencies. In fact, there were many financial examinations that did not prevent an insolvency, but rather, provided only a post-mortem on how the company “went under.” The McKinsey report suggested that a new examination format be developed, one that is more frequent and timely. The NAIC A6 Subcommittee adopted this concept in 1974 with the hope that these new examinations would help to either impede and/or prevent company failures.

In 1979, the U.S. General Accounting Office (GAO) released a report titled, “Issues and Needed Improvement in State Regulation of the Insurance Business.” Among the criticisms in this report, the jurisdictions were cited for failing to systematically analyze complaint information, to use complaint information in the examination process, to exchange complaint information and to make complaint summaries available to the public.

In response to this report, the jurisdictions, through the NAIC, established various task forces and subcommittees which were charged with reviewing the criticisms of the GAO and recommending the appropriate action needed to “repair” these problems. In 1981, the EX3—Market Conduct Surveillance Task Force was created and charged with “studying and making recommendations regarding efficient use of state resources in monitoring industry market conduct performance with respect to both ongoing monitoring activities and examinations.”

The focus of these new examinations would not be “macroscopic” as are financial examinations but rather, microscopic to geographic area, process or line of business. This new examination would detect management errors of small impact initially, but with possible damaging long-term effects.

Early on, it became evident that the jurisdictions needed to develop a means of tracking the complaints they received, and also of comparing those complaints to complaints received by another jurisdictions. Issues discussed by the NAIC task forces included the development of a database for the jurisdictions should report the data, how to compile and analyze the data, the development of a market share run by jurisdiction and by line and the development of a complaint index by the use of market share and complaint share.

In time, many jurisdictions developed market conduct examination programs. These programs would come to rely upon the complaint information. The 1989 minutes of the NAIC reflect that “[T]he development of an online complaint database of all lines of insurance readily accessible to the jurisdictions is the sine-qua-non for the competent scheduling of market conduct examinations. If the jurisdictions are to adequately monitor the marketplace and sales abuses, the NAIC must give high priority to the implementation of such a database.” By mid-1991, the NAIC Complaints Database System (NCDS) was available.

The jurisdictions took the criticisms of the GAO study to heart. Much has transpired since the 1979 GAO report. Constant improvements and revisions by the jurisdictions and the NAIC have helped to focus attention on the important role that market conduct examinations serve to the consumer, as well as to the industry.

One of the early mandates for regulators was to provide “a better job of early detection of problem companies.” The complaint database helped to fill this void. In the 1989 minutes, a commissioner was quoted as saying the “NAIC needs to address issues of public relations and the demonstrated lack of trust that the consuming public has for the insurance industry.” The need was recognized that jurisdictions had to do more to “hold companies responsible for accurate and clear communication to the consumers in language that they can understand and act upon.”

Market Conduct Examiners

An insurance department must establish minimum educational and experience requirements for all persons (professional employees and contract staff) involved in market conduct examinations that are commensurate with the duties and responsibilities of the position. The insurance department should adopt a policy requiring the professional development of staff through job-related post-secondary courses, professional programs, continuing education courses and/or other training programs. Persons involved in market conduct programs may need to be periodically evaluated by the insurance department to ensure that job duties and responsibilities are being conducted in a professional manner.

Various jurisdictions have examiners that are either insurance department employees, self-employed, exclusively or primarily as insurance examiners, on a contractual basis with an insurance department, or employees of a firm engaged exclusively or primarily as an insurance examiner, on a contract basis with one or more insurance departments.

The Examiner-in-Charge (EIC) is responsible for managing the examination, functioning as the coordinator with the company, and along with other examiners that complement the EIC's skills. The examination team should have the appropriate expertise to ensure it is capable of fully conducting an efficient examination. This means, for example, that at least one team member has claims expertise and one has underwriting expertise, etc. In some lines of business it may also be useful to have an advertising/sales and contract language expert as part of the examination team. For managed care examinations it may be useful for one team member to have experience in health care management or managed care. As a reminder, the focus of any level of a program should be upon the function of that examination team and not necessarily the number or skills of examiners.

A market conduct examiner may obtain on-the-job training from the assigned EIC and other field examiners. While experience, a strong curriculum and continuing education are essential, a qualified examiner must also have specialized knowledge of specific lines of business. This knowledge may come from prior employment in the regulated industry or from participation in extensive and specialized field examinations.

Specialization in marketing, product development, underwriting, claims management, policy language development and rating methodology are all vital parts of conducting an examination. Furthermore, as the industry changes, so must the examiner. The examiner must become knowledgeable and remain knowledgeable through continuing education programs about a wide range of complex processes.

Since 1989, the NAIC has offered education programs to its members and state insurance department staff. In late 2006, the NAIC Insurance Regulator Professional Designation program was launched. Designed to provide state insurance regulators at all state levels with an opportunity for professional growth through completion of specific educational requirements, the NAIC-sponsored professional designation recognizes a regulator's expertise in insurance regulation.

Four NAIC designations are available: Associate Professional in Insurance Regulation (APIR), Professional in Insurance Regulation (PIR), Senior Professional in Insurance Regulation (SPIR) and Investment Professional in Insurance Regulation (IPIR). Additional information on the NAIC Insurance Regulator Designation Program is available at www.naic.org/education_designation.htm.

The Insurance Regulatory Examiners Society (IRES) has recognized the designations of Accredited Insurance Examiner (AIE) and Certified Insurance Examiner (CIE) as an indicator of an experienced market conduct examiner. The course of study to be completed for these designations approaches the course work of an MBA with an insurance emphasis, taken on a self-study basis. There are two paths available in both the AIE and CIE designations: life/health and property/casualty. Regardless of which path is taken, courses include business law, accounting, management, business statistics (emphasis on sampling techniques), economics, product development and marketing methods.

To earn an AIE, an applicant must successfully complete the required course work under a single education path, be an IRES General member in good standing, and meet specific employment and experience requirements. To earn a CIE, applicants must have previously earned (or meet the educational requirements to earn) an AIE under either the Property-Casualty Educational Path or a Life-Health Educational Path, complete the required course work following the same path taken to earn the AIE, be an IRES General member in good standing, and meet specific employment and experience requirements. Regulators and insurance industry professionals may also obtain a Market Conduct Management (MCM) or Advanced Market Conduct Management (AMCM) designation from IRES by successfully completing its designated MCM and AMCM courses.

Specialized functional areas that an examiner must be cognizant of include sales and advertising, market distribution, underwriting, rating, statistical coding, claims management (including adjusting) and, in managed care, appeals processes, service areas, sales methods and provider relations. A competent examiner needs to obtain a great deal of expertise in many areas.

As with all industries today, there is an increasing need for and use of computer applications. ACL, for example, is a valuable asset for market conduct examiners. However, the use of this and other computer programs is only applicable if there is a thorough knowledge of the line of business being examined, as well as an understanding of the correct variables that can be used in order to obtain the files needed for review.

Examinations

Some aspects of a market conduct examination can be accomplished at an insurance department, while others cannot. An examiner will often need to delve deeper into what is actually occurring in the marketplace, and one way to do this is through an on-site examination. On-site reviews provide a means to ascertain how a company is actually underwriting its risks, and may detect other underlying problems. The examiner should independently identify these practices, and not rely upon how the company says they are underwriting the risks or conducting their business.

While conducting an on-site examination, the examiner will be able to, through the use of sampling, review policies issued and declined, review claim handling practices and directly determine how and why specific cases were handled as they were.

Critics of market conduct examinations often allege that examinations are too technical or dwell on an individual problem rather than a company's general business practices. There is, however, another side to that allegation. Technical issues—such as carelessness in the use of policy forms or vagueness about licensing or confusion about which rate plan to use—could indicate that a company has inadequate controls over its products and processes. Such business practices could, in turn, lead to consumer dissatisfaction, which leads to an increase in consumer complaints, which can trigger the need for a market conduct examination.

Noncompliance that generates complaints about policy language, claim treatment or policyholder service can lead to major management concerns, as well as financial insolvency. While identifying potential “problem” companies, a market conduct examination and any resulting corrective measures can also reverse bad practices and help companies compete properly.

B. Scope

An effective market conduct examination program incorporates four basic elements: (1) a system for scheduling examinations; (2) examination procedures tailored to the nature of the examinee's operations; (3) timely, action-oriented reporting; and (4) cooperation and coordination among the jurisdictions.

One of the insurance department's major responsibilities is to evaluate compliance by insurers and other regulated entities with statutes and regulations. The major market conduct examination areas are: (1) company operations/management; (2) complaint handling; (3) marketing and sales; (4) producer licensing; (5) policyholder service; (6) underwriting; and (7) claims.

An examination can be most effective if it focuses on general business patterns or practices of an examinee. While not ignoring random errors, the market conduct examinations should concentrate on an insurer's general practices.

Examination of underwriting, policyholder service, claims, marketing and sales, producer licensing and complaint handling is conducted to determine factually what the company is engaging in as a business practice. The findings of the examination should be reported in a factual, unbiased manner, and should be written in a form that relates directly to statutory and regulatory standards or requirements. The examining state's insurance commissioner will then decide what action, if any, is appropriate.

The incidence of unlawful market practices varies considerably by line of business, class of risk, marketing approach and geographical area. For example, misleading advertising is more likely a problem in some lines than in others. Rating errors are likely to be more prevalent for a complex line of business, such as commercial multi-peril policies, than dwelling fire policies. Claim practices may reflect the influence of a particular regional claims manager and, therefore, be a local rather than a company-wide problem.

In examining a company's market practices, primary reliance is placed on information developed by the staff members who process complaints and perform complaint analysis, who review and approve rates and policy forms, who regulate producers (agents and brokers), information from other jurisdictions and other indicators (e.g., financial examinations).

An insurance department is also concerned with ensuring that a climate of competition continues to exist within the insurance marketplace. A jurisdiction's unfair trade practice act prohibits practices that involve restraint of trade, or practices tending to foster monopoly—such as unfairly discriminatory underwriting practices—much as federal antitrust law applies to other industries. Improper activities of this type should be investigated in all branches of a regulated entity in those phases of operations where such practices could occur.

Each jurisdiction should exert every effort to ensure that market conduct examinations are conducted in the most efficient and meaningful manner. Insurance regulators realize that if the system of state-based regulation is to function effectively, cooperation among jurisdictions is important. Although each jurisdiction is responsible for examining company practices in its own jurisdiction, to avoid duplication of effort and to make use of information developed, interstate cooperation is important. Whenever an examination is scheduled in an office of a company that conducts business in more than one jurisdiction, the jurisdiction calling the examination is encouraged to share its findings with other states in accordance with the provisions of this handbook.

The NAIC has developed and continues to expand its electronic Market Information Systems (MIS) databases to facilitate the sharing of information between jurisdictions. Use of the MIS databases and other services will enhance the effectiveness of market conduct examinations. Each jurisdiction is encouraged to share its examination schedule and findings with other NAIC members through use of the NAIC Market Action Tracking System (MATS).

MATS allows market conduct examiners and analysts to communicate schedules and results of examinations and other market actions. MATS allows for the calling of market conduct examinations and non-examination inquiries and market actions, in addition to providing easy access to complete information about the entities involved in the action. MATS can be used to view or update market actions for a specific entity or a number of entities. Information in MATS is maintained for both ongoing and completed market conduct actions. Market actions captured in MATS are: comprehensive examinations, targeted examinations, focused inquiries (typically inquiries made of multiple market participants), and other non-examination regulatory interventions. MATS also provides notification of new and updated action information via the Personalized Information Capture System (PICS).

The Financial Examination Electronic Tracking System (FEETS), which became available in July 2011, allows state insurance regulators to follow the progress of individual and group financial examinations. While MATS provides historical information regarding combined (market and financial) examinations, FEETS is used exclusively for financial examinations.

C. Overview of Examination Methods

Many jurisdictions perform some type of a market conduct function or examination procedure. The common element among all jurisdictions performing market conduct examinations is an evaluation of compliance with the jurisdiction's requirements for consumer protection. However, the types of examinations being performed and the definition given to market conduct varies from state to state.

The content and method of examinations appear to be guided more by each jurisdiction's approach to marketplace involvement, rather than from some form of traditional market conduct method. The ultimate goal of a market conduct examination should be to identify and correct an insurer's operating practices that are in conflict with contract provisions, state laws, rules, regulations, or upon orders of the commissioner. Contract provisions or other actions by an insurer generating consumer dissatisfaction or complaints that are not addressed in state laws, rules or regulations should be noted for potential legislative action. Subjects regularly included in an examination are operations/management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting and claims.

Issues such as proper and prompt payment of claims, fair application of underwriting standards and truthful presentation of all policy provisions are also common areas of inquiry. A jurisdiction's market conduct function may include examination of these areas, either separately or combined. A jurisdiction's approach to market conduct may also be dictated by the extent of its resources. Full comprehensive examinations, limited-scope target examinations and the full range of variations in between are all effective regulatory tools.

The *Insurance Department Resources Report-Volume One*, an annual survey of NAIC member jurisdictions, provides data regarding staffing; budget and funding; examination and oversight of insurance producers; and consumer services and antifraud. This state-by-state comparative report contains an array of valuable statistics that includes the size of budget and staff, annual budgets, revenues collected, number of insurers and producers, and the number of consumer complaints filed. The IDRR survey of 2014 data revealed that more than 65% of all jurisdictions perform market conduct reviews or examinations. Market conduct examiners are utilized by more than half of the jurisdictions. Jurisdictions may also use financial examiners, contract examiners or part-time market conduct examiners, who often also perform other functions as part of that insurance department's internal staff. Due to various forms of resource limitations, permanent full-time market conduct personnel are not always utilized.

The best approach to adequately monitor the insurance marketplace is to utilize a combination of standard tested market conduct procedures in such a manner that recognizes a jurisdiction's own special needs and concerns. There is no substitute for competent, well-trained, full-time market conduct examiners. It is essential that jurisdictions develop comprehensive training for examiners. Examiners particularly need sufficient current information on statutory and case law in order to identify relevant issues at the planning stage of the examination and, if necessary, to adjust examination procedures in response to new developments. This handbook, while stressing this goal, is designed to be of assistance to all jurisdictions and levels of personnel involved with the market conduct process.

The use of computers enhances an examiner's ability to perform sampling, record examination findings, produce a report of the findings and expedite insurer related procedures. Access to the NAIC databases and use of email allows for the transfer of information, as well as easy access to insurers' financial and market data. Numerous information systems are available, including the Market Action Tracking System (MATS), which provides summaries of market action findings that can enhance examination procedures. The NAIC supports the use of audit software programs that can have a dramatic impact on improving the productivity, efficiency and accuracy of the examination process.

D. Confidentiality

The issue of confidentiality is significant in the successful execution and completion of any examination performed by a state insurance department. Subject to a state’s examination law, an examiner has the authority to view regulated entity information. In the course of examining a regulated entity, an examiner reviews, or has the opportunity to review various types of information, e.g., policyholder, applicant, claimant and insured nonpublic health or financial information and proprietary company data.

The work papers an examiner creates and maintains during an examination may be considered confidential, if they contain or are based upon confidential data. It is therefore essential that not only examiners, but all insurance department regulators involved with an examination treat confidential regulated entity data, examination work papers and other work products created during the examination process as confidential documents, pursuant to their state requirements.

Definition of Confidentiality

For the purpose of this handbook, confidentiality can be defined as “the nondisclosure of certain information except to authorized person(s) and the prevention of unauthorized access, use and distribution of that information.”

Scope

The broad term “information” can be defined as any and all data in any form, whether maintained in hardcopy, a computer or other electronic device or media. Confidential information may be provided to state regulators in written format, electronically, or even verbally. Examiners need to be aware of the format in which confidential information is presented, and take necessary precautions to prevent unauthorized access, disclosure, reproduction and distribution of that information.

Examples of Confidential Information

Ultimately, state law and federal law will designate what materials are considered confidential. Examples of confidential information relevant to insurance regulators include, but are not limited to:

- Third-party information (e.g. underwriting files and claim files) provided by a regulated entity that is being reviewed by department of insurance personnel or a third-party contractor performing services on behalf of a department of insurance, including regulated entity attorney-client communication or attorney work product;
- Regulated entity proprietary information (e.g. company procedural manuals, marketing materials, underwriting guidelines, internal audits, self-evaluations, compliance plans, best practices organizations membership programs, etc.); and
- Documents or other records created, produced, obtained by or disclosed to examiners and exchanges of information between state insurance department personnel, including department attorneys and examiners regarding the review of a regulated entity. This type of communications may include communication with representatives of other state insurance departments.

What Makes Data Confidential?

The type of data under review by an examiner may be considered confidential under federal and/or state law. Many jurisdictions have either promulgated the *Model Law on Examinations* (#390) or created a substantially similar statute or law, which sets forth confidentiality provisions of documents, including work papers, created, produced or obtained by or disclosed to an insurance commissioner or any other person in the course of any market conduct actions. Although the report, once adopted and with the passage of the required time period, becomes public, under the Model, the underlying work papers remain confidential. The *Market Conduct Supervision Model Law* (#693) also addresses this issue and specifically references the confidentiality of documents obtained or produced as part of the market analysis process. However, not all states have adopted the NAIC models and ultimately, examiners need to be aware of applicable state statutes, rules and regulations regarding confidentiality.

Federal privacy rules issued under the federal Health Insurance Portability and Accountability Act (HIPAA) address confidentiality of protected health information, which includes information regarding the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the payment for the provision of health care to an individual. Examiners should be familiar with HIPAA and how it impacts the conduct of examinations.

The confidentiality of information related to substance abuse and chemical dependency treatment is protected by section 543 of the federal Public Health Service Act, and its implementing regulation, 42 CFR, Part 2. The federal Gramm-Leach Bliley Act, (GLBA) which became law in 1999, was enacted to ensure that financial institutions protect customers' nonpublic personal financial information. Even individuals who are not technically "customers" of an insurance company, for example, individuals who have completed and submitted an application for insurance but were denied coverage, are also protected under GLBA.

In addition to these federal laws, many states have enacted state privacy laws (informed consent laws) that place further protections on privacy of health information. Examiners should not only review all applicable federal laws, but also review applicable state laws, which may be more restrictive than the provisions contained in federal law. In addition, examiners should note that the provisions contained in state informed consent laws and the federal HIPAA law do not prohibit state insurance department access to a regulated entity's records.

Examiners need to also be aware of what circumstances (if any) data can be disclosed to third parties. For example, confidential information regarding abuse, neglect, or domestic violence may only be disclosed under specified circumstances.

Maintaining Confidentiality

An examiner and all other state insurance regulators to whom confidential information has been entrusted, have an ongoing obligation to maintain the confidentiality of nonpublic personal information provided by a regulated entity's applicants, insureds, policyholders and claimants.

Proprietary company procedural manuals, marketing materials, underwriting guidelines, internal audits, self-evaluations, compliance plans, best practices organizations membership programs, etc. may be considered confidential by the regulated entity, and the examiner also has a duty to prevent unauthorized disclosure of such materials.

The pre-examination packet or coordinator's handbook provided to the regulated entity prior to the onset of an examination should outline state insurance department policies and procedures for maintaining the confidentiality of documentation reviewed during an examination. Providing confidentiality provisions in this fashion ensures that state insurance department confidentiality procedures are well documented and provides for consistency of the handling of examination work papers, upon which the examination findings will ultimately be based.

Level of Confidentiality

Examiners should be aware of applicable state and federal confidentiality statutes, rules and regulations, and referral of any questions regarding confidentiality to department of insurance counsel is encouraged.

General Guidelines for Maintaining Confidentiality of Data

The following guidelines for maintaining confidentiality of data apply to examiners, state insurance department personnel and third-party contractor(s) performing services on behalf of a department of insurance. These guidelines include, but are not limited to:

- As part of the examination process, examiners should be mindful not to disclose, publish or disseminate confidential information and agree to use their best efforts and take all reasonable steps to protect such confidential information from unauthorized reproduction, publication, disclosure or distribution. If state law addresses confidentiality of examination work papers, it is generally not necessary to enter into confidentiality agreements between insurance department employee examiners and the entity being examined. Any requests to enter into such agreements should be reviewed by insurance department counsel. In the event a contract examiner is being utilized, insurance department counsel should review applicable law and any contracts to determine the best course of action for protecting the confidentiality of regulated entity information.
- Examiners should be aware that it may not be appropriate to discuss, either verbally or in a written fashion, details of specific areas of an examination with any regulated entity representative. Inappropriate discussion with individuals not authorized to receive sensitive information may have a harmful affect on the company and on the examination itself. When in doubt, an examiner should exercise discretion and contact a member of senior management when discussion of sensitive information is necessary;
- Applicable state insurance department information security policies should remain in effect when using or accessing state insurance department computer resources or company information systems from any remote location;
- Examiners should ensure that hard copies of all confidential data obtained from a regulated entity are secure from unauthorized access. All physical copies of work papers drafted in the course of an examination should also be kept in a secure environment. Examiners should be aware of any statutory limitations regarding access to other types of sensitive information, such as information concerning medical test results (e.g. HIV and other laboratory test results), relating to domestic violence, and regarding mental health, alcohol and substance abuse and treatment thereof. Examiners should maintain medical records and records relating to sensitive information under lock and key, with access granted to a limited number of individuals. In any case, with any on-site examination, the department of insurance or the Examiner-In-Charge (EIC) should require a room with a lock, or at a minimum, locking file cabinets to store confidential information.
- Limiting unauthorized access to confidential data includes limiting access to all forms of electronic, verbal and written confidential information stored and disseminated via hard drives, laptops, personal computers, electronic mail, the Internet, network servers, telephone communications (both land line and cellular), facsimile machines, photocopiers, scanning devices, digital images and videography, and electronic equipment, such as peripheral media read/write storage devices (CDs, diskettes, flash drives, memory sticks, thumb drives, etc.);
- Examiners should assume that no storage or transmission of confidential or sensitive data via any of the above methods is considered secure; instead, adequate encryption of data is required and secure access passwords should be established for all confidential documents and changed on a regular basis. Password-protected screensavers should also be employed and used;
- During an examination, and upon the conclusion of an examination, all written confidential material which will no longer be used should be handled in accordance with state record retention laws. If permitted by state law, documents to be destroyed should be disposed of in accordance with the document destruction procedures established by the state; and

- When an examination is completed and the information required to be retained under the particular state's retention laws has been properly saved and secured, all electronic hardware used in the course of the examination, including hard drives, laptops, personal computers, voice messaging systems, facsimile machines, photocopiers, scanning devices, digital cameras and audio/visual recording devices and peripheral read/write storage media (CDs, diskettes, flash drives, memory sticks, thumb drives, etc.) should be sanitized so that recovery of confidential information is not feasible.

Privilege

There are instances where examiners may request data and have procedures and laws in place to protect the confidentiality of the information; however the regulated entity resists providing the information claiming a "privilege." Information that is privileged is generally not subject to the discovery process in court proceedings, nor can it be subpoenaed; however, if the information is not protected and is disclosed to someone, the privilege may be waived. These privileges are established by common law, statutes, court rules and judicial decisions.

Some privileges which may be asserted include:

- Attorney-client privilege: Protects the actual communications between the client and lawyer and only extends to information given for the purpose of obtaining legal advice or representation. The information is generally not protected if it is available from another source and must be claimed and not waived by the client;
- Attorney work product privilege: "Tangible and intangible material which reflects an attorney's efforts at investigating and preparing a case, assembling of information, determination of the relevant facts, preparation of legal theories, planning of strategy, and recording of mental impressions." *Young v. Grand Jury Subpoena*, 622 F.2d 933, 935 (1979); and
- Self-critical analysis or self-evaluative privilege: A more recent common law and in some states, statutory privilege designed to protect qualifying internal self-evaluative documents from discovery by adverse parties. Self-critical analysis can be broadly defined as any critique by a person or entity of its own operations, policies, or processes. Note: "The Privilege of Self-Critical Analysis," 96 HARV. L. REV. 1083 (1983). Many courts have refused to acknowledge the privilege or have applied different criteria for determining when it protects the self-evaluative documents.

If the regulated entity cites a privilege as a reason to deny access to certain records requested by the examiner, the examiner should request the entity's position in writing and consult with appropriate insurance department legal staff.

E. How to Use This Handbook

Intended Use

The original *Market Conduct Examiners Handbook* was developed as a collaborative effort by jurisdictions actively involved in the market conduct examination process. In 2005, the *Market Analysis Handbook* and the *Market Conduct Examiners Handbook* were merged into the *Market Regulation Handbook*. The handbook was designed to reflect established practices and to assist each jurisdiction in developing its own market conduct examination procedures. The NAIC model statutes and regulations were selected as the basis for the handbook, because insurance statutes in many jurisdictions have evolved from NAIC model laws.

This handbook is only a guide and should be used by each jurisdiction as a tool for developing jurisdiction-specific procedures and guidelines. To effectively use this handbook, it is recommended that each jurisdiction closely review the handbook to determine those standards that reflect the statutes and regulations of the given jurisdiction and those that do not. Each jurisdiction should develop its own procedural manual reflecting audit procedures based on the standards and methodology set forth in this handbook and modified to meet the specific requirements of the laws of that jurisdiction.

This handbook is designed solely to provide assistance to each jurisdiction in developing effective and consistent examination methodology. It is not intended that examiners apply any requirements to the examination process beyond the laws of their respective jurisdictions.

It is also important that each jurisdiction communicate to its market conduct examiners the intent and scope of any planned market conduct examination and its examination priorities within the scope of the examination. This includes direction regarding in which areas examination efforts are to be concentrated, and what standards and criteria are to be considered within any particular subject area. For example, a jurisdiction may wish to concentrate on determining compliance with a limited number of key components of compliance within a particular regulation, rather than every possible violation, whatever its significance. Specific direction provided by a jurisdiction will serve to sharpen an examination's focus on regulated entity compliance and also conserve jurisdiction examination and company resources.

Updating the Handbook

This handbook is updated and released on an annual basis. Updates to the handbook that are adopted periodically during the year by the Market Regulation and Consumer Affairs (D) Committee will be posted on the NAIC website. Instructions for accessing the updates on the NAIC website are located at the front of the most recently published *Market Regulation Handbook*.

Standards

Chapter 16 contains examination standards that are relevant to nearly all types of examinations. Chapters 17 through 28 contain standards that are specific to various product lines and specialized entities.

F. Disclaimers

This handbook was designed primarily as a guideline for regulatory agencies to use in developing their own procedures for performing market conduct examinations. It does not reflect policies or procedures that are required to be implemented by any jurisdiction. To the extent possible, jurisdictions are encouraged to follow the standards established in this handbook. The text of this handbook becomes the procedure or policy of a given jurisdiction only after it has been adopted by that agency. Deviations from this handbook by an agency to accommodate the specific requirements of its own jurisdiction should not be construed as a failure of that agency to implement adequate examination procedures.

G. Examination Techniques and Handbook Revisions

The insurance marketplace is dynamic. Examination techniques are constantly changing in order to effectively regulate specialized insurers, new insurance products, methodologies and marketing techniques. Regulators are therefore encouraged to share applicable new examination techniques and tools with other jurisdictions and with the NAIC.

Chapter 9—Examiner Qualifications and Compensation

A. Classifications

Classifications of Examiners

The following classifications are recommended (depending on staff levels):

- Associate Examiner;
- Insurance Examiner;
- Senior Examiner;
- Examiner-in-Charge; and
- Administrative Examiner

B. Qualifications

Examiners Generally

It is recommended that an Associate Examiner, Insurance Examiner, Senior Examiner, Examiner-in-Charge, or Administrative Examiner shall be:

- a. An insurance department employee;
- b. Self-employed, exclusively or primarily as an insurance examiner, on a contract basis with an insurance department; or
- c. An employee of a firm engaged exclusively or primarily as an insurance examiner, on a contract basis with one or more insurance departments.

Associate Examiner

It is recommended that an Associate Examiner shall be an entry-level examiner who has not yet met the qualifications for Insurance Examiner.

Insurance Examiner

It is recommended that an Insurance Examiner shall have completed at least two of the eight courses required for certification by the Insurance Regulatory Examiners Society (IRES) as eligible to hold the designation of Accredited Insurance Examiner (AIE); or meet the non-curriculum conditions required by the IRES accreditation program to be eligible to hold the title of AIE or Certified Insurance Examiner (CIE), including but not limited to IRES experience requirements, IRES continuing education requirements, compliance with IRES Code of Professional Conduct and Ethics and payment of IRES fees relating to maintenance of continuing certification.

Senior Examiner

It is recommended that a Senior Examiner shall be certified by the Insurance Regulatory Examiners Society (IRES) as eligible to hold the designation of Accredited Insurance Examiner (AIE) or Certified Insurance Examiner (CIE); or meet all conditions required by the IRES accreditation program to be eligible to hold the title of AIE or CIE, including but not limited to IRES experience requirements, successful completion of required IRES curriculum, IRES continuing education requirements, compliance with IRES Code of Professional Conduct and Ethics and payment of IRES fees relating to maintenance of such continuing certification.

Examiner-in-Charge

It is recommended that an Examiner-in-Charge (EIC) shall be certified by the Insurance Regulatory Examiners Society (IRES) as eligible to hold the designation of Certified Insurance Examiner (CIE); or meet all conditions required by the IRES accreditation program to be eligible to hold the title of CIE, including but not limited to IRES experience requirements, successful completion of required IRES curriculum, IRES continuing education requirements, compliance with IRES Code of Professional Conduct and Ethics and payment of IRES fees relating to maintenance of such continuing certification. An Examiner-in-Charge must be a Senior Examiner and have the responsibility of overseeing the exam site of an examination.

Administrative Examiner

It is recommended that the Administrative Examiner must have the qualifications of an Examiner-in-Charge and have the responsibility of overseeing more than one team of examiners concurrently. Additional responsibilities may include, but are not limited to, examination scheduling, identifying target examinations, pre-examination conferences, review and approval of examination reports, ensuring compliance with examination requirements, review of company response to report recommendations, handling rebuttals, coordination of market conduct functions with other divisions and jurisdictions and handling personnel matters.

C. Minimum Qualifications of Multistate Examiners

It is recommended that an examiner shall only be eligible to participate in a multistate insurance examination if: employed or contracted with an insurance regulatory agency; have at least two years of insurance regulatory examination experience; and preferably be certified as either an Accredited Insurance Examiner (AIE) or Certified Insurance Examiner (CIE) by the Insurance Regulatory Examiners Society (IRES).

D. Conflict of Interest for all Examiner Classifications

No examiner shall either directly or indirectly have a conflict of interest or be affiliated with the management of or own a pecuniary interest in any company subject to examination. This statement should not be construed to preclude an examiner from being a policyholder or claimant under an insurance policy; a grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity, if done under customary terms and in the ordinary course of business; an investment owner in shares of regulated diversified investment companies; or a settler or beneficiary of a blind trust into which any otherwise permissible holdings have been placed. These conflict of interest guidelines shall not prevent the occasional use of independent professionals for consulting purposes.

E. Examiner Compensation

Regulators may access suggested examiner compensation information via myNAIC at the Market Regulation Handbook link on the StateNet home page. The examiner compensation information is located in the Market Regulation Handbook Reference Documents section of the web page. Non-regulators may access the examiner compensation information on the Market Conduct Examination Standards (D) Working Group web page which is found at www.naic.org >> **Committees** >> **Committees, Task Forces & Working Groups** >> **Market Regulation and Consumer Affairs (D) Committee** >> **Market Conduct Examination Standards (D) Working Group** >> **Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

Salary

The rates posted on the above-referenced web page are suggested rates and shall be subject to provisions in any jurisdiction governing salaries and expenses of insurance examiners. Necessary exceptions or clarifications should be prepared by the jurisdiction employing or contracting the examiners and should be consistent with the intent of this policy.

The daily rate is to be computed beginning at the time the examination is initiated and terminating upon completion of the examination or the examiner's active participation therein and to include actual travel time. If air travel is used, only one day's travel time will be authorized. If a motor vehicle is used, travel time allowed shall be computed at the rate of not less than 400 miles per day. To determine travel time for an examiner who uses a motor vehicle, divide actual mileage by a minimum of 400 miles, which results in the number of travel days.

No salary charge shall be made for days on which examiners are absent (except as noted in the paragraph above), provided the company is open for the normal transaction of business.

If the examiner is assigned to an exam and available for work on any day that the company has closed for business, it is recommended that salary shall be allowed for that particular day.

Expense Reimbursement

Expense reimbursement is to be computed for the time beginning when the examiner is to report for duty and terminating on completion of active participation and is to include travel time.

If the examiner is assigned to an exam and available for work on any day that the company has closed for business, it is recommended that expense reimbursement shall be allowed for that particular day.

Expenses shall be paid on a basis consistent with the per diem rates prescribed by the Office of Governmentwide Policy (OGP) for reimbursement of subsistence expenses during official travel. These rates for the following expense categories are published annually by the U.S. General Services Administration (GSA). Insurance departments may obtain these rates at www.gsa.gov.

- Lodging;
Reimbursement should be on the basis of actual expense (receipts required) or consistent with guidelines accepted by the supervising jurisdiction.
- Meals;
Reimbursement should be on the basis of actual expense (no receipts required) or consistent with guidelines accepted by the supervising jurisdiction.
- Travel; and
 - To Site
Reimbursement should be on the basis of (a) airfare costs (receipts required); or (b) actual to site mileage traveled, using the current Internal Revenue Service per mile rate.
 - On-Site
Reimbursement shall be provided for local travel, including rental car usage where reasonably appropriate.
 - Travel Frequency
It is recommended that travel reimbursements be authorized to the examiner's domicile every other weekend. Expenses will be paid based on the lesser of airfare or mileage. This reimbursement is made in lieu of the per diem allowance. It is understood that the travel will be done with a minimum amount of work time lost.
- Incidental.
Reimbursement should be on the basis of actual expense, yet consistent with guidelines accepted by the supervising jurisdiction.

Payment of Expenses

Payment of examiner expenses and supporting documentation for examiner expenses will be in accordance with the laws and fiscal procedures of the examiner's home jurisdiction.

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Chapter 10—Types of Examinations

Market conduct examinations can be conducted on the following types of insurers: life, accident and health, and property/casualty insurance companies, as well as health maintenance organizations, health service corporations, third-party administrators, title insurers, statistical reporting agencies, affiliates, producers and all other entities licensed by the insurance department. These examinations are conducted to ensure (1) equitable treatment of policyholders; and (2) compliance with applicable statutes and regulations.

While market conduct examinations can fall into several categories, most are defined by variables such as the reason, scope and method of conducting the examination. Most jurisdictions have established procedures for when to perform an examination, as well as for the type of examination that is necessary, based upon the needs of the department and the marketplace.

A. Types of Examinations

Routine Examinations

Certain jurisdictions have statutory requirements that examinations be performed at regular intervals, either in conjunction with financial examinations or separately. Examinations performed on a regular basis may detect problems unrecognized through the usual indicators. Routine examinations usually allow for a minimum of 30 days' notice for the preparation of materials by the company. If circumstances dictate that greater or lesser notice is required, discretion should be permitted to the jurisdiction in charge.

Comprehensive Examinations

Comprehensive examinations are full-scope examinations that generally involve a review of all of a company's business practices. A comprehensive examination would include a review of the company's operations/management, complaint handling, marketing and sales, advertising materials, licensing, policyholder service, underwriting and rating, nonforfeitures, policy rate and form filings, claim handling and other state-specific requirements.

Additional or alternative areas may be included for an examination of a company conducting business in specialty areas; for example, health insurance entities. An examination of a health insurer may also include a review of its grievance procedures, network adequacy, quality assurance and improvement, provider credentialing and utilization review practices.

Target Examinations

Target examinations are a focused examination reviewing either a specific line of business or a specific business practice, such as underwriting, marketing or claims. Prompt-pay examinations are another example of a target examination.

Target examinations are specific as to the area of concern and may be called by any jurisdiction at any time, with or without notice to the insurer as circumstances dictate. In the event of a target examination, it is recommended that a review of the company's current complaints, as well as a review of its operations/management area be conducted.

Limited-Scope Examinations

Limited-scope examinations usually involve alternative examination methods available other than, or in addition to, the traditional on-site market conduct examination.

Examples of a limited-scope examination are as follows:

- **Interrogatories**—A compilation of written questions regarding a specific subject, procedure or product submitted to the company in order to obtain information. Verification of the information is accomplished by a review either in-house or during an on-site examination.

- Re-examinations or compliance examinations—These types of examinations confirm compliance with a previously issued order of the director/commissioner or other administrative action and serve to verify that the company has initiated corrective actions for adverse findings detailed in a prior examination report.
- Desk examinations—Used as a means of follow-up on an issue found during an examination that did not rise to the level of a clear violation, but still caused the insurance department some concern.
- Small company examinations (small is defined as county mutual companies, fraternal organizations or a company that has written a predetermined premium volume)—An opportunity to review a small company's practices when the expense and time required for a traditional examination might not be warranted. Because of the potentially smaller field sizes, this is an opportunity to use ACL and other computer programs to conduct portions of the review.

B. Examination Sequence

Initial Examination

An initial examination is the first time a jurisdiction has conducted an examination of an entity. Initial examinations are also used to identify the examination of an entity where a significant amount of time has lapsed since the jurisdiction previously examined the company.

Subsequent Examination

A subsequent examination indicates that the entity was previously examined by a jurisdiction. This term is most commonly used by states that conduct routine examinations.

Re-Examination

Re-examinations are follow-up examinations that are based on specific issues. Re-examinations are often shorter in duration than an initial or subsequent examination. The focus of re-examinations is to determine company compliance with previous market conduct examination reports, recommendations or administrative orders.

C. Jurisdiction of the Examination

Examinations are also categorized based on whether there are one or more states involved in a coordinated examination.

Single State Examinations

Most market conduct examinations are single state examinations. As the name implies, there is only one jurisdiction involved in the examination.

Multistate Cooperative Examinations

The concept of zone examinations has not traditionally been considered relevant for market conduct purposes. The reason generally given is that although a company may be solvent in all jurisdictions, if found solvent in any one, the market behavior in one (or even within one) jurisdiction can significantly vary from behavior present in another jurisdiction. In addition, each jurisdiction has its own statutes and regulations that vary widely, thus making zone examinations usually inappropriate.

While these concerns remain true, many of the defined unfair trade acts and practices, as well as unfair claims acts and practices are similar from jurisdiction to jurisdiction. These similarities may form the basis for the states to agree to perform multistate cooperative examinations utilizing common agreed-upon standards. Such an examination could form a baseline upon which other jurisdictions could reduce the scope of additional examinations and, thus, the duration of such examinations.

There are times when several jurisdictions have a joint interest in the market performance of a company and their collective concerns may be best met through a cooperative examination of that company. In such a multistate cooperative examination, it is not relevant which zones may be involved. The jurisdictions participating may agree to prepare a single joint report or prepare separate formal reports for each jurisdiction.

Multistate cooperative examinations may also be inappropriate when a company's behavior is specific to one jurisdiction. A multistate examination may also be inappropriate when the laws specific to one jurisdiction or a few jurisdictions require extensive interpretation by the regulating authority in order to be functionally evaluated.

D. Method of Examination

There are a variety of ways an examination can be conducted by a state. A typical examination may include one or more of the following methods.

On-Site Examination

On-site examinations are conducted on the premises of the company. Most of these types of examinations are conducted at an insurer's home office or at the location where the records under examination are stored. Since the examiner(s) conducts most of his/her work at the company location, the company is required to provide a work site for the examiner(s).

Examinations are conducted at any location of the company where the policy or claim records are located. Members of an examination team frequently may be required to complete portions of an examination at sites other than the home office or branch sites of the company.

Desk Examination

Desk examinations are examinations that are conducted by an examiner at a location other than the company's premises. Desk examinations are generally performed at the insurance department's offices, with the company providing requested documents for review.

This type of examination can be used when a jurisdiction wants to ensure a company has adequately responded to an examination report or where the examination is extremely narrow in its scope. The company conducts their own examination according to guidelines and standards provided by the examining jurisdiction. Once the company completes the examination, it is reviewed by the examining jurisdiction. If the examination results are not satisfactory or do not appear reliable, another examination method may be engaged.

E. Lines under Examination

The lines of business under examination may also be a defining factor in an examination. A company that engages in multiple lines may be examined in all or a portion of the lines of business in which it writes; for example, personal lines only versus the company's commercial business.

In addition, there are several types of specialized examinations that review lines of business that are not "traditional." Premium finance companies, surplus lines brokers, statistical agents and third-party administrators are all examples of specialized lines of business.

F. Use of Hierarchical Description

An examination type will be reasonably precise if the user identifies the examination with a descriptive phrase from each of the six areas in this chapter. This creates a hierarchical description of the areas of an examination, describing the types of market conduct examinations that could be conducted by a state.

Selection of Type + Exam Sequence + Specialty Area (LOB) + Scope + Jurisdiction + Method. Some examples of usage of hierarchical descriptions are noted below:

Type Selection	Routine	Target	Target	Target
Exam Sequence	Subsequent	Initial	Initial	Follow-up
Specialty (LOB)	P&C	Health	Title	Life
Scope	Limited (Undwr)	Limited (Clms)	Comprehensive	Limited (Undwr)
Jurisdiction	Single state	Single state	Single state	Multistate
Method	On-site	Desk	On-site	Combination

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Chapter 11—Automated Examinations Tools and Techniques

This chapter provides guidance to market conduct examiners and promotes the use of automation tools during market conduct examinations. A variety of software tools are referenced and several automation tests are detailed to assist examiners with the implementation of automated procedures.

A. Purpose of Automated Examinations

Primary incentives for the use of automated examination processes are to shorten the length of an examination (which can contribute to reduced examination expenses) and allow the examiner to test entire populations of data for compliance with statutes, rules and regulations. By testing the entire population, a reliable statement of compliance can be made and trends of compliance (or noncompliance) more easily identified. As electronic examination data is collected and archived by states, information about the company's data and prior examination results may become useful for new examinations. Examiners may perform portions of an automated examination before traveling to the company or individual's location.

B. Automation Tools

The following are the tools referenced in this chapter which are available to an examiner.

1. NAIC Systems

The NAIC systems contain a variety of data related to companies and individuals operating in the insurance industry. An examiner can look up a company or individual and readily identify which applications contain information about the entity. The following applications provide information to examiners that may prove useful during their examination:

a. Market Action Tracking System (MATS)

MATS allows market conduct examiners and analysts to communicate schedules and results of examinations and other market actions. MATS allows for the calling of market conduct examinations and non-examination inquiries and market actions, in addition to providing easy access to complete information about the entities involved in the action. MATS can be used to view or update market actions for a specific entity or a number of entities. Information in MATS is maintained for both ongoing and completed market conduct actions. Market actions captured in MATS are: comprehensive examinations, targeted examinations, focused inquiries (typically inquiries made of multiple market participants), and other non-examination regulatory interventions. MATS also provides notification of new and updated action information via the Personalized Information Capture System (PICS).

The Financial Examination Electronic Tracking System (FEETS), which became available in July 2011, allows state insurance regulators to follow the progress of individual and group financial examinations. While MATS provides historical information regarding combined (market and financial) examinations, FEETS is used exclusively for financial examinations.

b. Complaints Database System (CDS)

CDS has been operational since 1991 and is only available to regulators. Complaint information is recorded identifying the type, reason and ultimate disposition. Reports readily provide the number of complaints and are used for analyzing trends related to complaints for an individual or company.

- c. **Regulatory Information Retrieval System (RIRS)**
RIRS has been operational since the 1960s and was implemented as an electronic database in 1985. RIRS is a regulator-only NAIC database containing final, adjudicated regulatory actions against insurance or non-insurance entities and includes both licensed and non-licensed entities. This system enables state insurance regulators to track, on a nationwide basis, the regulatory history of individuals and entities affiliated with the insurance industry. The origin, reason and disposition of the regulatory action are recorded in the database.
- d. **State Producer Licensing Database (SPLD)**
NAIC owns and NIPR helps maintain a comprehensive state producer licensing database called “SPLD” for the exclusive use of state regulators. This NAIC database contains all of the information in the Producer Database (PDB), plus all state submitted regulatory actions and confidential information available only to regulators. SPLD is a regulator-only database accessible through iSite+, and is not subject to the Fair Credit Reporting Act (FCRA).
- To search for producers via iSite+:
- Log into the regulator-only portion of myNAIC and select iSite+ from the login categories;
 - In the Tools drop down menu, select Search – Individual Entity; and
 - Enter the known criteria for the entity (e.g., last name, first name) and select Search.
- The examiner may need to review the basic demographic data to verify the correct entity was selected.
- e. **Financial Applications**
The Financial Applications section contains the annual statement financial information for insurance companies that report to the NAIC. The most useful financial application for market conduct examiners is the annual statement Pick-a-Page. In Pick-a-Page, the Summary Page exhibit of direct written premiums in any particular state can be obtained.

2. ACL® For Windows

ACL is the NAIC-recommended software to assist with the audit and evaluation of electronic data during an examination.

ACL is a Windows-based PC program that allows the examiner to manipulate and analyze vast quantities of data at a high rate of speed. Like other audit software, such as CA Easytrieve®, ACL is dependent upon data the company chooses to capture from their computer systems.

The examiner must focus on the relationships that exist among the data collected to use ACL properly. An examiner must think like an interpreter, evaluating the meaning of data in relation to specific areas of review. There are times when the company does not capture the data needed to effectively use ACL for a particular purpose. The examiner must be able to distinguish between useful and non-useful data.

ACL requires the examiner to acquire special knowledge and training; achieve a comfort level with company data and NAIC Market Information Systems (MIS)/IT staff; be creative; and be effective—concentrate on areas that will yield benefits.

Some areas of the exam may benefit from ACL, while others will not. A regulator may find the following examples of ACL applications useful. These are “theoretical” examples that have not been tested in the field. Regulators are asked to share ideas regarding the use of ACL with fellow examiners. The current schedule of NAIC-sponsored ACL training classes can be found on the IT Examination (E) Working Group web page.

3. TeamMate™

TeamMate is a Windows-based file repository and auditing software package that states may purchase to assist them in conducting examinations. This software enables the examiners to compile examination workpaper documentation into a paperless electronic file. The software package tracks completion and review of examination procedures, and is capable of including the examination documentation (Word documents, spreadsheets, watermark images, etc.) entirely within the program. The TeamMate audit management software has two models, a distributed version and a centralized version. The NAIC currently utilizes the distributed model.

To assist in the utilization of TeamMate for market regulation purposes, the NAIC has developed Market Regulation TeamMate TeamStores. The NAIC Market Regulation TeamStores were developed to provide the states with uniform procedures that mirror the market conduct examination standards found in Chapters 16-28 of the *Market Regulation Handbook*.

Information on how to purchase a TeamMate license can be found on the IT Examination (E) Working Group web page. The current schedule of NAIC-sponsored TeamMate training can also be found on the IT Examination (E) Working Group web page, and TeamMate training is available to regulators upon request.

4. Spreadsheets

Spreadsheet applications are computer programs for creating and manipulating spreadsheets. Data in a spreadsheet can be defined and formulas created for calculations, etc. Examples of spreadsheet applications are made utilizing Microsoft Excel software. Lotus 1-2-3 is another popular spreadsheet package.

5. Databases

Database software provides for queries and reports to be created against a database. Database examples are included utilizing Microsoft Access.

6. Word Processing Software

Word processing software facilitates the creation of letters and other documents. Sample text is included in this chapter.

7. Market Conduct Sampling Utilities Program (MCSU)

The Market Conduct Sampling Utilities program (MCSU) is a Microsoft Excel program designed to assist regulators in testing random sampling tolerance and confidence levels. Determination of sample size and probability of the accuracy of sampling results can be readily calculated using this program. The MCSU conforms to the methodology of the revised Chapter 14—Sampling as adopted by the Market Regulation Handbook (D) Working Group in 2006. The MCSU Excel program and accompanying Help File are available to regulators in the Reference Documents section of the Market Regulation Handbook web page on StateNet.

8. State Systems

The examiner should identify what information is stored electronically in their state systems and whether it can be extracted for automated testing. If a company's data will be tested against the state's data, the initial request for data sent to the company should consider the state's data format to simplify testing. For example, producer name fields should be requested in the same format as it is maintained in the state; e.g., last name, first name.

9. Computer System Size Limitations

Examiners should be aware that email servers may have a standard size limitation for receiving and sending data. When sending an attachment through email, Internet servers may have a size limit on files that can be attached to the email. If the file exceeds this size limitation, then a compression utility tool, such as WinZip or WinAce, can be used in order to send the file. If the sender is using a compression utility tool to send the information, the receiver must also have the same software on their computer system in order to open the compressed file type (.ZIP, .RAR, etc.) as a readable document.

If an email cannot be sent due to server limitations on file size, there are other options available to the examiner. Sending the file through File Transfer Protocol (FTP) is another option. The only drawback to this method is having to acquire a password, which can sometimes pose time restrictions. The best solution is to post the file on an Internet website. The examiner could send the file to a web server, create a link to that file and other examination team members may be allowed access to the file. If the information is sensitive, the examiner will need to establish a secure site, with the file available only for people who have access to the secured site.

Another option available to examiners is to burn a file to a CD; however, this option would be the slowest option compared to other available options.

C. Reference Tools, Training and Assistance

The following references, training and assistance are available to assist examiners with the utilization of automated tools.

1. NAIC-Sponsored Training

The NAIC provides a variety of training opportunities and educational events which may prove beneficial to examiners. Available training includes classes for Introduction to ACL, Introduction to ACL—Market Conduct and Advanced ACL. In addition, web-based instruction for NAIC systems is available, as well as regularly scheduled events such as the annual NAIC/NIPR Insurance Summit Conference. Information on technical training may be found on the Education and Training website http://www.naic.org/education_technical_training.htm.

2. NAIC File Repository

The NAIC File Repository is designed to allow state regulators to submit files or download files from a centralized location at the NAIC. Various programs and test files can be sent to the repository for other states to download. States are encouraged to share files via the file repository. The file repository is accessed via iSite+.

3. Internet

The Internet has a wealth of information related to the use of software and can provide specific formulas or macros for some functions. Many chat rooms and bulletin boards exist where advice can be sought for problems encountered during an automated examination.

4. IIPRC

The Interstate Insurance Product Regulation Commission (IIPRC) is a valuable resource for market regulators in compacting states when they are working with IIPRC-approved products. The IIPRC website, www.insurancecompact.org, contains pertinent information about the Compact law, uniform standards and reviewer checklists. Market regulators can visit the website to learn more about the IIPRC's processes and procedures, including the mix-and-match process that allows an IIPRC-approved product component—such as an application, policy, rider, amendment or endorsement—to be used or “mixed and matched” with a compacting state-approved product component. The IIPRC office staff and reviewers are easily accessible to respond to regulator questions about uniform standards or questions regarding a product filing submitted to and/or approved by the IIPRC. Contact information for the IIPRC office can be found on the IIPRC website. Compacting states have one or more designated representatives that actively participate in IIPRC meetings and activities and may also be a good resource to provide guidance on working with IIPRC-approved products.

5. State Insurance Departments/NAIC Staff

State regulators and NAIC staff are available to provide guidance to regulators about automated examination procedures and processes. For the names of individual contacts within the NAIC or at state insurance departments, please contact the NAIC Market Regulation Department at 816-842-3600 or via the NAIC website at www.naic.org.

6. NAIC Help Desk

The NAIC Help Desk is available to assist regulators as needed. Regulators may contact the Help Desk at 816-783-8500 or at help@naic.org.

D. Data Requests and Access

This section provides examples of data requests that may be used in a market conduct examination and the corresponding automated techniques used to perform the review. Typically, the file requests can be sent to the company with the notification letter or a computer/technical contact person can be requested in the notification letter and the requests can then be sent directly to them. It is best suited to have a technical contact person involved directly in all pre-examination meetings with the company to avoid confusion.

The data requests are basically the same requests that are used when asking the company for hardcopy computer print outs. But, by asking for the information in data files, the examiner can now easily test 100 percent of populations and quickly pull statistically sound random samples to be used to review actual hardcopy files.

1. Example of a Standardized Data Request for ABC Insurance Company

Please provide the following data files for the examination period of Jan. 1, 2011 through Dec. 31, 2011. The files will be used on a PC, so please provide the information on a CD. The files should contain fixed length records in the layouts shown. The file format requested, in the order of preference, is delimited (comma or tab) text file or a Microsoft Access database. If a company's computer systems use different field sizes, please submit the company's data files and send revised file layouts with the files.

Complaints—Please provide a list of all complaints received from [state name] policyholders from the period of Jan. 1, 2011 through Dec. 31, 2011. Please include both complaints received directly and those forwarded from the [state name] insurance department.

Please note that an updated Complaint Standardized Data Request (SDR) was adopted by the NAIC in 2017. It can be accessed on the Market Regulation Handbook Updates page on StateNet, which regulators can access via iSite+. Please refer to the updated Complaint SDR in that location. Non-regulators may access the SDR on the Market Regulation Handbook Updates page via the login information provided at the beginning of this handbook:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
Complaint Number	1	10	A	Number used to track complaint
Complainant's Name	11	50	A	Name of person making the complaint
Type	61	25	A	Type of complaint
Date of Complaint	86	8	D	Date the company received the complaint (YYMMDD)
Policy Number	94	10		Complainant's policy number if applicable (Fill with zeros if not)
Complaint Form	104	5	A	How the complaint was received (phone, email, fax, letter)
Reason for Complaint	109	0	A	Complainant's problem, reason for complaining
Resolution	159	50	A	Resolution of complaint
Date of Response	209	8	D	Date company responded (CCYYMMDD)

* Start and Length only used if sending the file as an ASCII text file.

** Type: Whether the field is alphanumeric (text), numeric or date.

2. Data Formats

There are a number of different formats in which the data can be provided. Consideration should be given as to what format the company can provide, what software program the examiners will be using to view the data, how much space will be available on the examiner's hard drive and how the company will transfer the data to the examiners.

Recommendation—ASCII delimited, ASCII fixed length and text files are the best data formats to use when requesting information. Each of these can be used in any of the current software packages available. ACL, Microsoft Access, Microsoft Excel and Lotus, etc., are the easiest formats for companies to provide. These formats require little to no additional formatting, compress well and most company mainframe computer systems can download directly into these formats. However, if the files are used in any software package besides ACL, duplicates of the file will be made when the files are saved in the corresponding software package's format. ACL will only make duplicates of ASCII files.

ASCII Delimited Files—These are called delimited files because a field separator character separates the fields. To facilitate with the reading of these files, ACL uses a Delimit Utility.

Two common delimited file types include:

- CSV – Comma Separated Values; and
- TSV – Tab Separated Values

Example:

```
"987654321","JONES, THOMAS P","21","19850505","","00000000"
"876543210","MILLER, BEVRA K","21","19960814","","00000000"
"765432109","NOBEL, RICHARD C","21","19890906","","00000000"
"654321098","PRICE, MARLENE","21","19940428","","00000000"
"543210987","RICE, WILLIAM P","21","19860102","","00000000"
"432109876","SMITH, BRIAN K","21","19900424","C","19961204"
"321098765","TAYLOR, CARL R","21","19870407","","00000000"
"210987654","WILLIAMS, CLIFFORD","22","19890605","","00000000"
```

ASCII Fixed Length—Every record is a pre-defined or fixed length and the fields are continuous but the same size in each record. The file must be separate in individual fields in ACL and given headings/names. This does not change the data. ASCII fixed length files take up the least amount of room on a hard drive and are the best method of compressing data for file transfer.

Example:

```
987654321JONES, THOMAS P.....2119850505-00000000
876543210MILLER, BEVRA K.....2119960814-00000000
765432109NOBEL, RICHARD C.....2119890906-00000000
654321098PRICE, MARLENE.....2119940428-00000000
543210987RICE, WILLIAM P.....2119860102-00000000
432109876SMITH, BRIAN K.....2119900424C19961204
321098765TAYLOR, CARL R.....2119870407-00000000
210987654WILLIAMS, CLIFFORD.....2219890605-00000000
```

EBCDIC—EBCDIC data, encoded according to the Extended Binary Coded Decimal Interchange Code (EBCDIC), refers to printable characters. This data type is the norm for all IBM mainframe and minicomputers. The length of this data type is a maximum of 32,767 bytes.

More Difficult to Use—Data files can also be requested in Microsoft Access, Microsoft Excel, Lotus, etc. These packages are more conducive to small populations, files without date fields and computers with larger hard drive space. There are also issues to deal with when using this requested data with ACL.

Microsoft Access—Using the Data Definition Wizard, Microsoft Access and XML data can be imported and defined directly, without the need for pre-processing. ACL maintains the integrity of the source data and allows the user to specify whether to keep field header information. The user can also specify which Microsoft Access table to be utilized. Installation of Microsoft Access on a computer to use files of these formats is not necessary.

Microsoft Excel—Using the Data Definition Wizard, Microsoft Excel data can be imported and defined directly, without the need for pre-processing. ACL maintains the integrity of the source data and lets the user specify whether to keep field header information. The user can also specify which Microsoft Excel worksheet to be utilized. Installation of Microsoft Excel on a computer to use files of these formats is not necessary. Problems with Microsoft Excel include: Microsoft Excel tends to corrupt date fields, and Excel 2003 is limited to 65,536 rows or records in any one file. Unless ODBC is used to read Microsoft Excel data in ACL, dates can display incorrectly. When Microsoft Excel data is imported, Microsoft Excel and the transferring technology use the system date format. If this format differs from the **Date Display Format** that the user sets in ACL, the dates from the Microsoft Excel data may display incorrectly in ACL. To avoid this problem, in ACL, select **Tools » Options**, then click the **Date** tab and enter a date display format to match the system date. To find the system date, select **Start » Settings » Control Panel » Regional Options**.

3. Common Issues

a. How a regulator can save space on a hard drive:

- Request that files be sent pre-sorted. For example, the files can be sorted by claim number or sorted by company code, then by policy number. ACL note: ACL will require that a new file is made for each different sorting;
- Include all companies in the review in one file with a company code to distinguish each company. ACL note: This will make any procedures performed in ACL run a little slower, but it can save space; and
- Request that the files come in a delimited format.

b. Documentation:

If using ACL, for any procedure or function performed, a “Log” screen will be shown that documents what was performed. The command logs records and displays the commands issued and the results obtained during a data analysis project. The log can be exported to any of the following file types:

- HTML – Exports the results from the selected command as an HTML file;
- Log File – Saves the selected commands and command results to a new ACL command log file (.log) and adds it to the **Overview**;
- Script – Creates a script from the selected command and adds it to the **Overview**;
- WordPad – Copies the selected portions of the command log to a new Microsoft WordPad document; and
- Text – Saves the selected portions of the command log as a text file.

c. Record Count:

If using ACL, once a data file is brought in and the field names set, the program will automatically indicate the population size and will show it on the status bar at the bottom of the screen. If using Microsoft Access when opening the table or running a query, the program will either show the record count at the bottom of the screen or a message box will appear that displays the number of records after the query has been run.

E. Validation of Data

Common concerns related to automated examinations are how regulators can ensure accurate and complete data is sent for examination purposes. Examiners are encouraged to identify the information maintained by their state, which can be cross checked against data files submitted by a company. Annual statements and other reports may be useful in determining whether accurate and complete data is provided.

1. Control Totals

The company should provide the total value of several key fields when data is provided for examination. Once the data is converted into a software program, the totals of those key fields should be calculated to ensure there is a complete data conversion. If there are discrepancies in any of the totals, the examiner and company must determine the cause of the discrepancy and make corrections as needed.

2. Data Quality Analysis

After data is converted into a software package, a cursory review of the data should be conducted. The examiner should ensure each field appears to contain correct data; i.e., dates should appear in date fields, numeric amounts in dollar amount fields, etc.

The following functions can assist in verifying data quality:

- ACL: the Sequence, Verify and Statistics functions found in the Analyze menu;
- Microsoft Excel: the Validation function found in the Data menu; and
- Microsoft Access: create validation rules when converting by selecting the Database Utilities function in the Tools menu and then selecting Convert Database.

F. Sampling

The concept of automated examinations assumes a portion or all of an examination will be conducted electronically. Although the automated examination concept can be used to sample an entire population of data, the need for sampling a portion of the records/files will continue. For instance, examiners may want to test a sampling of paper files against electronic files to ensure the electronic files are maintained in an accurate and complete manner. Examiners should reference the chapter on sampling, for a more complete description of the purpose of sampling and the various sampling techniques.

1. Sampling with ACL

Record sampling treats each record equally, resulting in a sample that is unbiased (i.e., is not biased on the value in the records). Therefore each record has an equal chance of being selected.

In random sampling, the population (“p”), number of items (“n”) to be selected and a random seed are specified. ACL then uses the random seed to generate “n” random numbers between zero and “p.” If the same random number is selected more than once, the duplicate choices are replaced with unique random numbers. This means that in Random Record samples, the same record will never be selected more than once.

2. Example of Pull Lists

When an examiner needs to sample paper files, it is common for a list to be created and provided to the company for recovery. Electronically, a sample of records may need to be selected for the examiner to scrutinize when the application of an automated test is not feasible or recommended. The use of automated tools, such as ACL and Microsoft Excel, is encouraged for the creation of pull lists or electronic samples.

If utilizing Microsoft Excel, a pull list can be created as follows:

- From the Tools menu, select Data Analysis. A box will appear with a list of options; select Sampling. The Sampling dialog box will appear;
- Enter the input range. The input range should be a numeric field (i.e., policy number) from which the sample will be generated. In addition, the regulator should determine if periodic or random sampling should be utilized. If periodic sampling is selected, the regulator should enter the distance between files selected (i.e., every 10); and if random sampling is selected, the regulator should enter the number of samples desired. Enter the desired output range in the output options;
- Microsoft Excel will create a new worksheet providing a list of the sample; and
- If manual files are required, the worksheet page then can be printed off and provided to the company.

G. Complaint Handling

Note: This automated analysis is only useful in reviewing companies with automated complaint registers.

Complaint Handling Standards

- ___ All complaints are recorded in the required format on the company complaint register.
- ___ The company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules, regulations and contract language.
- ___ The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations.

Data File Supplied by the Company

A list of all complaints received during the examination period, both directly and from the insurance department, provided in the following format.

Please note that an updated Complaint Standardized Data Request (SDR) was adopted by the NAIC in 2017. It can be accessed on the Market Regulation Handbook Updates page on StateNet, which regulators can access via iSite+. Please refer to the updated Complaint SDR in that location. Non-regulators may access the SDR on the Market Regulation Handbook Updates page via the login information provided at the beginning of this handbook:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
Complainant's First Name	1	25	A	First Name of Complainant
Complainant's Last Name	26	25	A	Last Name of Complainant
Type of Coverage	51	50	A	Type of Coverage
Date of Complaint	101	8	D	Date the Company Received the Complaint (CCYYMMDD)
Policy Number	109	10	A	Complainant's Policy Number if Applicable (Fill With Zeros If Not)
Complaint Form	119	5	A	How the Complaint was Received (Phone, Email, Fax, Letter, etc.)
Type of Complaint	124	50	A	Complainant's Problem, Reason for Complaining
Disposition	174	50	A	Disposition or Resolution of Complaint
Date of Response	224	8	D	Date Company Responded (CCYYMMDD)
Complainant Type	232	50	A	Type of Complainant

Data File Supplied by the Consumer Services Division of the Insurance Department

A list of all complaints received on this particular company during the examination period, provided in the following format.

Please note that an updated Complaint Standardized Data Request (SDR) was adopted by the NAIC in 2017. It can be accessed on the Market Regulation Handbook Updates page on StateNet, which regulators can access via iSite+. Please refer to the updated Complaint SDR in that location. Non-regulators may access the SDR on the Market Regulation Handbook Updates page via the login information provided at the beginning of this handbook:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
Complainant's First Name	1	25	A	First Name of Complainant
Complainant's Last Name	26	25	A	Last Name of Complainant
Type of Coverage	51	50	A	Type of Coverage

Date of Complaint	101	8	D	Date the DOI Received the Complaint (CCYYMMDD)
Policy Number	109	10	A	Complainant's Policy Number if Applicable (Fill With Zeros If Not)
Type of Complaint	119	50	A	Complainant's Problem, Reason for Complaining
Disposition	169	50	A	Disposition or Resolution of Complaint
Complainant Type	219	50	A	Type of Complainant

Tests:

1. Comparison of Insurance Department/Company Records: The insurance department's file can be compared to the company's file to ensure that the complaints forwarded by the insurance department are being accurately recorded. This can be done by comparing either the complainant name or policy number fields in each file. This can help determine if the complaints are being properly recorded.
2. Formal Complaint Records: The NAIC Complaints Database System (CDS) contains closed consumer complaints against firms and individuals involved in the insurance industry. These complaints are broken down by state, line of business, type of complaint and disposition. These numbers are then compared to premium written to give a more accurate measurement of the insurer's comparative performance in the marketplace. This comparison is called the "complaint index." These reports should be reviewed to determine if there is a pattern of specific types of complaints or if the particular state being reviewed has a high complaint index compared to the other states.
3. Type of Complaint: With the file supplied by the company, counts can be run by type of complaints. Any patterns or unexpected results in the type of complaints can be reviewed.
4. Disposition: With the file supplied by the company, the number of days between the date of complaint and the date of response by the company can be calculated. This can be used to determine if the time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations on promptness. A random sample of closed complaints can be taken to see if the company has taken adequate steps to finalize the complaint.

H. Producer Licensing

The area of producer licensing is ideal for automated procedures. Examiners can easily compare the records of licensing/appointments against the company's records to determine if violations exist. Comparisons can be made to the company's producer records, new business records (to determine when applications are written) and/or commission records to ensure compliance. Data related to commission records or applications written is not reflected in the NAIC State Producer Licensing Database (SPLD). Only lines of authority and license classes licensed or appointed for are shown in the SPLD.

1. NIPR Gateway

The Gateway facilitates the electronic exchange of producer information between state insurance regulators and the entities they regulate. The goal is to simplify communications and to distribute information electronically, including licensing applications, appointments/terminations and the Address Change Request (ACR). Designed to improve the effectiveness and efficiency of the state licensing process, the key benefits of the Gateway are reduction in paperwork, data entry and costs; development of national standards regarding electronic transmission of licensing data; faster turnaround time; and increased revenue.

2. Comparison of Insurance Department/Company Records

- Example using Microsoft Excel; and
- Example using ACL Audit Software.

Producer Licensing Standards

- ___ No one other than a duly licensed producer may solicit, procure, receive or forward applications for insurance.
- ___ No insurer licensed to do business in the state may pay commissions or make any consideration of anything of value to an unlicensed person, firm or corporation.

Data Files Supplied by the Company:

1. Producer Licensing—List of producers licensed in this state to solicit business during all or part of the examination period, provided in the following format.

Please note that an updated Producer Standardized Data Request (SDR) was adopted by the NAIC in 2017. It can be accessed on the Market Regulation Handbook Updates page on StateNet, which regulators can access via iSite+. Please refer to the updated Producer SDR in that location. Non-regulators may access the SDR on the Market Regulation Handbook Updates page via the login information provided at the beginning of this handbook:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
CO CODE	1	5	A	COMPANY CODE (IF FILE CONTAINS MORE THAN ONE COMPANY)
SOC SEC NO – TAX ID	6	9	A	SOCIAL SECURITY NUMBER OR FEDERAL TAX ID NUMBER
PRODUCER/AGENCY LAST NAME	15	25	A	PRODUCER'S LAST NAME OR THE NAME OF THE AGENCY
PRODUCER FIRST NAME	40	25	A	PRODUCER'S FIRST NAME
ADDRESS	65	25	A	PRODUCER'S BUSINESS STREET ADDRESS
CITY	90	25	A	PRODUCER'S BUSINESS CITY ADDRESS
AGENT OR PRODUCER CODE	115	10	A	PRODUCER'S COMPANY CODE NUMBER
APPOINTED DATE	125	8	D	APPOINTED DATE (CCYYMMDD)
TERMINATED DATE	133	8	D	TERMINATED DATE (CCYYMMDD) (IF APPLICABLE)

2. Commissions—List of all persons/agencies, appointed and unappointed, to whom commissions were paid on business written in this state during the examination period, provided in the following format.

Please note that an updated Commissions Standardized Data Request (SDR) was adopted by the NAIC in 2017. It can be accessed on the Market Regulation Handbook Updates page on StateNet, which regulators can access via iSite+. Please refer to the updated Commissions SDR in that location. Non-regulators may access the SDR on the Market Regulation Handbook Updates page via the login information provided at the beginning of this handbook:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
CO CODE	1	5	A	COMPANY CODE (IF FILE CONTAINS MORE THAN ONE COMPANY)
SOC SEC NO – TAX ID	6	9	A	SOCIAL SECURITY NUMBER OR FEDERAL TAX ID NUMBER
PRODUCER/AGENCY LAST NAME	15	25	A	PRODUCER'S LAST NAME OR THE NAME OF THE AGENCY
PRODUCER FIRST NAME	40	25	A	PRODUCER'S FIRST NAME
ADDRESS	65	25	A	PRODUCER'S BUSINESS STREET ADDRESS

CITY	90	25	A	PRODUCER'S BUSINESS CITY ADDRESS
AGENT OR PRODUCER CODE	115	10	A	PRODUCER'S COMPANY CODE NUMBER
APPOINTED DATE	125	8	D	APPOINTED DATE (CCYYMMDD)
TERMINATED DATE	133	8	D	TERMINATED DATE (CCYYMMDD) (IF APPLICABLE)
TERMINATION CODE	141	10	A	REASON FOR TERMINATION

3. New Business Written—List of all automobile policies issued as new business in the state during the examination period, provided in the following format (for this example, automobile policies were used; however, any line of business could be used):

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
CO CODE	1	5	A	COMPANY CODE (IF FILE CONTAINS MORE THAN ONE COMPANY)
POL PREFIX	6	4	A	POLICY PREFIX (IF ANY)
POLICY NO	10	9	A	POLICY NUMBER
POLICY TYPE	19	5	A	TYPE OF POLICY STANDARD, PREFERRED, ETC.)
INCEPTION DATE	24	8	D	POLICY INCEPTION DATE (CCYYMMDD)
GARAGED STREET ADDRESS	32	25	A	STREET ADDRESS OF LOCATION WHERE PRIMARY CAR IS GARAGED
GARAGED CITY	57	25	A	CITY WHERE CAR IS GARAGED
GARAGED COUNTY	82	25	A	COUNTY WHERE CAR IS GARAGED
GARAGED STATE	107	2	A	TWO LETTER STATE CODE FOR WHERE CAR IS GARAGED
GARAGED ZIP CODE	109	5	A	ZIP CODE WHERE CAR IS GARAGED
RATING TERRITORY CODE	114	10	A	CODE SPECIFYING RATING TERRITORY (PLEASE PROVIDE LIST OF CODES)
BI LIMITS PER PERSON	124	7	N	APPLICABLE BODILY INJURY LIMITS PER PERSON, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
BI LIMITS PER ACCIDENT	131	7	N	APPLICABLE BODILY INJURY LIMITS PER ACCIDENT, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
UM/UIM LIMITS PER PERSON	138	7	N	UNINSURED/UNDERINSURED MOTORIST PER PERSON, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
UM/UIM LIMITS PER ACCIDENT	145	7	N	UNINSURED/UNDERINSURED MOTORIST PER ACCIDENT, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
AGENT/PRODUCER CODE	152	10	A	PRODUCER'S COMPANY CODE NUMBER OR SOCIAL SECURITY NUMBER

Data Files Supplied by the Insurance Department’s Licensing Division:

4. Licensed Producers—List of all producers licensed with the insurance department to solicit business during the examination period for the company, provided in the following format.

Please note that an updated Producer Standardized Data Request (SDR) was adopted by the NAIC in 2017. It can be accessed on the Market Regulation Handbook Updates page on StateNet, which regulators can access via iSite+. Please refer to the updated Producer SDR in that location. Non-regulators may access the SDR on the Market Regulation Handbook Updates page via the login information provided at the beginning of this handbook:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
SOC SEC NO – TAX ID	6	9	A	SOCIAL SECURITY NUMBER OR FEDERAL TAX ID NUMBER
PRODUCER/AGENCY NAME	15	25	A	PRODUCER’S NAME OR THE NAME OF THE AGENCY
LICENSE TYPE	40	5	A	TYPE OF LICENSE, P&C, LIFE, ETC
APPOINTED DATE	45	8	D	APPOINTED DATE (CCYYMMDD)
PRODUCER TYPE	53	5	A	PRODUCER TYPE, RESIDENT (RES) OR NON-RESIDENT (NONRS)
TERMINATED DATE	58	8	D	TERMINATED DATE (CCYYMMDD) (IF APPLICABLE)

Tests:

Look for unlicensed/unappointed producers:

1. Compare the company’s Producer Licensing list to the insurance department’s Licensed Producers list, extracting any producers on the company’s list that are not on the Department’s list.
2. Compare the company’s Commissions list to the insurance department’s Licensed Producers list, extracting any producers on the company’s list who are not on the insurance department’s list.
3. Compare the company’s New Business Written list to the insurance department’s Licensed Producers list, extracting any producers on the company’s list who are not on the insurance department’s list.

Look for producers writing/soliciting business prior to being licensed/appointed:

1. Compare the company’s commissions list to the insurance department’s Licensed Producers list, extracting any producers on the company’s list who received commissions prior to the appointment date on the insurance department’s list.
2. Compare the company’s New Business Written list to the insurance department’s Licensed Producers list, extracting any policies on the company’s list with policy effective dates prior to the corresponding producer’s appointment date on the insurance department’s list.

I. Marketing and Sales**1. Advertisement Approvals**

The approach for determining advertising approval compliance will vary based on the method the insurance department uses for maintaining policy form approvals.

Please note that an updated Marketing and Sales Standardized Data Request (SDR) was adopted by the NAIC in 2017. It can be accessed on the Market Regulation Handbook Updates page on StateNet, which regulators can access via iSite+. Please refer to the updated Marketing and Sales SDR in that location. Non-regulators may access the SDR on the Market Regulation Handbook Updates page via the login information provided at the beginning of this handbook:

Assumption #1—Insurance department records include hardcopy originals of approved advertising and electronic tracking by form number and approval date.

1. Secure an electronic listing of approved form numbers and date of approval.
2. Secure from the company a corresponding electronic listing of advertising form numbers and dates first used.
3. Run a comparison that would produce a listing of all company-identified advertising forms, which do not match with the insurance department's listing.
4. Run a comparison that would produce a listing of all company-identified advertising forms which were utilized prior to the date of approval in the insurance department's listing.

Assumption #2—Insurance department records include scanned text of all approved advertising materials, in addition to form number and approval date.

1. Follow procedures under Assumption #1 to verify that form number and date of use match insurance department records.
2. Secure an electronic copy of the insurance department's scanned text of all advertising forms approved for the company being examined.
3. Secure an electronic copy, or manually scan in, all advertising materials being utilized by the company being examined.
4. Run a comparison that would produce a list of all forms in which the text does not match the insurance department's approved copy.

Assumption #3—Insurance department records include imaged copies of all advertising forms approved, in addition to form number and approval date.

1. Follow procedures under Assumption #1 to verify that form number and date of use match insurance department records.
2. Secure an electronic copy of the insurance department's imaged advertising approvals.
3. Secure electronically imaged copies of all advertising forms from the company being examined, or image copies of all materials provided.
4. Run a comparison that would produce a list of all forms in which the images do not match with the insurance department's images of the approvals.

2. Unfair Discrimination

As when looking at insurance company files manually, the examiner will need to be fairly innovative when using automation to discover unfair discrimination. This is especially true in marketing and sales, where companies tend to be less automated. Unfair discrimination may more easily be found using automation when reviewing many different records of insureds. Leading evidence of unfair discrimination may typically occur when performing the tests in the underwriting/rating and claims review sections.

When performing the tests in the underwriting/rating and claims sections, the examiner should stay alert for potential cases where insureds were treated differently from other insureds. For example, in underwriting and rating, the examiner may discover a homeowners insurance application that had identical characteristics to a declined application that was located in a ZIP code with a high percentage of minorities, older homes, etc. The use of ACL will help the examiner segregate insureds who have the same characteristics as other insureds, but were treated differently.

ACL's Classify command can be used to identify many different unique identifiers when looking for discriminatory practices. This use of ACL can allow the examiner to see unique patterns in lines of business; Standard Industrial Classification (SIC) codes; plan codes; territories; and other information that would not have been identified elsewhere. ACL and the examiners are limited if the company does not retain such information in their database.

3. Internet Advertisements

Examiners should use the Internet to review an insurer’s online advertisements. In addition to obtaining a list of advertisements from the company, the examiner should choose their Internet provider’s search engines to find applicable sites. Reviewing paper copies of the insurer’s Internet advertisements can be done if the examiner does not have access to the Internet; however, it is recommended that an actual online review be made. This is because of the media capabilities and interactive nature of many sites.

In addition to looking for a company name, the examiner may wish to consider searching for applicable product types, affiliated entities, managing agencies, etc. Not all “hits” will constitute advertisements. For example, corporate information for investors or the public, news releases and community service-related website may be sponsored by, or refer to, the insurer being examined. Examiners should note and record the source or web address (URL) of any particular website in question to determine whether the advertisement was authorized by the insurer. Advertising standards found in the applicable sections of this handbook should apply to Internet advertisements. In general, the same rules prohibiting misleading, deceptive or false advertising should apply.

4. GeoAccess® Program (Managed Care Mapping Tool)

The Managed Care section uses GeoAccess® software. Some states use GeoAccess® software primarily for reviewing HMO networks for compliance with travel distance standards. GeoAccess® makes additional software packages that can also be utilized by a state. The following GeoAccess® software packages are commonly used: DataCleaner, GeoCoder and GeoNetworks:

a. Primary Usage

A state may receive data files from each HMO that list the number and ZIP code of all enrollees, and the name, address and specialty type/facility type of all participating providers. DataCleaner is used to clean up each provider file. The following tasks, unique to DataCleaner, are performed:

- Address information is standardized. DataCleaner matches the submitted address to internal systems data. The internal systems data is all of the official United States Postal Service (USPS) addresses for each state. If the submitted data is not an exact match to the USPS systems data, DataCleaner fixes it, if possible. If it is not possible to match the submitted address, an error message will be generated. The state can return non-standardized records to the HMO to correct.
- Duplicates are identified and removed. License number, type and standardized address are used to identify unique providers. Any duplicates are flagged and can be left in the data file at the user’s option. It is suggested that the state removes duplicates.
- Geocodes are assigned. DataCleaner assigns longitude and latitude coordinates to each record. Geocoding can be performed at the ZIP code level or at the street address level. The geocodes are stored in the systems data of the GeoCoder software.

GeoNetworks is used to “populate” each enrollee file. (“Populate” means there is a unique record for each enrollee. If the submitted data showed one record for the ZIP code 65202 containing 10 enrollees, the “populated” enrollee file contains 10 records for the ZIP code 65202, with each record representing a person. This keeps the submitted enrollee files to a minimum size for ease of transmitting). GeoNetworks can then be used to geocode the enrollee file, using the same GeoCoder system data that DataCleaner accesses when geocoding is performed in DataCleaner.

Finally, GeoNetworks is used to compare the populated and geocoded enrollee files to the cleaned and geocoded provider files. GeoNetworks functions like a comparative database. Each record in the enrollee file is compared to each record in the provider file. The software retains how far each enrollee would have to travel to get to each provider. (Some states use travel distance standards rather than travel time standards.) The software then summarizes results according to the user's preference for state, county or city summarization.

A final product is a report that shows a list of each county in which enrollment was submitted and the portion (percentage) of enrollees that meet the travel distance standard specified by the user. The reports can be customized to show other information as well, including the number of enrollees and providers in each county, the type assigned to each county (urban, rural or suburban/basic) and the average distance an enrollee in each county has to travel to get to the specified provider type.

The following is an example of how the GeoNetworks program has been used by the Missouri Department of Insurance, Financial Institutions and Professional Registration:

In the past, the Missouri DIFP ran GeoNetworks reports for 63 provider types per HMO network. The DIFP has established a unique standard for each provider type. The DIFP varies the standard for each provider type depending upon the county type. For example, enrollees in an urban county must be within 10 miles of their PCP, suburban/basic PCP access standard is 20 miles and rural PCP access standard is 30 miles. GeoNetworks can run a single PCP report for all three access standards simultaneously.

Finally, map view features in GeoNetworks permitted the Missouri DIFP to examine circumstances under which an exception to the regulatory distance standard should be made. GeoNetworks was used to compare an HMO's provider data to all providers in Missouri. For example, the distance standard for OB/GYNs in rural counties is 60 miles. In some counties, there are no OB/GYNs within 60 miles. GeoNetworks allows the Missouri DIFP to locate the nearest OB/GYN based upon state data and compare that to the nearest OB/GYN with whom the HMO secured a participation contract. The regulation stipulates that an exception would be granted if the HMO's OB/GYN were no further than 25 additional miles past the nearest possible provider.

b. Secondary Usage

States have discovered that the Data Cleaner and GeoNetworks are useful software packages for tasks other than HMO network analysis. A state can track HMO enrollment by ZIP code on a quarterly basis. DataCleaner is used to convert quarterly enrollment submissions to county, regional and metropolitan area enrollment charts. These charts are used in an HMO's annual report and are available on a custom basis to the general public. GeoNetworks is used to print service area maps for each HMO and regional enrollment maps.

c. Support

Training is available for all the GeoAccess[®] software packages. Complete information regarding GeoAccess[®] software products is available at <https://www.optum.com>.

J. Policyholder Service

1. Policyholder Service Practices

a. Calculation of Nonforfeiture Benefits

Standard: The company correctly calculates the benefit amount when a policy is switched to a reduced paid-up status.

Data File Supplied by the Company:

Request a listing of all life policies that were switched to reduced paid-up during the examination period. The data should include the policy number, insured name, cash value, reduced paid-up amount, application date, insured's age, rate, etc.

Test:

Use ACL to produce a list of policies where the amount of benefit after being switched to the reduced paid-up status is not consistent with the other policies with the same characteristics and cash value amounts.

b. Premium Billing

In reviewing an insurer's procedures related to premium billing, the examiner should look to applicable state laws to determine, contractually, what is or isn't allowed and what forms of disclosure are necessary. Once this information is determined, an automated checklist can be devised to cite relevant components of the statutes to use as a guide to determine adherence to the statutes, rules or regulation.

Once this initial review has been undertaken, the examiner's review of the insurer's files must be based upon applicable state underlying laws. For instance, what types of disclosures are required to be provided to the insured or policyholder? Is the insured or policyholder aware of the triggers for premium billing? That is, does the insured or policyholder understand that the premiums are billed monthly and that they must pay by a certain date, or risk the coverage being canceled? Does the insured or policyholder understand the role of the grace period and how it may or may not affect the policy, which they have placed on a premium billing cycle? Are premium finance methods being utilized? Are such methods consistent with the plan?

Assuming that the law allows and sets limited parameters for premium billing plans, the examiner must determine if the insurer provides "clear language" to the insured or policyholder so that the insured/policyholder understands the terms and conditions of the selected premium billing plan. The examiner should look for such disclosure statements and signatures of the policyholders, which detail that the terms and conditions were disclosed and that the insured or policyholder understood them. The examiner should determine who explains the plans. Is it an agent or finance officer? How knowledgeable is this individual? Has the individual been trained or certified? The examiner should ascertain the qualifications of those providing guidance and advice to the insured or policyholder.

The examiner's review of premium billing should be thorough but limited. The examiner must determine if the premium billing plan adheres to the law, if the insured or policyholder is properly instructed regarding what the plan entails, if the documentation in the insurer's file is adequate to indicate the insurer's adherence to the law and in the event a state law is silent, was the insured or policyholder adequately advised by a knowledgeable company representative of the terms and conditions of premium billing?

c. Refunds of Premium/“Free Look” Periods

Evaluation in this area can be made by using several essential fields:

- Date of application;
- Date of policy issue;
- Effective date of policy if different from policy issue date;
- Date policy was delivered or mailed;
- Date of cancellation request from insured;
- Date policy was cancelled;
- Date of premium refund; and
- Actual premium refund.

The following computed fields should be created using ACL, Microsoft Excel or Microsoft Access:

- Cancellation date minus the issue date or effective date;
- Date of cancellation minus delivery/mail date of the policy;
- Premium refund date minus the date of cancellation request from insured or the date the policy was canceled; and
- The appropriate premium refund amount (using a short rate or pro rata refund table).

Using the above fields, perform the following analysis:

- Determine the population using the cancellation date minus the issue date or effective date to find the policies which should have had refunds. Analyze for refunds owed but not made or refunds made when not owed.
- Compare the premium refund due to the actual refund amount.
- Compare the various computed number of day fields to see trends and verify company procedures in handling “free look” periods and premium refunds.
- Develop mean, mode and standard deviation for number of days for premium refund made and determine any possible cash flow issues including cash flow underwriting.

K. Underwriting and Rating

1. Comparison of Insurance Department/Company Records

a. Rate Approvals and Filings

Standard: The company uses only rates that have been properly filed with the insurance department.

Data File Supplied by the Company:

All new business written during the time frame of the examination. Included in this data should be the effective date of the rates used to calculate the premiums.

Download from the insurance department a listing of rates filed for use by the company. The download should include the effective date of the new rates.

Tests:

1. Run a comparison to ensure the rates used on the policy were filed and approved prior to the effective date of the policy.
2. Use the Classify command to identify the number of different rate edition dates used during the time frame of the examination.
3. Use the Join command to load the rates filed with the insurance department and those used in the company data.
4. Produce a report where the effective dates of the policy were prior to the date the rates could be used.

b. Policy Form Approvals and Filings

Standard: The company uses only forms that have been properly filed with the insurance department.

Data File Supplied by the Company:

All new business written during the time frame of the examination. Included in this data should be the effective date/version date of the forms and form numbers used as part of the policy.

Download from the insurance department a listing of form numbers filed for use by the company. The download should include the effective date of the forms.

Tests:

1. Run a comparison to ensure the forms used on the policy were filed and approved prior to the effective date of the policy.
2. Use the Classify command to identify the number of different form edition dates used during the time frame of the examination.
3. Use the Join command to load the forms filed with the insurance department and those used in the company data.
4. Produce a report where the effective dates of the policy were prior to the date the forms could be used.

c. Rating Practices

Standard: The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan.

Data File Supplied by the Company:

Homeowners New Business Written—List of all new business homeowners policies issued in this state during the exam period, provided in the following format:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
POLICY NO	1	9	A	POLICY NUMBER
INSURED'S CITY	10	30	A	CITY WHERE PROPERTY IS LOCATED
INSURED'S COUNTY	40	30	A	COUNTY WHERE PROPERTY IS LOCATED
TOWNSHIP/VILLAGE	70	30	A	TOWNSHIP/VILLAGE WHERE PROPERTY IS LOCATED IF APPLICABLE
ZIP CODE	100	5	A	ZIP CODE WHERE PROPERTY IS LOCATED
CLASS	105	5	A	PUBLIC PROTECTION CLASS CODE

Test:

Determine that the correct protection class is assigned to a homeowner's policy based upon city, county/township/village and ZIP code by comparing company data to ISO protection class codes maintained in the insurance department's Property and Casualty division.

ISO protection class codes should be kept in a database format. Both of the ISO protection class codes and the company's homeowners new business can be analyzed using Microsoft Access or ACL. By comparing or linking the policies' City, County, Township/Village (if applicable) and ZIP Code fields to the corresponding ISO City, County, Township/Village (if applicable) and ZIP Code fields, it can be determined if the Protection Class Codes match. A separate list can be generated for the policies where the Class Codes do not match. The company or the examiner can then determine by looking at the policy file if the class code is correct or in error.

d. HMO: Average Age

To ensure the appropriate amount of premium is being charged for a group of individuals, the examiner may want to re-calculate the average age used when calculating the group's premiums. This may be accomplished by obtaining the group census information from the underwriting file and from the computer system, if available. A comparison to the information in the hardcopy of the census and the information in an automated rate calculation program using a sampling method can be completed.

If there is not an automated rate function, the examiner should re-calculate the average age using the census form from the file. It may be necessary to enter the birth date or age information into a spreadsheet for calculation. Once the information is available in an electronic form, either by downloading the information from the rate calculation program or by entering the data into a spreadsheet program, the function of determining the average age is fairly simple. The following example shows how Microsoft Excel can be used to calculate the average age:

First, choose Insert from the menu and then choose Function. Use the Statistical category and the AVERAGE function options. To calculate the average age, either highlight the beginning and ending field or enter the beginning and ending cell (include a colon between the first and last field) in the Number 1 field.

Once the average age is calculated, it can be compared to established rates to determine if there are discrepancies.

e. Premium Audits

Standard: The company conducts premium audits within a specified time frame.

Data File Supplied by the Company:

List of all policies on which premium audits were required. Fields should include the date the premium audit was due and when the premium audit was completed.

Tests:

1. Run a comparison to calculate the number of days between the date the premium audits were due and when they were actually received.
2. The examiner can calculate the average number of days for the company to perform the premium audit and use the **Sort** command to analyze the premium audits that took longer than the average.

f. Underwriting Practices

Standard: The company underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Data File Supplied by the Company:

Homeowners New Business Written—List of all new business homeowners policies issued in this state during the examination period, provided in the following format:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
POLICY NO	1	9	A	POLICY NUMBER
POLICY TYPE	10	10	A	TYPE OF POLICY (PREFERRED, STANDARD)
YEAR OF CONSTRUCTION	20	4	N	YEAR THE DWELLING WAS CONSTRUCTED
ZIP CODE	24	5	A	ZIP CODE WHERE DWELLING IS LOCATED
POL INCEPTION YEAR	29	4	N	YEAR THE POLICY WAS WRITTEN

Test:

For companies where the preferred program is a function of the age of the dwelling, it can be determined if newer dwellings (under 20 years of age) are being underwritten as preferred policies correctly. In Microsoft Access, Microsoft Excel or ACL, the age of the dwelling can be calculated for all policies written. Then it can be determined if all dwellings that are under 20 years of age are using the “Preferred” policy form. Any policies that have dwellings that are under 20 years of age but are not using the “Preferred” policy form can be pulled out and investigated.

The ZIP code information can be utilized for those policies that erroneously did not receive the preferred policy form. A count can be run to see what the percentage of error by ZIP code is to the total business written. This could detect redlining.

g. Risk Selection (Declinations, Rescissions, Terminations)

Standard: Policies can only be canceled within 59 days of the effective date of the policy unless certain conditions exist.

Data File Supplied by the Company:

List of all policies canceled by the company for the time frame of the examination. The listing should include the effective date of the policy, cancellation date, and reason code.

Tests:

1. Calculate the number of days between the date of effective date of the policy and the cancellation date.
2. Filter out all policies canceled after the first 60 days and classify according to the reason code to insure policies were not improperly canceled.
3. If the data includes amount of original premium, term of the policy, amount of unearned premium refunded, date of refund and short rate/pro rata factor used, the examiner can recalculate the unearned premium and compare it to the amount refunded.
4. A regulator should use the Count command to identify how many (what percentage) of the total number of canceled policies have the characteristics on which focus is deemed necessary.
5. The examiner can also use the Classify command to identify the number of unique cancellation reasons to ensure they have a list of all reasons used.

h. Coverage Analysis

Standard: Insurers are required to issue auto policies with Uninsured/Underinsured Motorist (UM/UIM) limits, which are equal to the Bodily Injury (BI) limits on the policy, unless the named insured specifically requests, in writing, to reduce the limits or to waive the coverage entirely.

Data File Supplied by the Company:

New Business Written—List of all new business automobile policies issued in this state during the examination period, provided in the following format:

FIELD NAME	START	LENGTH	TYPE	DESCRIPTION
CO CODE	1	5	A	COMPANY CODE (IF FILE CONTAINS MORE THAN ONE COMPANY)
POL PREFIX	6	4	A	POLICY PREFIX (IF ANY)
POLICY NO	10	9	A	POLICY NUMBER
POLICY TYPE	19	5	A	TYPE OF POLICY (STANDARD, PREFERRED, ETC.)
INCEPTION DATE	24	8	D	POLICY INCEPTION DATE (CCYYMMDD)
GARAGED STREET ADDRESS	32	25	A	STREET ADDRESS OF LOCATION WHERE PRIMARY CAR IS GARAGED
GARAGED CITY	57	25	A	CITY WHERE CAR IS GARAGED
GARAGED COUNTY	82	25	A	COUNTY WHERE CAR IS GARAGED
GARAGED STATE	107	2	A	TWO LETTER STATE CODE FOR WHERE CAR IS GARAGED
GARAGED ZIP CODE	109	5	N	ZIP CODE WHERE CAR IS GARAGED
RATING TERRITORY CODE	114	10	A	CODE SPECIFYING RATING TERRITORY (PLEASE PROVIDE LIST OF CODES)
BI LIMITS PER PERSON	124	7	N	APPLICABLE BODILY INJURY LIMITS PER PERSON, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
BI LIMITS PER ACCIDENT	131	7	N	APPLICABLE BODILY INJURY LIMITS PER ACCIDENT, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
UM/UIM LIMITS PER PERSON	138	7	N	UNINSURED/UNDERINSURED MOTORIST PER PERSON, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
UM/UIM LIMITS PER ACCIDENT	145	7	N	UM/UIM PER ACCIDENT, DO NOT USE DOLLAR SIGNS, DECIMALS OR COMMAS
AGENT/ PRODUCER CODE	152	10	A	PRODUCER'S COMPANY CODE NUMBER OR SSN

Tests:

Look for policies with Uninsured/Underinsured Motorist (UM/UIM) limits less than Bodily Injury (BI) limits, for both per person and per accident limits:

1. Run a comparison on the company's New Business Written list, extracting any policies where UM/UIM limits are less than BI limits.
2. Send the list of extracted policies to the company for them to produce the actual waivers signed by the policyholders.

L. Claims**1. Claims Practices**

Acknowledgments

Standard: The initial contact by the company with the claimant is within the required time frame.

Data File Supplied by the Company:

All claims closed with payments during the time frame of the examination.

Tests:

1. Calculate the number of days between the date the company received notice of the claim and the initial contact by the company with the claimant.
2. Several jurisdictions recognize both a telephone call and a letter as suitable means for notification.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.
4. Stratify the dates for the number of days it took the company to acknowledge the claim and investigate patterns of untimely response.

b. Settlement Time Per Policy

Standard: Claims are resolved in a timely manner.

Data File Supplied by the Company:

All claims for the line of business under review for the time frame of the examination.

Tests:

1. Calculate the number of days between the date the company had all of the information to make proper payment and the date the claim was settled.
2. Many computer systems will contain the dates the company first received notice or when a claim was set up, but may not include the actual date that the company had all of the required information. The examiner will need to inquire as to what information is actually available.

c. Benefit Payment/Calculations—Denials

Standard: The denial letters by the company with the claimant are within the required time frame.

Data File Supplied by the Company:

All claims denied during the time frame of the examination. The data should include the date of claim, the date the company received all information to pay on the claim, and the date the denial was sent.

Tests:

1. Calculate the number of days between the date the company received notice of the claim and the initial contact by the company with the claimant.
2. Several jurisdictions recognize both a telephone call and a letter as suitable means for notification.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.
4. Use the Classify command to review all of the unique reason codes in the population to ensure all are accurate.

d. Mandated Benefits—Status Letters

Standard: The company sends status letters to the insureds as required by regulation.

Data File Supplied by the Company:

All claims with the dates of all correspondence mailed to the insured.

Tests:

1. Calculate the number of days between the dates of the correspondence sent to the insured to determine if correspondence is being sent within the required time frame.
2. It is important to note that some jurisdictions recognize both a telephone call and a letter as suitable means for notification. This may be difficult to determine in the data.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.

e. Deductible Refunds

Standard: The deductible reimbursement to the insureds upon subrogation recovery is made in a timely and accurate manner.

Data File Supplied by the Company:

A listing of all subrogation files for the time frame of the examination.

Tests:

1. Calculate the number of days between the date the company received the subrogation amount and the date the company provided a refund to the insured.
2. Several jurisdictions recognize both a telephone call and a letter as suitable means for notification.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.

f. Median Settlement Time

The examiner can use automation techniques, such as ACL and Microsoft Excel, to calculate the median settlement time, which in turn can be used to indicate general business practices of the company.

Not for Distribution

Chapter 12—Scheduling, Coordinating and Communicating

A. Company Selection

Company Selected

Each state should develop a standard planning process for its market conduct examinations based upon statutory examination requirements, market analysis, participation with multistate actions and unusual circumstances that require immediate investigation or examination. Consideration should also be given to developing a standard planning process for continuum responses, other than examinations, especially for responses that are more in-depth than inquiring about a single issue. A state will apply the criteria that it has established for calling examinations to the information developed from the standard planning process, in order to determine which insurers should be examined. An examination call sheet and supporting documentation should be collected at this time. Regulators may also refer to the items listed in the Market Conduct Uniform Examination Outline in Section R and the Reasons for Examination in Section S of this chapter.

Internal Data Requested from Insurance Department

Prior to an examination being approved, specific information should be compiled from the various sections within the insurance department. Examples of this information include: licensing (insurer lines of authority, producer/agency appointments); consumer complaints (number and types of complaints); market regulation and compliance history; rate and form filings; and financial analysis and examination. A notice (e.g., via e-mail) should be sent to the sections informing them that an examination of the company will commence and asking for any other relevant information.²¹

Justification of Examination

If not otherwise documented in the NAIC Market Analysis Review System (MARS), a memorandum should be prepared by summarizing all relevant data used to determine the necessity of the response or examination. For examinations, a call sheet should be prepared—along with the examination plan and estimated time sheet—and submitted to the appropriate insurance department personnel for approval. The proposed examination memorandum is approved, disapproved or returned to staff with instructions to obtain additional information.

Development and Monitoring of Examination Plan or Continuum Response Plan

A well thought out and documented plan provides guidance for the examination team or employee (whether contracted resources or employees are used) and the insurer's examination coordinator alike. An examination plan may include a primary document that is shared with the examinee and a supplemental document to provide further guidance to the examiners. The primary document may be incorporated into the pre-examination packet or examination coordinator's handbook.

The primary examination plan should address the following, where applicable:

- Clear identification of the entity or entities to be examined, including locations or regional offices;
- Stated objectives for the examination that allow justification for calling the examination or performing the continuum response;
- Estimated time frames and allowance that are allotted to each broad functional area being examined;
- Budgeted expenses for examiner work time;
- Estimated travel, lodging and meal expenses;
- Estimated incidental or administrative costs and supplies directly associated with the examination;
- A list of factors that could potentially contribute to increased examination costs, such as delays in responding to examiners on unforeseen compliance matters;
- In the case of examinations, an explanation of expense reimbursement and invoicing process;

²¹ In cases of routine examinations, this information may be solicited from the various insurance department sections during the planning phase of the examination subsequent to the examination call letter being issued; however, the information should be obtained prior to the commencement of any field work.

- If available, a brief discussion of potential ways to reduce examination costs, such as conducting portions of the examination through secure electronic data processes; and
- Contact information and procedures for addressing questions, concerns or appeals about the examination or response process, examination or response plan, or subsequent examination-related invoices.

The supplemental examination or continuum response planning document for the examination team or applicable examiner should be designed to focus the process on the specifically targeted areas of review. The materials provided with the supplemental document are likely to include more investigatory materials that constitute confidential investigatory materials and examination work papers. As such, the supplement should be treated accordingly. It should include:

- Directions relating to which *Market Regulation Handbook* examination standards should be incorporated into the examination;
- Market analysis-related materials that offer insight into the nature of any issues or concerns to be examined;
- If not otherwise provided, work sheets and guidance for relating state-specific laws and regulations to examination handbook standards; and
- Directions for accessing appropriate reference documents, bulletins, legal opinions, etc.

Additional considerations are appropriate for those states using contracted examiners. Prior to entering into any agreement for contracted services, it is important to consult with department of insurance legal staff to determine what applicable state requirements apply, such as “request for proposal” and contract bidding, execution and monitoring. Additionally, it is important to verify that use of contract services meets with department of insurance management approval. If not already addressed in the contract, it is proposed to provide written directions for the contract examination team to address the following issues:

- Provisions relating to confidentiality, data protection, ownership of examination work papers, and other relevant matters such as drug-free workplace rules that may have otherwise not been included in the contract;
- Instructions for preparing billing invoices including supporting documentation. It is generally a best practice to obtain detailed documentation of time and expense reimbursement for audit purposes. Practices may vary by state, but it is generally important to provide sufficient documentation to regulated entities required to reimburse examination expenses. That permits the regulated entity to maintain sufficient documentation for its internal and external audit purposes;
- Timing for presentation of invoices and billings. In general, more frequent invoices along with more frequent and detailed presentation to regulated entities required to reimburse expenses improves communication;
- Guidance for expense reimbursement allotments and travel, including frequency of travel, such as those established by Continental United States (CONUS) rates and/or Government Accounting Office (GAO) standards;
- Guidance relating to whether holidays, sick leave and travel time are to be reimbursed; and
- Provisions for communication and prior approval of any anticipated cost overruns or proposal for alterations of the examination work plan.

B. Scheduling Examinations

The individual responsible for scheduling examinations should consider the following elements:

1. In determining priorities, the relative significance of the following indicators should be evaluated:
 - a. Statutory examination requirements;
 - b. Internal complaint analysis;
 - c. Compliance with applicable statutes and regulations, including producer licensing;

- d. Rate and form review;
- e. Market share analysis;
- f. Examination findings from previous market conduct examinations;
- g. Information from the commissioner of another jurisdiction;
- h. Reports and analysis from NAIC information systems, including the Regulatory Information Retrieval System (RIRS), Complaints Database System (CDS), Financial Analysis and Solvency Tracking System (FAST) and email;
- i. Financial analysis and IRIS ratios;
- j. Information from other external sources;
- k. Changes in the control environment;
- l. Pre-admission;
- m. Market Conduct Annual Statement; and
- n. Findings from previous financial examinations.

When scheduling examinations, consideration should also be given to periodic examination of domestic insurers, even in instances where the domestic insurer is not active in the domestic market. In these instances, a multistate examination should be considered.

- 2. Document an explanation of the basis for calling the examination.
- 3. Review of current and previous examinations (examination history) of the specified company or companies as found in the Market Action Tracking System (MATPS).

C. Scope of Examinations

There are various market conduct areas, which may be covered in an examination. These include, but are not limited to:

- 1. Company Operations/Management
- 2. Complaint Handling
- 3. Marketing and Sales
- 4. Producer Licensing
- 5. Policyholder Service
- 6. Underwriting and Rating
- 7. Claims

The areas to be covered by the examination (e.g., underwriting only or claims only), the line(s) of business, as well as the time period under review must be clearly defined. The location of the examination must be determined—e.g., corporate headquarters or regional offices. The scope should include a preliminary estimate of timing and costs.

D. Selection of Examiner-in-Charge (EIC) and Team

The EIC is the on-site supervisor of the examination team. The examination team may be comprised of one or more examiners in addition to the EIC. When selecting the examination team, states should match examiners' areas of experience to the appropriate examination.

E. Estimating Time Requirements

In estimating time requirements examiners should:

1. Identify the subject area(s) of the examination in terms of the lines of business to be covered and the functional area (e.g., marketing and sales, underwriting, claims, etc.).
2. Identify the specific survey to be performed for each line of business; i.e., the steps to be carried out to collect the necessary information. Consideration should be given to the recordkeeping system of the company so that adjustments can be made in examination procedures to accommodate the data processing methods of the company as long as the integrity of the examination is not compromised.
3. Estimate the size of the field, obtain the data and determine the sample size for each survey.
4. Estimate the length of time required for the examination. A final examination plan, including an estimate of the duration and cost of the examination, should be completed by the EIC as soon as possible.

Final adjustments should be made within the first two weeks of the examination and communicated to the company. The examination plan needs to reflect actual field discoveries as to the quality and availability of data, the level of the company's cooperation, the location of the data, etc. As the examination matures, the EIC may need to adjust the examination plan. The company should be notified of any changes and the justification.

F. Calling the Examination

All jurisdictions are encouraged to utilize the NAIC Market Action Tracking System (MATS) for announcing market conduct examinations, in addition to focused inquiries and non-examination regulatory interventions. Once the triggers, subject area and estimated duration have been identified, a market conduct examination should be entered and announced (called) via MATS. MATS is available to regulators only.

MATS allows market conduct examiners and analysts to communicate schedules and results of examinations and other market actions. MATS allows for the calling of market conduct examinations and non-examination inquiries and market actions in addition to providing easy access to complete information about the entities involved in the action. MATS can be used to view or update market actions for a specific entity or a number of entities. Information in MATS is maintained for both ongoing and completed market conduct actions. Market actions captured in MATS are: comprehensive examinations, targeted examinations, focused inquiries (typically inquiries made of multiple market participants), and other non-examination regulatory interventions. MATS also provides notification of new and updated action information via the Personalized Information Capture System (PICS).

Insurance departments are encouraged to log examination information using MATS for market conduct examinations conducted on all types of entities. It is particularly important to include all single state examinations, regardless of scope, so that other jurisdictions can coordinate their own examination efforts and avoid the unnecessary burden of simultaneous separate examinations by multiple jurisdictions.

The Financial Examination Electronic Tracking System (FEETS), which became available in July 2011, allows state insurance regulators to follow the progress of individual and group financial examinations. While MATS provides historical information regarding combined (market and financial) examinations, FEETS is used exclusively for financial examinations.

G. Notice of Examination Reported to MATS

Examinations need to be entered into MATS no later than 60 days before the expected date of the on-site examination. Exceptions to this rule are examinations that are called to respond to more immediate concerns.

1. Notify Domiciliary State (MATS PICS event subscribers will automatically be notified. Not all regulators subscribe to PICS.)
2. Notification to Company
 - a. Timing of Notice—At least 60 days prior to the examination date, a notification letter should be sent to the company. This letter should specify the necessary information and arrangements referenced in Subsection (b) that follows.

If the company demonstrates a clear need for additional time to prepare for the examination, additional time may be granted prior to the commencement of the examination. These notice periods need not be followed if: (1) there is reason to believe that advance notification to the company might result in the destruction of important records; or (2) the interest of policyholders or claimants would be prejudiced by delaying the examination of company records.

- b. Content of Notice—The notification letter should advise the company of the following information and arrangements (Some states may include this in the form of an examination coordinator's handbook or pre-examination packet.):
 1. The scope, intent and period to be covered by the examination and estimated start and end date. The duration of the examination may be adjusted based upon on-site conditions. If it becomes necessary to change the starting date, the company should be notified of the change;
 2. The legal basis for examination and cost and billing procedures;
 3. Arrangements for receiving copies of relevant company procedural guidelines, manuals, policy forms with notice of approval, advertising materials, producers' records, renewal material, methods used to solicit business, any required consumer complaint register and any other pertinent data;
 4. Requests for data that require lead time to develop—e.g., claims runs, loss and expense ratios (acquisition, administrative and claim cost), policy runs, licensed producers runs— or any alternate and/or appropriate methods of isolating records, if necessary;
 5. Office space, supplies and equipment required to conduct the examination;
 6. A request that the company respond to the notification letter and furnish the name of its examination coordinator;
 7. The parameters of examinee conduct, and the procedures by which companies can report complaints against examiners and resolve problems which may develop related to company examinations;
 8. If the examination team expects to utilize audit software during the examination, the letter should include notification to the company of the intent to use the audit software. Information relative to the installation procedure should accompany the notification letter, and
 9. The pre-examination packet or examination coordinator's handbook provided to the regulated entity prior to the onset of an examination should outline state insurance department policies and procedures for maintaining the confidentiality of documentation reviewed during an examination.

H. Company Identifies Examination Coordinator(s)

Prior to the commencement of the examination, the company must identify company personnel who will have the authority and responsibility to respond to the criticisms of the examiners, as well as provide additional information as needed.

The company responds to appendices/other requested information received. The company is instructed to respond to the insurance department by a specified date with answers to various questionnaires or interrogatories contained within the preliminary pre-examination packet or examination coordinator's handbook, as well as provide any other requested information by the date specified.

I. Examination Audit Plan Drafted

1. A state shall determine the phases and/or standards of the examination that are to be reviewed. An estimate of the amount of time required to conduct each phase of the examination should be made, with the understanding that additional time may be necessary depending upon the findings of the examination.
2. The type of information to be included in an audit plan is as follows:
 - a. The scope of the examination;
 - b. The justification for the examination (summarized);
 - c. The lines of business to be examined;
 - d. Company procedures to be examined/omitted and the reasons for doing so;
 - e. A time estimate for completing the examination; and
 - f. An identification of factors that will be included in the billing.
3. Determine the type of report to be prepared—either one by test or one by exception.

J. Initial Examination Team Meeting, Including Contractors (Optional)

States that use contract firms must determine goals, restrictions, procedures, oversight and billing procedures. It is recommended that the insurance department meet with the examination team prior to the team going on-site. To the extent possible, instructions provided to contractors should also be shared with the company.

K. Pre-Examination Contact

Under ordinary circumstances, the EIC will contact the company coordinator prior to the beginning of the examination and make all necessary arrangements. This contact may be by telephone, a letter or a pre-examination visit. It is during this pre-examination contact that the work space, data requests, necessary supplies, office equipment and other examination details should be discussed. The EIC will also make the necessary arrangements to begin the field portion of the examination.

L. Pre-Examination Procedures

1. Insurance Department Records Review
 - a. The EIC of the scheduled examination should, prior to the examination, review the following:
 1. Prior examination reports with related correspondence directive to the company and the company's response, if any;
 2. Information from other jurisdictions applicable to the examination;

3. Information available from the NAIC, including the following, should be reviewed:
 - Examination Jumpstart Reports;
 - Regulatory Information Retrieval System (RIRS);
 - Complaints Database System (CDS) and the Complaint Index Report;
 - Market Action Tracking System (MATS); and
 - Financial Analysis and Solvency Tracking System (FAST).

In addition to the above information, sharing of audit software applications designed for specific uses or entities should be accomplished through the use of the NAIC File Repository.

4. Consumer complaint records to determine any recent trends in the number or nature of complaints;
 5. Producer licensing information; and
 6. Rate and form filings.
- b. The EIC should contact other department supervisors to develop additional information or guidelines for the examination. Necessary authority (e.g., warrant or subpoena) for the examination should also be secured.
 - c. To the extent that any of the information requested is available in the insurance department's office, it may not be necessary to obtain such information at the company office.

2. Pre-Examination Visit or Telephone Call

In addition to the notification letter, it is advisable to provide further detail to the company prior to the commencement of the examination. This additional communication can be accomplished through a pre-examination visit, telephone call or combination of both. The purpose of the pre-examination visit or telephone call includes:

- a. Discuss the examination process and expectations with company officials responsible for the areas to be examined and the designated company coordinator;
- b. Review the company recordkeeping and computer systems. Identify normal market conduct procedures, which may require modification to accommodate the data processing methods of the company and to avoid unnecessary costs to the company. For companies that do not maintain hardcopy files, those files must be accessible via Cathode Ray Tube (CRT), micrographics, imaging, microfiche or any other medium, and capable of duplication to hardcopy if the examiners so request;
- c. Request copies of previous examinations and internal audit reports;
- d. Determine other branch locations, which handle business within the jurisdiction that may impact the examination;
- e. Arrange for security access and working space for the examination team, along with required office supplies and equipment needed to conduct the examination;
- f. Review materials requested in the notice; and
- g. Discuss working hours and travel arrangements.

3. Instructions to the Examination Team
 - a. The EIC should contact all examiners scheduled for the examination and convey the following information:
 1. Name and location of company;
 2. Date and time the examination will begin;
 3. Specific instructions concerning the conduct and purpose of the examination and the time period under review;
 4. Name of designated company coordinator;
 5. Scope of the examination;
 6. Administrative issues, including working hours and travel arrangements;
 7. Develop an audit trail procedure for the examination; and
 8. Organization of work papers.
 - b. Prior to the start of the examination, the EIC should communicate with other members of the examination team to:
 1. Discuss all pre-examination findings and familiarize the examination team members with pertinent information developed;
 2. Outline each examiner's assignment to be completed during the examination;
 3. Receive input from the examination team as it pertains to ideas or suggestions for successful completion of the examination;
 4. Discuss maintenance of working papers to provide a record of all conclusions and supporting analyses and data. The working papers should include:
 - Summary of conclusions and the analyses that support them;
 - Factual support for the analyses, including detailed worksheets indicating individual file data; and
 - Screen prints where media is electronic;
 5. Emphasize properly documenting work papers and exceptions. Most jurisdictions document exceptions with the use of critique forms and photocopies of appropriate files and materials. Examiners should review insurance department guidelines concerning proper "chain-of-custody" for evidence, when noted exceptions might involve administrative, criminal or additional civil actions; and
 6. Examiners should be aware of requirements for the handling of confidential materials; e.g., alcohol and drug abuse, medical records.

M. Data/Files

Data Requests Are Provided to the Company

Detailed instructions for data requests should be provided in the pre-examination packet or examination coordinator's handbook. States should utilize the uniform data requests or inform the company that they will be supplying alternative data requests. The request should clearly state the file type, format and medium. Examples of data requests are policy types by policy number and issue date; claim types by claim number and date received; commissions paid by name, date and amount; producer contracts by name and effective date; and policy forms by type and firm date of use.

Data Received from the Company

Upon receipt of the completed data requests, the examiner should validate the data. File selection may take place in advance of the examination team's arrival or upon arrival at the examination location. The EIC may instruct the company, prior to arrival or upon arrival, of the files to be pulled or reports to be provided when the on-site examination has begun.

EIC Reviews Appendices/Other Requested Information

The EIC should review the company's responses to the questionnaires and/or interrogatories and request any additional information needed.

Samples Determined

Depending on the circumstances, the examiners will use company-provided printouts, ACL or other methods necessary to select the files for the sample or census review.

N. On-Site Coordination

1. Once the examination team has arrived on-site, the EIC should take the opportunity to introduce the examination team members. The EIC should explain the examination process to the company coordinator. The EIC should inform the company at this time if the examiners have any special needs or additional requests.
2. The EIC should notify the chief examiner of the start of the examination and report any changes or developments resulting from the preliminary meetings with the company's representatives.
3. The EIC shall be responsible for timely progress reports, including adverse findings, to the insurance department and to the company, as may be advisable.
4. The EIC shall be responsible for the efficient conduct of the examination and supervision of the examination team.

O. Request for Information

When an examiner perceives a violation of a statute, regulation or policy provision or discloses a rating, underwriting, claim or producer licensing error—the company will be provided a written form requesting an explanation of the error or a written acknowledgment of the error. This form is commonly referred to as a criticism or a “crit” sheet. The criticism and the company's response become part of the examination documentation. The company is allowed a specified time period to respond.

1. Summary of Findings

Upon completion of the file reviews, the examination team prepares a report of their findings. The examiners should share the summary of findings with the company.

2. Final Examination Team Meeting

Upon completion of the field work of the examination, the EIC should offer to conduct an exit meeting with the company to discuss significant findings, explain the next steps in the examination process and allow the company to present any outstanding concerns. The EIC should not re-argue the findings of the team at this time.

P. Communicating with Company Management

1. The EIC should ensure that communication with company personnel is clear, concise and to the point.
2. The EIC should encourage an open line of communication between the examination team and company personnel.
3. The EIC should make it clear to company personnel that requests for documentation and other information should be provided in a timely manner.
4. The EIC should ensure that all communication with company personnel is well documented.

5. The EIC should deal directly with the company examination coordinator, but not allow this arrangement to restrict the examination process or excessively shield key personnel with whom examiners need to communicate.
6. The EIC should explain to company personnel that the timely completion of the examination depends on communication and cooperation.

Only through open communication between the examination team and company personnel will both parties be on the same page, thus leading to a “no surprises” wrap-up or exit conference.

Q. Post-Examination

Post-examination procedures may vary according to state examination laws or administrative procedures and requirements.

1. Wrap-Up or Exit Conference

A wrap-up or exit conference is initiated by the examination team at the completion of the on-site examination. The company’s management personnel should be included in this conference. The examination team will summarize its findings and discuss issues pertinent to the report. The wrap-up or exit conference can be accomplished face-to-face, via teleconference, or via written form.

The EIC should advise company personnel of the resolution process utilized by his/her insurance department. The process should include the following:

- a. Process used to draft the report;
- b. Timetable necessary for submitting the report to the company; and
- c. Timetable designated for the company’s review of the report.

2. Drafting of the Examination Report

The examination team will prepare the initial draft of the report. The format of the report should be in accordance with NAIC uniform contract examination report guidelines and include a summary of all findings of the examination. See Chapter 15—Writing the Examination Report for guidance on writing examination reports.

3. Review of the Examination Report

The report should be submitted to the insurance department and reviewed by designated personnel of the department.

4. Company Review and Acceptance of the Report

The report is sent to the company. Instructions relative to the resolution of the report should be included. The timetable given to the company for review of the report should be stipulated in the instructions. Items necessary for resolution may include one or more of the following:

- a. A formal letter of acceptance;
- b. A statement of corrective actions on developed issues;

- c. A letter signed by each company director acknowledging the contents of the report, where required; and
- d. Any other information or acknowledgment specifically required by state statute.

5. Informal Conference on the Report

If all issues relating to the report are not mutually agreed upon, the company may request an informal conference with the insurance department. This conference should be held at the insurance department's office.

6. Formal Hearing on Report

If problems relating to the report continue to exist (following the informal conference), a formal hearing should be held to resolve any issues in the report.

7. Regulatory Action

Final regulatory disposition will be determined by the insurance department, not the examiner. A disposition may include one or more of the following items:

- a. No further regulatory action;
- b. Re-examination referencing issues noted in previous examination report;
- c. Consent order;
- d. Agreement or order of stipulation;
- e. Payment of a monetary penalty; and
- f. Waiver of right to a hearing.

8. Distribution of Report and Final Regulatory Action

A copy of the report should be forwarded to the insurance commissioner of the domiciliary state. Examination results should be entered into appropriate NAIC database. Additionally, final (adjudicated) actions should be entered into the appropriate NAIC database.

9. Post-Examination Questionnaire

The post-examination questionnaire is designed to aid in the final evaluation of the examination team. It is important that the coordinator identify challenges as they arise and provide feedback that improves the examination process. The questionnaire should be completed by the company's examination coordinator at the conclusion of the examination field work. It may be included in the pre-examination packet/examination coordinator's handbook or mailed to the company at the conclusion of the examination. A sample post-examination questionnaire is included at the end of this chapter.

R. Market Conduct Uniform Examination Outline

1. Examination Scheduling
 - a. Each state shall prioritize examinations.
 1. Each state shall establish criteria for calling a market conduct examination. (See Section S of this chapter for an example of items that may be considered.) States shall establish a priority or weight for each of the criterion being considered.
 2. Each state shall prepare a schedule of examinations and select a person responsible for developing and maintaining the schedule. Exceptions may be made when an examination is called as a “no-knock” examination; and
 3. The trigger or reason for the examination shall be maintained in the examination documents, preferably the work papers.
 - b. States shall utilize the NAIC Market Action Tracking System (MATS).
 1. As soon as scheduled, each state shall enter the examination into MATS, which is administered by the NAIC; and
 2. Each state shall adopt a system for ensuring proper implementation and maintenance of the MATS system.
 - c. Each state shall follow a timetable for entry of examinations into MATS.
 1. Examinations shall be entered into MATS no later than 60 days before the expected date of the on-site examination. Exceptions to this rule are examinations that are called to respond to more immediate conditions.
2. Pre-Examination Planning
 - a. Internal planning by states on companies selected for examination.
 1. Each state shall develop a standard planning process. Many of the items reviewed may have been used in the examination priority process and may become the basis for the pre-examination planning. In addition to the items found in the examination scheduling, the following information may be considered:
 - Information from prior examinations;
 - NAIC database;
 - Internal database such as the complaint index;
 - Discussions with other insurance department personnel;
 - The financial statement;
 - Interview with the company; and
 - Information received from other states’ examinations.
 2. The plan should be maintained in a manner that may be incorporated into the work papers.
 3. At the end of the planning process, the state shall determine the phases and/or standards of the examination that require more attention; the phases or standard that require average examination scrutiny or attention; and those that require a reduced emphasis or may be waived:
 - Special emphasis: Larger samples, more scrutiny, more examination time allotted;
 - Standard emphasis: Initial sample follows NAIC guides, average scrutiny and examination time allotted; and
 - Reduced emphasis: Smaller samples, review may be limited to procedures only, reduced scrutiny and examination time allocation.

4. Each state shall prepare an examination work plan prior to the examination. The work plan or planning memorandum shall include:
 - The scope of the examination;
 - The justification for the examination;
 - A time and cost estimate; and
 - An identification of factors that will be included in the billing.
 - b. Each state shall develop a system to announce the examination to the selected company.
 1. The announcement of the examination should be sent to the company as soon as possible, but in no case not any later than 60 days before the estimated commencement of the on-site examination. The announcement notice should contain:
 - The name and address of the company or companies being examined;
 - The name and contact information of the Examiner-in-Charge;
 - The date the on-site examination is expected to begin;
 - The statutory authority for the examination;
 - The identification of items that will be billed to the company, if any;
 - A request for the company to name its examination coordinator; and
 - Additional information may be requested at a later date.
 - c. Each state shall develop a preliminary examination packet or examination coordinator's handbook that should be sent to the examination coordinator as soon as possible, but in no case not later than 30 days before the estimated commencement of the on-site examination.
 1. The preliminary information shall contain the following information:
 - General instructions;
 - The scope of the examination;
 - The materials requested to perform the examination;
 - Standardized data requests;
 - Requirements for accommodations and supplies;
 - Time and cost estimates;
 - Travel information;
 - Specific instructions regarding sample communications with the company and other pertinent information;
 - Location of on-site examination;
 - Security arrangements; and
 - Billing procedures.
 - d. Standardized Data Requests.
 1. States shall adopt a standardized data request. The standardized data request will be broad and states may choose not to use all fields.
 2. If a state deviates from the standardized data request, it will notify the company of the deviation and may want to allow additional time for the company to provide the information.
3. Examination Procedures
- a. The state shall conduct a pre-examination conference with the company coordinator and key personnel to clarify expectations prior to the commencement of the examination.

- b. The state shall develop a system for exchanging information with the company that advises them of the errors and other problems developed during the examination. The system could consist of “crit” sheets, summaries, or both. Any form of communication concerning errors should include the following information:
 - 1. Record numbers or other identifying factors;
 - 2. The examiner’s statement of the problem or error and, if relevant, the applicable law and/or standard; and
 - 3. A request for signature and comment from the company.
 - c. Each state shall develop a procedure for document handling, including the removal of original documents to a location other than the state insurance department. To address the issue of confidentiality, original work paper documents shall remain at the state insurance department, especially if the examiner is a contracted employee of the state department.
 - d. States shall use the NAIC sampling guidelines or develop their own scientifically based sampling program.
 - 1. All sampling methods should be random;
 - 2. If using a method other than the NAIC sampling guidelines, the method shall indicate the confidence levels, tolerable error rates and include extrapolation; and
 - 3. All sampling methods shall avoid pre-selection; however, stratified sampling is allowed. (See the Sampling Chapter of this handbook for further discussion.)
 - e. Each state shall offer to conduct an exit conference at the end of an examination. The exit conference should offer the following:
 - 1. The examination status and proposed findings;
 - 2. The report process; and
 - 3. An explanation of any post-examination billing.
4. Examination Reports
- a. The states shall utilize a standard format found in the *Market Regulation Handbook*, to include the following:
 - 1. Title page;
 - 2. Table of contents;
 - 3. Salutation;
 - 4. Foreword;
 - 5. Scope;
 - 6. Executive summary;
 - 7. Results of previous examinations;
 - 8. Prominent facts of the current examination;
 - 9. Summarization; and
 - 10. Appendices.

The examination report may be written by test or by exception. States shall report the method utilized to the company and in the scope of the report.

- b. States shall utilize a standardized timeline as required by state statute or the *Model Law on Examinations* (#390) as outlined below:
 - 1. The draft report is delivered to the company within 60 days of completion of the examination;
 - 2. The company must respond with comments to the state within 30 days;
 - 3. The insurance department has 30 days to informally resolve issues and prepare a final report (unless there is a mutual agreement to extend the deadline); and
 - 4. The company has 30 days to accept the final report or request a hearing.

- c. The states shall include the company's response in the final report. The response may be included as an appendix or in the text of the examination report. If it is not in the final report, the report should indicate that a response is available. The company is not obligated to submit a response. Individuals involved in the examination should not be named in either the report or the response, except to acknowledge their involvement.
- d. States shall publish examination reports as public documents where allowed by law. States should publish examination reports on the insurance departments' websites. States shall develop a process for releasing examination results to the public. A press release may be used.
- e. States shall devise an enforcement strategy; specifically, the role of market conduct activities in that effort. The primary role of examiners is to be fact-finders when determining compliance, which can then be used by the insurance department to determine sanctions or fines. An enforcement strategy should have a system in place to differentiate between willful actions and inadvertent ones, and consider appropriate administrative resolutions, whether financial or non-financial. States should also want to consider a methodology for determining the amounts of fines, based on a host of criteria—the size of the company, the company's market share, whether the problems have been corrected and any host of mitigating or aggravating circumstances. States should also be certain to communicate the basis of any assessed penalty.
- f. Each state shall establish a follow-up examination process.

S. Reasons for Examination

- 1. Complaint Index—States should review complaints to determine where problems exist. Insurance departments may develop an index for each company measuring the number of complaints to that company's market share by premium volume.
- 2. Recent Complaints—An increase in recent complaints filed against an insurance company may suggest concern. In order to address those complaints, an examination may be necessary in order to obtain remedial action.
- 3. Market Share—Due to its volume of premium, the practices of a particular insurance company can impact a large number of consumers. If the state needs to review a particular line of business or particular type of product, the state may choose those companies with the most premium volume.
- 4. Financial Examination—Financial examiners may discover an issue during an examination which warrants further review from a market conduct perspective. A market conduct examination may occur simultaneously with a financial examination. The financial examiners may incorporate the findings of the market conduct examiners into the financial examination report.
- 5. Information from Other States—Findings by other state regulators may generate a need to discover whether the same or similar practices are occurring in another state. One state may extend an invitation to other states to participate in a multistate examination.
- 6. Legal Request—An insurance department's legal division may discover an illegal practice(s) which warrants further discovery through an examination.
- 7. Shift in Business Practices—A company may change its product mix, resulting in a significant change in its operations. If a company has not adequately managed for such a change, it may not have the expertise to properly and fairly treat its consumers. An examination may address problems before such problems become widespread.

8. Principals Involved—The state may become aware that individuals have had a past history of regulatory noncompliance. The NAIC maintains information systems identifying suspect individuals and associated past regulatory actions. An examination can identify improper activity prior to its impact on a large number of consumers.
9. Information from Statistics—States may maintain several databases. For example, Missouri law requires the reporting of certain information, such as financial statements, premium volume and amounts of claims paid categorized by ZIP code, malpractice claims, etc. Statistical tests evaluate aberrations that may necessitate further discovery by means of an examination. Many states participate in the Market Conduct Annual Statement (MCAS). General information and additional detail regarding MCAS may be found on the NAIC website www.naic.org/industry_market_conduct_statement.htm.
10. Policy Approval Suggestions—A policy analyst may note a trend in policy form filings that may necessitate further discovery by means of an examination.
11. Request of the Director/Commissioner—The Director/Commissioner may ask for an evaluation of certain practices or certain products.
12. Result of Last Market Conduct Examination—Based upon a review of the findings of a prior examination, the state may determine the need for further review.
13. Industry Suggestion—Insurance company personnel may bring to the state's attention a particular practice or product that may need a further evaluation.
14. Member of Group Being Examined—Typically, many insurance companies operate under an umbrella holding company sharing the same personnel and similar operational management. While examining one insurance company, it may be more cost-effective to review several companies within the same group.
15. Periodic: Length of Time Since Last Examination—The mere passage of time without an examination, in conjunction with other factors, may indicate the need for an examination.
16. New Operation: Never Examined or Under New Management—Much like the shift in business practices described above, a new company or a new management team may not have the expertise to properly and fairly treat its consumers. An examination may address problems before the problems become widespread.
17. Re-Examination: Understanding at Time of Stipulation—In some cases, during the negotiation of an examination's resolution, the examined company and the insurance department will agree that some mitigating circumstance created the cited noncompliance. The company may indicate that it is now in compliance. In order to verify that remedial action has occurred and that the company has accomplished full compliance, the state may perform a second examination.
18. Evaluation of New Law—The state may target an examination in order to determine the compliance with and the effectiveness of recently enacted statutes.
19. Media—States may receive information through a news broadcast or trade journal that prompts further evaluation.

T. Market Conduct Examination Pre-Planning Checklist

Company Name: _____

NAIC Company Code: _____ NAIC Group Code: _____

Company Home Office Location: _____

Examination Site Locations: _____

I. COMPANY SELECTION

Complete	Date Completed	Examiner(s)	Due Date	Task
<input type="checkbox"/>				1. Company selected
<input type="checkbox"/>				2. Justification
<input type="checkbox"/>				3. Internal data request
<input type="checkbox"/>				4. Scope of examination
<input type="checkbox"/>				5. Examiner-in-Charge (EIC) and team named
<input type="checkbox"/>				6. Anticipated duration determined

II. COMPANY NOTIFICATION

Complete	Date Completed	Examiner(s)	Due Date	Task
<input type="checkbox"/>				1. Notice of examination reported to MATS
<input type="checkbox"/>				2. Notice of examination sent to company
<input type="checkbox"/>				3. Pre-examination packet or examination coordinator's handbook sent to company
<input type="checkbox"/>				4. Company appointed examination coordinator
<input type="checkbox"/>				5. Company responded to appendices received

III. EXAMINATION TEAM

Complete	Date Completed	Examiner(s)	Due Date	Task
<input type="checkbox"/>				1. Examination audit plan drafted
<input type="checkbox"/>				2. Initial team meeting—contractors (optional)
<input type="checkbox"/>				3. Pre-examination contact
<input type="checkbox"/>				4. Pre-examination visit (optional)
<input type="checkbox"/>				5. Completed all necessary travel arrangements

IV. DATA/FILES

Complete	Date Completed	Examiner(s)	Due Date	Task
<input type="checkbox"/>				1. Data requests sent to company
<input type="checkbox"/>				2. Data received from the company
<input type="checkbox"/>				3. EIC review of appendices/other requested information completed
<input type="checkbox"/>				4. Samples determined and sent to the company

V. EXAMINATION STAGE

Complete	Date Completed	Examiner(s)	Due Date	Task
<input type="checkbox"/>				1. Request for information (RFIs)
<input type="checkbox"/>				2. Interim conference
<input type="checkbox"/>				3. File sampling
<input type="checkbox"/>				4. Summary of findings
<input type="checkbox"/>				5. Final examination team meeting
<input type="checkbox"/>				6. Offer to hold exit meeting

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U. Market Conduct Examination Checklist

Company Name _____
 NAIC Group and Company Code _____
 State Certificate of Authority Number _____

Examination

✓	DATE	INITIAL	DESCRIPTION
<input type="checkbox"/>	___/___/___	___	Examination Commences
<input type="checkbox"/>	___/___/___	___	Examination Site Review by Section Chief
<input type="checkbox"/>	___/___/___	___	Examiner-in-Charge (EIC) Weekly Report Week 1
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 2
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 3
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 4
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 5
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 6
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 7
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 8
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 9
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 10
<input type="checkbox"/>	___/___/___	___	EIC Weekly Report Week 11
<input type="checkbox"/>	___/___/___	___	Examination Field Work Completed

Post-Examination

✓	DATE	INITIAL	DESCRIPTION
<input type="checkbox"/>	___/___/___	___	Report of Examination Completed
<input type="checkbox"/>	___/___/___	___	Peer Review of Examination Report Completed
<input type="checkbox"/>	___/___/___	___	Report Extension Approved by Director/Commissioner (optional extension of 60 days)
<input type="checkbox"/>	___/___/___	___	Report of Examination Filed with Insurance Department
<input type="checkbox"/>	___/___/___	___	Notice to Examinee with Proposed Report (within 60 days of completion of field work)
<input type="checkbox"/>	___/___/___	___	Response from Examinee Received (within 30 days of receipt of proposed report)
<input type="checkbox"/>	___/___/___	___	60 Days for Rebuttal Expires
<input type="checkbox"/>	___/___/___	___	Director/Commissioner's Review Completed (within 30 days of rebuttal expiration)
<input type="checkbox"/>	___/___/___	___	Order to Approve, Reject/Reopen, Hearing
<input type="checkbox"/>	___/___/___	___	Final Report to Examinee with Director/Commissioner's Order

U. Market Conduct Examination Checklist, cont'd

Company Name _____
 NAIC Group and Company Code _____
 State Certificate of Authority Number _____

<input type="checkbox"/>	___/___/___	___	Update NAIC Market Action Tracking System (MATS)
<input type="checkbox"/>	___/___/___	___	Company Directory Affidavits Completed and Received (within 30 days of receipt of final report)

Billing and Copies

✓	DATE	INITIAL	DESCRIPTION
<input type="checkbox"/>	___/___/___	___	Billing Completed Month 1
<input type="checkbox"/>	___/___/___	___	Billing Completed Month 2
<input type="checkbox"/>	___/___/___	___	Billing Completed Month 3
<input type="checkbox"/>	___/___/___	___	Billing Completed Month 4
<input type="checkbox"/>	___/___/___	___	Circulation
<input type="checkbox"/>	___/___/___	___	Examination File Copy
<input type="checkbox"/>	___/___/___	___	Insurance Department Staff Copy
<input type="checkbox"/>	___/___/___	___	Insurance Department Staff Copy #2 (if more than one office)
<input type="checkbox"/>	___/___/___	___	Market Conduct Book Copy
<input type="checkbox"/>	___/___/___	___	State of Domicile Copy
<input type="checkbox"/>	___/___/___	___	NAIC Copy
<input type="checkbox"/>	___/___/___	___	Other Interested States' Copies
<input type="checkbox"/>	___/___/___	___	_____
<input type="checkbox"/>	___/___/___	___	_____
<input type="checkbox"/>	___/___/___	___	_____
<input type="checkbox"/>	___/___/___	___	_____
<input type="checkbox"/>	___/___/___	___	_____
<input type="checkbox"/>	___/___/___	___	_____
<input type="checkbox"/>	___/___/___	___	_____

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V. Post-Examination Questionnaire

<Date>

<Name>

<Title>

<Name of Company>

<Address>

<City> <State> <ZIP>

Dear <Name>:

RE: Post-Examination Questionnaire
<Examination #>
<Name of Company>

The (State) Department of Insurance has recently completed a market conduct examination of your company. The attached Post-Examination Questionnaire is designed to give us your perception of our performance during the recent examination of your company. It will allow us to evaluate our current procedures, as well as strive for improvement that should be mutually beneficial.

I appreciate you taking a few moments of your busy schedule to complete the questionnaire. As coordinator for that examination, your insight into the professionalism and efficiency with which the examination was conducted would be helpful. Please be assured your responses will only be shared with the Director's management team. To assure confidentiality, return the form to my attention with "Personal and Confidential" marked on the envelope. Please return the questionnaire to my attention at (State) Department of Insurance, P.O. Box 12345, 444 State Avenue, Anywhere, State 55555-3456 by <Date>. Thank you.

Very truly yours,

X. Sammy Nation, CIE
(Market Conduct Chief Examiner)

Post-Examination Questionnaire
Market Conduct Examination Evaluation

<Examination #>
<NAIC> <Name of Company>
<Date>

Examiner-in-Charge _____

Participating Examiners: _____

1. Did the materials provided prior to the examination provide sufficient information to allow you to adequately prepare for the presence of the examiners? Yes No
Comments _____

2. Did the pre-examination conference help in facilitating the examination process? Yes No
Comments _____

3. Did the examiners observe company restrictions on non-smoking areas? Yes No
Comments _____

4. Did the examiners observe proper working hours, dress codes, use of parking facilities, use of facilities and any other company procedures (security check-in, security check-out, equipment care, maintenance, etc.) that you asked to be observed? Yes No
Comments _____

5. Were the examiners punctual in responding to their duties? Yes No
Comments _____

6. Did the examiner properly use the resources of the company in a considerate and ethical manner (examination-only use of telephone, copy equipment, computers, etc.)? Yes No
Comments _____

7. Were the examiners professional in demeanor and appearance when on the job? Yes No
Comments _____

Not for Distribution

Post-Examination Questionnaire
Market Conduct Examination Evaluation

<Examination #>
<NAIC> <Name of Company>
<Date>

- 8. Were the examiners positive in manner, helpful in the response to your questions, and courteous and respectful in their contact and communications with you and your staff? Yes No
Comments _____

- 9. Were the examiners properly directed and supervised by the Examiner-in-Charge so that the examination was as orderly as could be expected? Yes No
Comments _____

- 10. Did the examiners appear to you to work efficiently on the files sampled? Yes No
Comments _____

- 11. Were sufficient documents requested and retained at one time so as to remain busy at all times?
 Yes No
Comments _____

- 12. Did the examiners appear knowledgeable in the lines of business reviewed and in the work and procedures performed? Yes No
Comments _____

- 13. Have you benefited from the examination performed by the examiners? Yes No
Comments _____

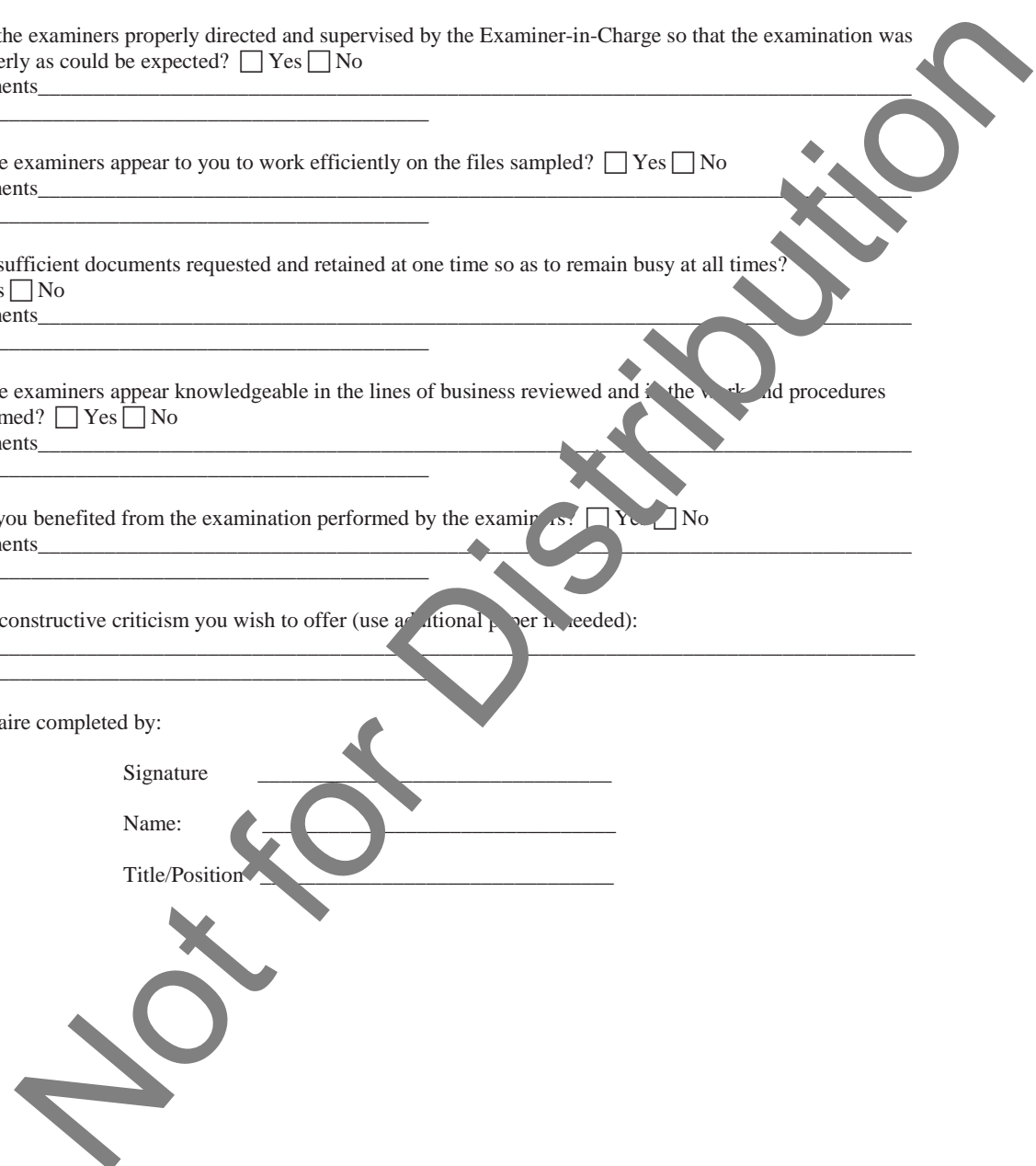
- 14. Other constructive criticism you wish to offer (use additional paper if needed):

Questionnaire completed by:

Signature _____

Name: _____

Title/Position _____



Not for Distribution

Chapter 13—Standardized Data Requests

This chapter provides guidance to market conduct examiners and promotes the use of standardized data requests during market conduct examinations. Examiners should also consult the standards in the Market Conduct Uniform Examination Outline, which is located in Chapter 12.

The intent is to establish a set of standardized data requests that all the states can use for uniform examinations. Each type of standardized data request contains two parts: (1) a master field list, and (2) a data request layout. The master field list is composed of the majority of fields that could be requested in the examination request. The fields are sorted alphabetically and include the desired format and a description of each field. The actual data request layouts are for each data table that could be requested in a data request. Each table layout includes a brief description of the data to be included in the table, along with possible uses for the data submitted. The type and scope of examination would determine which tables and fields would need to be requested.

The following parameters were taken into consideration during the development of standardized data requests:

- An examiner can add fields that are specific to business in their state or cover areas that have not been covered in the master list. The examiner should inform the company of additional requests and give the company a longer time period to provide those files;
- The companies are not required to maintain each field. The master list is just an example of the types of data that might be requested. The examiner should review the actual data request with the company prior to the creation of any files. The discussion should determine which fields the company can or cannot provide. For fields that cannot be provided, the company and examiner need to determine the best way for the examiners to obtain the information needed;
- The fields are designed to mirror information normally kept in specific fields of the company's computer system. They were not meant to be for information that is kept in "memo" fields. For example, a company may keep the amount of the claim payment in a numeric field specifically marked for that purpose, but would keep all of the adjuster's notes on how the adjuster arrived at that amount in a memo or notes field. These cannot be easily provided and can be quite large, so they would need to be reviewed during the actual examination and not requested in the initial data request;
- The fields selected were intended to enable the examiner to break down a file for sampling or perform 100 percent compliance tests. For example, a file of paid claims would include the claim feature code so that it would be broken down into the different feature code populations (e.g., first-party vs. third-party) and sampled; or a file of commissions paid would be reviewed directly for 100 percent licensed and appointed compliance testing; and
- The fields may also be used for completeness testing. Completeness testing for market conduct examinations differs from that conducted for financial examinations. The market conduct examiner will normally try to compare to the financial State Pages. Since State Pages are not usually audited, results of these tests can be inconclusive. Other fields must be placed into the data request to help the examiner feel comfortable that the file is accurate and complete. These types of fields would include the NAIC company code, state, policy effective date or policy inception date.

Each master list is laid out in the basic structure of a typical mainframe file definition and contains the following information:

- **Field Name**—This is an eight-space abbreviation of what the field is. The name is limited to eight spaces because some types of software, such as dBase, will not work properly if the field name is longer than eight spaces. A large portion of the industry supplies examiners with dBase files because dBase files can be downloaded from most mainframe computers. Also, when using programs like ACL and Microsoft Access, it is best to have short field names when programming queries;

- **Length**—This field tells the company how long the field should be. The actual field length may vary from company to company, but it is good to give the company a starting point. The examiner should allow the company to change the length, if necessary, but ask that the company inform the examiner if such a change is made. This instruction is also included at the top of each of the sample data requests that follow the master list. Having a standard length can save time for the examiner. If the same request is used from company to company, the format in ACL and Microsoft Access can easily be copied and reused from one examination to the next;
- **Type**—This tells the company whether to format the information in a given field as an alphanumeric field (both letters and numbers possible) or as a numeric field (only numbers possible). This is especially important for fields such as ZIP codes that could start with a zero. If a ZIP code field is formatted as a numeric field, any leading zeros will be removed. A ZIP code that should be “01742” will show up as “1742” in a numeric field;
- **Decimals**—This is only used with numeric fields and tells the company how many decimal places should be in the number. If decimal places are not specified, the examiner will not be able to distinguish between \$100 and \$1;
- **Description**—This explains what the field is and if specific layouts are needed. For example, it may specify whether a particular field should contain “yes” or “no,” or a description might specify a date format of “MM/DD/YY”; and
- **Suggestions for possible data requests**—Helps examiners who may not be very familiar with some of these fields; the master list contains suggestions for what kind of request would contain each field.

Included within each standardized data request file are sample data requests to help demonstrate how fields are picked from the master list and used in an actual data request. Standardized data requests were also developed to help a less experienced examiner get started. At the top of each sample data request is an explanation of what the request is and how/when to use it.

Further lines of business and directions will be available on the *Market Regulation Handbook* web page on StateNet as additional standardized data requests are adopted by the NAIC.

A. Standardized Data Requests (SDR)

What is an SDR?

The SDR is a “wish list” of possible needs that could be asked for during an examination. It includes field names and descriptions, along with suggestions for possible data requests to help an examiner get started. Examiners can deviate from this list by informing the company in writing.

The SDR:

- Provides a list of individual fields from which an examiner can pick and choose for an examination;
- Assists with uniformity of requesting data from companies;
- Is not an “everything” list. It does not cover all areas (especially topics such as privacy or medical malpractice, where electronic data requests are a new arena). A standardized data request should be considered a working document;
- Is not a mandatory list of what companies have to maintain electronically. An examiner needs to be prepared to be flexible and willing to accept paper documents; and
- Is not intended to replace on-site portions of examinations. Some information that is mandatory to check for compliance can only be found by reviewing actual hardcopy files and may not be feasibly retrieved electronically.

How Do I Use A Standardized Data Request (SDR)?

The following is a step-by-step guide to using an SDR, once a company has been selected for examination.

- What type of examination is needed?
 - Annuity;
 - Life;
 - Health, long-term care or Medicare supplement;
 - Credit life and accident/health;
 - Title;
 - Property and casualty; and/or
 - Personal or commercial;
 - All areas (producer, commissions, complaints);
 - Advertising; and/or
 - Privacy.
- What areas will be reviewed?
 - New business;
 - Terminations, cancellations, nonrenewals, territory rating;
 - Claims;
 - Advertising;
 - Producer licensing;
 - Replacements (life and annuity); and/or
 - Underwriting.
- What is the time frame and scheduling?
 - Examination period;
 - When to send the data request;
 - When to have the data due; and
 - When the on-site portion of the examination will commence.
- What standards and tests can be used?
 - *Market Regulation Handbook*:
 - Determine which standards and tests apply; and
 - Consider the type of examination and any indicators that triggered a targeted examination.
- What are the applicable rules and statutes of the examining state?
 - Individual state;
 - Multiple states; and
 - Language and provisions in company forms may require a higher standard than the applicable state's rules and statutes. For example:
 - A life and annuity company may have a higher minimum/guaranteed interest rate than required; and
 - A property/casualty company may have a longer grace period or window for accepting past due premiums than required.
- What types of records are needed?
 - Policies issued or applications taken; and
 - Paid claims or denied claims.
- What fields are needed to determine populations and samples or 100 percent compliance?
 - Required fields:
 - Policy number or claim number for identification purposes;
 - Application, effective, paid or denied date to determine if items are within the examination period;
 - State (also used to verify that correct data was provided);
 - Code (used to determine business type and/or relevant policy form(s));

- Producer code (used to quantify results by producer or look for patterns of practice by producers); and
- Reason code (for determining populations);
- Optional additional fields; and
 - Names (to easily verify that correct sample files are provided);
 - Insured; and
 - Beneficiary;
 - Interest;
 - Rates; and
 - Amount paid;
 - Underwriting; and
 - Riders; and
 - Endorsements;
 - Claims;
 - Insured/Claimant name;
 - Date of loss; and
 - Claim payment amount;
- Fields needed to cross-reference or join tables:
 - Policy number on claims lists (to join the claim record with the policy record);
 - Social Security number or tax ID (to search for unreported replacements and producers with multiple producer codes);
 - Producer code on business and claims lists (to determine producer identity);
 - Plan code on business and claims lists (to determine business type and/or policy form); and
 - Insured name, when SSN or tax ID not available (can also be used to look for unreported replacements).
- How should the data request be organized?
 - Customize the standardized data request to the company;
 - Separate data requests by computer systems;
 - Producer licensing;
 - Life;
 - Annuity;
 - Homeowners;
 - Auto; and
 - Health;
 - Separate requests by various areas to test, including, but not limited to:
 - Auto; and
 - Claims paid (this file may include total losses, partial losses, first- and third-party cases);
 - Claims not paid;
 - Cancellations;
 - New business; and
 - Unfair discrimination;
 - Homeowners;
 - Claims paid; and
 - Claims not paid;

Not for Distribution

- Provide the company with specific instructions or parameters for each table or file requested:
 - Do not be surprised if the company interprets something differently than a previously examined company;
 - Replacements—Determine whether the examiner wants to review replacements where the company is the existing insurer, the replacing insurer or both (an internal replacement);
- Provide the company with guidelines on how each table will work; and
 - Field Name—Eight character or less identifier for field being requested;
 - Length—Number of characters examiner has provided for this field's data;
 - Be sure the company knows to adjust the field lengths as needed and not to just cut off data because the company runs out of room;
 - Type—The SDR uses only alphanumeric because companies are familiar with these types and not the more detailed options listed in ACL;
 - Description—Brief explanation of what each field should contain; and
 - End of record indicator—This field should contain a value for each record in a table so that the examiner will always know where the record ends;
- Provide a cover page with instructions relevant to the entire examination:
 - Company to be examined;
 - Examination period;
 - Applicable state(s);
 - Data submission protocol;
 - Data submission format;
 - Contact person at the insurance department; and
 - Due date for data requested.
- How can the right information be obtained?
 - Maintain communication with the company;
 - Compliance contact;
 - Person responsible for coordinating examination;
 - Systems contact; and
 - Person responsible for pulling electronic data;
 - Financial contact;
 - Person responsible for completing annual financial statement;
 - Schedule meeting or conference call to discuss; and
 - Definition and submission guidelines;
 - Fields and workarounds; and
 - Supporting documentation;
 - Code lists; and
 - Paper documents.
 - How to present questions.

Where Are the NAIC Standardized Data Requests Found?

Regulators may access the NAIC standardized data requests via myNAIC at the Market Regulation Handbook link on the StateNet home page. The standardized data requests are located in the Market Regulation Handbook Reference Documents section of the web page. Non-regulators may access the standardized data requests on the Market Conduct Examination Standards (D) Working Group web page which is found at www.naic.org >> **Committees >> Committee Task Forces & Working Groups >> Market Regulation and Consumer Affairs (D) Committee >> Market Conduct Examination Standards (D) Working Group >> Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

Revisions to the Producer, Commission and Complaint SDR, Property and Casualty Personal Lines SDR, Life and Annuity Insurance SDR and the Property and Casualty Commercial SDR were adopted in 2006 by the Market Regulation Handbook (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee. The Credit Life and Accident and Health SDR was also adopted by the Market Regulation Handbook (D) Working Group in 2006. The Title Insurance SDR and Sample Letter were adopted by the Market Regulation Handbook (D) Working Group in 2008. In 2009, revisions to the Commercial Property and Casualty SDR were adopted by the Market Conduct Examination Standards (D) Working Group. A health reform-related SDR and corresponding definitions were adopted at the NAIC 2015 Spring National Meeting.

Updated stand-alone NAIC Producer, Marketing and Sales, Commission and Complaint standardized data requests (which replace the combined Producer, Commission and Complaint standardized data request adopted in 2006) were adopted by the NAIC Executive (EX) Committee and Plenary in 2017. There are therefore eleven standardized data requests currently available, including:

1. Producer Data Request;*
2. Marketing and Sales Data Request;*
3. Commission Data Request;*
4. Complaint Data Request;*
5. Property and Casualty Personal Lines Data Request;
6. Life and Annuity Insurance Data Request;
7. Property and Casualty Commercial Standard Data Request;
8. Health, Long-Term Care and Medicare Supplement Data Request;
9. Credit Life and Accident and Health Data Request;
10. Title Data Request and Sample Letter; and
11. Health Reform-Related Data Request and Definitions.

*Regulators may access the updated NAIC Producer, Marketing and Sales, Commission and Complaint standardized data requests via myNAIC at the Market Regulation Handbook link on the StateNet home page. The standardized data requests are located in the Market Regulation Handbook Updates section of the web page.

Non-regulators may access the updated Producer, Marketing and Sales, Commission and Complaint standardized data requests via the Market Conduct Examination Standards (D) Working Group web page which is found at www.naic.org >> **Committees** >> **Committees, Task Forces & Working Groups** >> **Market Regulation and Consumer Affairs (D) Committee** >> **Market Conduct Examination Standards (D) Working Group** >> **Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

Chapter 14—Sampling

A. Purpose of Sampling

The systematic investigation of files is an integral part of market regulation. While it is rarely feasible to review all files of an examinee, the examination must nevertheless produce credible judgments about all files. For example, a judgment might assume the form of “claims processing errors for all claims in the state of ‘x’ during period ‘y’ exceeding ‘z’ percent,” even though all claims in a given state cannot reasonably be reviewed. Fortunately, it is not necessary to review all claim files in a given state to make such a judgment: applied statistics, a branch of probability theory in higher mathematics, provides an answer through sampling. It is important that both market conduct examiners and market analysts understand and properly apply sampling techniques. This chapter focuses primarily on sampling as it relates to proportions or percentages, although the same concepts generally apply to other statistics. For ease of reference, the term “regulator” will be used to refer to all insurance department staff who may use sampling.

Done properly, sampling permits valid generalizations or inferences about a wider population because the statistical properties governing the production of samples are known, via abstract mathematical probability theories, as well as countless empirical experiments and observations. The principles of sampling are not conceptually difficult; indeed, they are very nearly intuitive.

For example, the probability that the toss of a fair coin will result in “heads” is known to be 50 percent. After 100 coin tosses, the proportion of tosses resulting in “heads” will be very close to 50 percent. If the proportion were 30 percent, one would likely reject the idea (or “hypothesis”) that the coin is indeed fair and, making a statistical inference²² about the underlying process based on a sample. Because the coin has been deemed unfair, a valid generalization based on the sample (of 100 tosses) is that *future* coin tosses will also fail to produce a balanced ratio of head and tails. Of course, the inference could be wrong: in a tiny fraction of cases, even a fair coin will produce only 30 percent heads. But because the probability of this occurrence is remote, it would only happen in 0.002 percent of cases if the coin were really fair), one feels confident in making a judgment. Time and resources spent investigating the coin can be further reduced by reducing the sample size, or number of coin tosses, from 100 to 50. After 50 tosses the probability of 30 percent heads is .87 percent, and one can still be highly confident that the coin is unfair given the result.

Sampling is governed by the same principles of probability as those of a simple coin toss:

1. The probabilities of the underlying process must be known. In this context, the probability of selecting any given file from the entire population must be known. Therefore, sampling must be random. The relevant probabilities associated with non-random sampling techniques are generally unknown, and generalizations about a population from which the sample is taken cannot be made with a known probability (or confidence) of being correct.
2. Sampling methods should minimize the possibility of departures from randomness, or the introduction of statistical “bias.” Significant bias will invalidate statistical inferences. For example, if a skilled magician could manipulate coin tosses in such a way that one outcome is more likely than another, the inference that the coin is unfair would be incorrect. Rather, the sampling process was “biased,” or non-random.

²² Statistical inferences are made by *rejecting* a proposition or hypothesis and thereby accepting a contrary, mutually exclusive alternative, with some known probability of being correct. Rarely is the process the other way around, whereby a statistical test affirmatively establishes a proposition. This is because failing to reject a hypothesis at a probability of ‘x’ does *not* indicate that the hypothesis is correct with a probability of 1-x. Even an unfair coin will produce 50 percent heads some times, so that an outcome of 50 percent heads does not affirmatively establish that the coin is fair, even though the hypothesis that “the coin is fair” is not rejected.

3. Inferences from samples are never made with certainty, but only with some known and calculable probability of being correct. This probability is called *confidence*. After 50 tosses of a coin resulting in 30 percent heads, the coin can be declared unfair with a confidence of 99.13 percent (or $100 - 0.87$).
4. The level of confidence is largely dependent on the size of the sample. Inferences about a coin can be made with greater confidence after 100 tosses compared to 50. A confidence level of 95 percent or greater is generally accepted by most professions as sufficient to support conclusions. In some instances, a 90 percent confidence level may be acceptable; however, for regulatory purposes, a 95 percent confidence level is the initial acceptance sample size recommended.
5. Inferences are made only about the population from which a sample is taken. An inference that one coin is not “fair” does not indicate that all coins are not fair.

These principles do not mean that errors found in a non-statistical sample are not errors, but it does mean that great care must be exercised to not suggest that the errors are representative of any broader population or process. Random sampling is universally recognized in all regulatory venues as a valid science. Findings based upon non-statistical sampling methodologies may be subject to legitimate challenges when the jurisdiction attempts to affect a resolution without being able to show that the errors are representative. For example, it is unlikely that any court would accept generalized findings based on improper sampling procedures.

This chapter is designed for the non-technical reader. Technical details that may not be of concern to the general reader can be found at the end of this chapter. The discussion in this chapter is confined to the fundamentals of sampling. Regulators may confront situations where the sampling strategies presented in this chapter may require modification. Those wishing to pursue the subject further can avail themselves of a variety of textbooks. Two recommended texts are the *Handbook of Sampling for Auditing and Accounting* by Herbert Arkin (McGraw-Hill, publisher) and *Statistical Methods for Rates and Proportions* by Joseph L. Fleiss (John Wiley & Sons, publisher).

B. Sampling Generally

A sample should be a microcosm of the population or field from which it is drawn. It should be representative of all the relevant insurer processes under analysis, such as claims processing, cancellation notifications or complaint handling. The regulator should adhere to the methodology prescribed in this chapter to ensure that the sample is representative and that generalizations or conclusions about insurer processes are credible. Sampling should follow five steps:

1. Clearly and precisely define the population from which the sample will be taken. Any conclusions based on sample evidence can only be generalized back to the target population. Population definition should include the following parameters: time period under review, functional definition of the process under review and location and origin of the process.
2. Determine a sampling strategy, such as the level of confidence necessary to support conclusions, and the appropriate sample size necessary to achieve the selected confidence level.
3. Examine the files in such a way that conclusions about each file can be quantified in binary form, such as “pass/fail” or “deviates from statute/complies with statute.”
4. Calculate the percentage of deviations or failures present in the sample.
5. Based on the sample results, determine a numeric interval that contains the true or population deviation rate with a known level of probability or confidence. The “confidence interval” will form the basis of any conclusions about a process.

This chapter explains a two-stage sampling method that deviates slightly from this general format. An initial sample is taken which, due to its smaller size, is used only to determine whether further investigation is merited. If so, the regulator proceeds to a second, larger sample capable of supporting conclusions about overall error rates with reasonable precision. This method is designed solely for efficiency, or as a labor-saving device, since in many instances the regulator can reasonably conclude that further investigation is unnecessary after reviewing only a relatively small sample.

In a number of states, it has become common practice to start with a standard size sample, such as 50 or 100 items, based on the overall field size of the matter under review. If the entity being examined challenges the error ratio that results from the standard size sample, the regulator must then consider pulling a larger sample. In some cases, the use of a standard size sample is a sufficient screening sample to detect anomalies. In all cases, a sample size should be selected which supports conclusions with a 95 percent confidence level. In addition, regulators should balance the costs and benefits of the sampling method used.

The most common calculations necessary to make inferences are included in various tables in this chapter. In addition, computer programs are available which can randomly select files, compute statistical formulas, develop probabilities, make complex computations and even make a sample selection. One such program, ACES, is described in further detail later in this chapter.

C. Sampling Methods

The validity of random sampling depends to a large degree on knowledge of the population. No one method works well in all cases, and different methods should be tailored for the individual circumstances presented.

1. **Random Sampling.** The most widely known method of sampling is “random sampling.” All items in the target population or field (before selection) have an equal chance of appearing in a random sample. No items or units have been “preselected” out of the field. Random selection may be obtained through use of a random numbers table or a random numbers generator in computer software.
2. **Systematic Sampling.** Another method of sampling is to employ a systematic interval throughout a listing of all files. To sample 50 files drawn from 5,000 files, select every hundredth file after a random start number—say the third file. There are other methods for systematic sampling, such as changing the interval after each file selection, so that, on average, every one-hundredth file is selected.
3. **Stratified Sampling.** A variety of other sampling methods can be employed to adapt the principles of random sampling to more complex situations. For example, a regulator may have reason to focus on various subgroups, or *strata*, in an overall population. If the *stratum* is not large, its members may not appear in sufficient numbers in a sample of the overall population to support credible inferences about the subpopulation. *Stratified sampling* is designed for such instances. A stratified sample is obtained by performing a separate and independent random sample on each subpopulation of interest. The results are then combined into a single sample. For example, if a regulator is concerned about the impact of a specific processing center on overall claims settlement practices in a state, a random sample may be drawn from the center of interest, and a separate sample drawn from the remainder of claims in a state. The items in the resulting sample must be *weighted* to reflect the proportion of each subpopulation in the general or overall population before inferences can be made about the statewide claims processes.

If only a single claims processing center is of interest, rather than the overall population, a random sample may be drawn solely from the specific claims processing center. However, since the remainder of the population was not sampled, any conclusions based in the sample should be confined to the subpopulation from which the sample was taken. Broader generalizations will not be valid.

D. Standards

The sampling method used must be subject to the following standards:

1. **Pre-selection and Statistical Bias.** Pre-selection can introduce statistical biases into the sampling procedure, which, if significant, will invalidate results. Generally, the term deals with the avoidance of files within a universe of files from which a sample is drawn. Note that the term does **not** pertain to the process of selecting a target subpopulation of interest, a strategy that is perfectly valid. Rather, the term refers to biases introduced into the sampling process *after* the target population has been defined. Once defined, the sample should be randomly selected from all of the files in the target population.

Thus, homogeneity of the files in a sample should not be confused with pre-selection. Homogeneity is a means of defining the universe of files from which a sample will be drawn. The tests to be applied in a particular examination may in part define the universe of files from which the sample will be drawn. The distinction between pre-selection and targeting a specific *stratum* is made through a description of the universe of files. For example, if the test in an examination is focused on redlining for a particular geographic area, files outside of the particular geographic area would not be made part of the universe from which a sample is drawn. That does not represent pre-selection as used here, since no inferences based on the sample will be made about geographic areas that were excluded from the initial universe of files.

A famous example of pre-selection resulting in significant statistical bias in a sample is the 1936 *Literary Digest* poll of voting intentions. The *Literary Digest* predicted a large victory for challenger Alfred Landon over incumbent Franklin Roosevelt, a result ambiguously refuted by Roosevelt's victory with more than 60 percent of the popular vote. The *Literary Digest* had employed the same sampling techniques that had successfully predicted the outcome of prior elections: namely, pulling a sample from list of telephone numbers and registered vehicle owners. Unfortunately, the sampling universe (telephone and vehicle owners) was significantly unrepresentative of the target population (presumably consisting of all voters), since both telephone and vehicle ownership were highly correlated with income in the 1930s. Prior to the election of 1936, voting preference was not strongly correlated with income, so that, while the bias was present in prior samples, it did not significantly impact the validity of the survey. However, in 1936, the electorate became far more polarized along socioeconomic lines, rendering the statistical bias of the sampling so significant as to produce wildly inaccurate results. Contemporary pollsters take great pains to identify not only individuals of voting age or even registered voters, but *likely* voters, since the preferences of voters differ in significant ways from non-voters.

Pre-selection thus occurs due to the non-random selection of files within a given universe of files, whether or not the *purpose* is to attain a biased result. No pre-selection can be permitted. Generally, sample selection by the examinee should be avoided due to the difficulty in demonstrating that pre-selection has not occurred. Pre-selection is not the same as prior selection, where a sample is selected in advance of the arrival of the examination team. Should an Examiner-in-Charge (EIC) choose to select a sample in advance, precautions must be taken to ensure that the sample files are not disturbed prior to the examination review.

In a market regulation context, pre-selection is demonstrated by the regulator who avoids all files in the bottom shelf because they are inconvenient. The files on the bottom shelf may all belong to one claims person or underwriter, and that individual would thereby be deleted from the sample. Another example is the case where all complaints for a particular policy form are kept in a branch office and are consequently deleted because the regulator does not want to travel to that site. These examples are preselected based on location, but the same application is present for time, procedure or any of several other variables. The central point is that after a target population has been defined, no selection biases should contaminate the sampling process such that some items in the target population have a different probability of being selected than other items. Such biases can render the sample unrepresentative and unsuitable for making inferences about the target population.

Pre-selection can also occur due to the use of “pull lists” developed by the company’s computers/computer programmers. If company programmers reduce a field of 500,000 policies to a list of 500 files from which the regulators make their selection of 50 files, there may be pre-selection. Examples of this might be where no files appear in ZIP code XXXXX, or in the time frame from May 11 to May 20, or for claims closed without payment. Regulators can guard against this outcome by reconciling data obtained during the examination with other available data sources, or via simple reasonability reviews of the data. For example, some insurance departments collect ZIP code data, which can be used to assess whether the pull list contains the entire population of interest. All states have access to state-wide financial data, which may also be used to verify the accuracy of pull lists.

The EIC should note that it is his/her responsibility to ensure that no pre-selection has occurred. If a regulator places total reliance on the company, there would be no need for regulators to be there at all—and a self-report of the results of any sample drawn would be adequate. In all cases, the EIC should work closely with the company coordinator, system analysts and/or programmers to ensure that no pre-selection of files occurs.

2. **Confidence Level.** As discussed earlier, a confidence level is a measure of the probability that a conclusion about the true and unknown value in the overall population is correct, based on what is observed in a representative and unbiased sample. In many instances, the level of confidence is associated with a numeric interval within which, with a probability equal to the confidence level, the true value is likely to lie.

Confidence is directly related to sample size, but it is also related to the true proportion of errors within a population of files. Larger proportions are associated with a higher level of sampling variability and, therefore, require larger sample sizes to support the same level of confidence as smaller proportions. For example, other things being equal, the confidence interval will be widest for proportions of 50 percent (or conversely, the given interval will be associated with less confidence). Smaller samples are required when the true proportion moves away from 50 percent in either direction, or toward 0 percent and 100 percent. For example, for large populations, a sample of size 1,067 is necessary to produce a 95 percent confidence interval of ± 3 percentage points when the population proportion is 50 percent. A sample of only 203 files supports an estimate of the same interval at the same confidence when the proportion is reduced to from 50 percent to 5 percent (or increased to 95 percent). A regulator may have sufficient experience to know what proportions to reasonably expect for a specific process, and determine the minimum sample size necessary to support credible estimates.

For the first-stage acceptance sample, a minimum confidence level of 95 percent should be selected. For the second-stage sample, the regulator should use discretion in selecting an appropriate confidence level, although it should not be less than 90 percent.

While regulators may instinctively have negative feelings about certain company procedures, those instinctive feelings will not be valid in an administrative proceeding or in court unless findings can be shown valid with a high confidence level. A determination of the confidence level and margin of error should be made during the planning stage, prior to taking a sample. These two factors largely determine the appropriate sample size, and regulators should weigh the costs and benefits associated with increasing the sample size vs. acceptance of less precise estimates or a larger margin of error.

3. **Tolerance Level.** The tolerance level represents a critical threshold used during the initial acceptance sample to determine whether a process requires additional investigation. If the results of an initial sample cannot confidently rule out the possibility that the true processing error rate is above the tolerance level, a second sample of sufficient size to estimate the actual rate of processing errors should be taken.

The tolerance level is thus used to provide parameters for a mathematical construction. The expression of tolerance has little to do with the real tolerance that a jurisdiction may have for error. From a regulatory compliance standpoint, however, the tolerance level utilized can have an additional meaning beyond its use as an indicator of the size of sample needed to establish an error rate with a sufficient confidence level. Under the *Unfair Trade Practices Act* (#880) and *Unfair Claims Settlement Practices Act* (#900), one standard for establishing a violation of these laws is that a company commits a practice “with such frequency to indicate a general business practice.” Many states have included this general business practice standard (or a similar standard involving frequency) when enacting one or both of these models.

Historically, a benchmark error rate of 7 percent has been established for auditing claim practices and 10 percent for other trade practices. Error rates exceeding these benchmarks are presumed to indicate a general business practice contrary to these laws. For uniformity in the application of these laws, and absent state case law that may apply an alternative standard, states that have the general business practice standard are strongly encouraged to utilize the 7 percent and 10 percent standards both as tolerance levels for statistical sampling purposes and as benchmarks for evaluating when violations of the state’s unfair claim and trade practices statutes have occurred.²³

On the other hand, many other state laws are not dependent upon the frequency of commission of an act in order to constitute a violation of the law—each instance of commission of the act constitutes a separate and distinct violation. For example, conducting business in a state without a license may constitute a violation of law each time it occurs, whether it is done once or one hundred times. This may also be true for the unfair claim and trade practices statutes in those states that have not adopted the general business practice standard of the NAIC models. The sampling error rate relative to such laws represents the probable number of violations within the total population rather than a benchmark for evaluating whether or not a violation has occurred. While it is not strictly necessary to use the 7 percent and 10 percent tolerance levels in these circumstances, states are still encouraged to do so when calculating appropriate sample sizes for consistency in both application and presentation. For this reason, all calculations in this chapter utilize the 7 percent and 10 percent tolerance levels.

4. **Extrapolation.** Generalization or extrapolation of results beyond the field of files from which the sample is selected is not acceptable. If files are sampled from a Chicago branch underwriting office, results cannot logically be extrapolated to a branch office in Philadelphia. A sample can only be representative of the population from which it was drawn—and no other. Any alternative assumptions are very frail, insupportable, and probably invalid.

²³ With respect to sampling, readers are strongly cautioned not to confuse the two quite distinct meanings associated with the terms “tolerance level” and “benchmark error rate.” The former is a statistical construct with meaning only in terms of making probabilistic inferences, while the latter is a threshold used to establish the legal presumption of a general business practice. Important in this respect, the first stage sample cannot be used to establish with confidence that the true rate of noncompliance exceeds 7 percent or 10 percent. The small sample sizes only support the inference that one cannot confidently rule out such a possibility. The larger second stage sample is required to infer the actual rate of noncompliance, and determine whether this true rate exceeds some specified threshold.

E. Data Verification

In recent years, data verification processes have evolved into highly sophisticated, rigorous and organized systems for ensuring the integrity and accuracy of data. No amount of rigor in sample design can surmount data that is inaccurate: a valid sample drawn from inaccurate data will still produce invalid conclusions. A variety of data problems can introduce serious statistical biases and distortions into the sampling process. The examination process should incorporate a systematic investigation into the accuracy of data collected as part of the examination.

The most frequently used data verification procedures are related to *completeness, validity, internal consistency, duplicated or missing records and reasonability*. If a data problem cannot be remedied, procedures should be adopted to minimize the risk of statistical bias, and such procedures, along with their justification, should be explained in the examination report.

1. **Completeness.** Data from which a sample will be taken should include the entire universe of files or target population. To ensure completeness, such data should be reconciled with control totals, if available. Most states have access to a variety of data that can serve this purpose. All states can obtain state-wide data from the financial annual statement, including aggregate annual premiums written and earned, losses paid and incurred and additional expense items. Where the population to be sampled matches what captured on the financial annual statement, examiners should try to test for completeness. Because of the way annual statement data is reported, it can be difficult to match dollar for dollar. Examiners should keep this in mind when trying to test for completeness. For example, if the target population is all paid claims, the amounts in the examination data file should roughly reconcile with the paid loss amounts reported on the annual statement and what was reported on the Market Conduct Annual Statement (MCAS). Similarly, regulator complaint data provided by an insurer can be reconciled to each insurance department's recorded complaints.

Reconciliation is a time-consuming, and thus expensive, process for insurance regulators and companies. Reporting systems and standardized data request parameters change over time and it can be difficult to precisely reconstruct some records. Market regulation records are, by their nature, different from financial records. Reconciliation of market regulation records to the annual financial statement and the MCAS is a difficult and expensive process. The regulator should consider whether reconciliation is necessary in all samples. For example, if the regulator has a high confidence level in the company data, and the initial numbers provided are roughly consistent with annual statement data, it may not be necessary to test for completeness. On the other hand, if the regulator has evidence that the data provided from the company is incomplete or inaccurate, the need for reconciliation is increased.

Many states collect data beyond the data available to all states. If an insurance department collects policy or exposure counts, these data can reliably verify the completeness of any analogous data provided during an examination. Each state should systematically determine which control totals may be available, and implement a quality control strategy that utilizes such data.

2. **Validity.** Data fields should be systematically checked to determine that all values are valid and that all codes used correspond to the reporting specifications. Validity is generally determined in a *prima facie* sense: values are wrong “on their face” in that the true value cannot logically be as reported. For example, data that include codes that are not specified on the reporting protocols are simply “wrong,” and must be recoded. A payment reported under an automobile no-fault policy for an accident that occurred in an at-fault state will generally be incorrect.

As with all data problems, data records containing invalid values should not be discarded, because doing so would pose a risk of significantly biasing the subsequent sample. Rather, every effort should be made to determine the true values, and then recode the data as necessary.

3. **Internal Consistency.** Examiners should identify ways to ensure that each data record is internally consistent, such that values reported in different data fields are not logically contradictory to others. Similar to *validity*, inconsistency is determined on a *prima facie* basis: a data record is internally inconsistent when two or more values cannot logically be *simultaneously* correct. For example, if a data record for a private automobile insurance policy reported policy limits of \$50,000 per occurrence, but the paid loss amount is reported as \$70,000, the necessary conclusion is that one or both of these values are incorrect. Such inconsistencies, *when relevant to defining the universe to be sampled or to a process under investigation*, should be recoded to correct values prior to taking a sample.
4. **Duplication of Data Elements.** Duplicate items in a population from which a sample will be taken must be removed prior to sampling. The presence of a significant amount of duplicate data fields could introduce significant statistical bias into the sampling procedure. Random sampling is predicated on the fact that each item in a population has an identical probability of being selected. If an item appears three times in a dataset, the probability that it will be sampled is three times larger than that for a single item.

Duplication is a particular challenge in performing analysis of accident and health carriers. The process to remove all duplications can be extremely challenging and time-consuming. In this type of examination, the regulator must balance the time and cost of attempting to remove all duplications with the information sought by the query. If the regulator has a high degree of confidence in the overall data provided, it may make sense to factor in the existence of duplicates.

Duplication is defined with respect to the universe being sampled. For example, some insurers capture data by *claimant* rather than by *occurrence*. Three claims arising from a single automobile accident may appear in triplicate in a dataset. This does not constitute duplication if the intent is to sample the universe consisting of *all claimants*. However, if the target population consists of *all occurrences* from which claims arise, the duplicate records must be removed prior to sampling. Failure to do so could bias the sample in a number of obvious and not so obvious ways. For example, payouts for claims consisting of multiple claimants are very likely to be significantly higher than overall average payouts. There may very well be geographic correlates associated with the types of accidents likely to produce multiple claimants. Since it is extremely unlikely that all possible biases associated with duplication can be identified and corrected, the most prudent strategy is to remove the duplicates from the data prior to sampling.

5. **Missing Data Elements.** Missing data elements can potentially bias a sample in the same manner as duplicate items, if the data elements are relevant to the definition of the population from which the sample will be taken. For example, if the target population is *paid claims*, but the dataset contains a portion of claims for which payment status is not recorded and so are excluded from the sample, the sample will potentially be biased. Bias will occur if the relevant characteristics of the subset of items for which the information is missing differ on average from the overall population of paid claims. Since both the likelihood and degree of such potential differences are generally unknown, potential bias cannot be ruled out in a non-arbitrary way.

Ideally, no relevant data elements should be missing, although some small amount is often tolerated in many data quality control systems. If the percentage of missing elements is believed to be tolerable, an explicit explanation should be provided in the examination report, including a specification of the percentage of data that it was necessary to discard.

6. **Reasonability.** Reasonability checks identify anomalous data values that deviate significantly from averages, or “what one would expect to see.” Reasonability checks can be performed by examining the upper and lower extreme values for each data element, and comparing these values to the average value for the entire dataset. Values that appear unreasonable should be investigated to determine that they are correct. For example, an average annual premium for an automobile policy issued by a company being examined may be \$800, with the highest extreme reported as \$5,000 and the lowest extreme reported as \$30. Such values are not *prima facie* invalid, but they are anomalous to such an extent as to merit further investigation.

Data elements that are missing or inaccurate, but which are not relevant to defining a population, drawing a sample, or to the process under investigation, can safely be ignored. For example, if it appears that a substantial proportion of paid loss amounts are reported incorrectly in the data, but the sampling universe consists of all closed claims regardless of payment status, the data inaccuracies will not bias the resulting sample. Sampling proceeds without respect to reported loss amounts, and all files from the population “all closed claims” still have an equal chance of selection. An exception to this rule may be those instances in which the data reporting is so inaccurate as to suggest that errors are systematic and that the core data handling capacities of the company being examined are significantly flawed.

F. Problem Data and Departures from Random Sampling

In some cases, complete and accurate data which form the universe of files to be sampled cannot be obtained. In these instances, a regulator has one of two choices:

1. Redefine the target population to accommodate the portions of the data that are complete, accurate and available. If the new target population is narrower than the original population, conclusions based on the sample can be made only about the narrower population. If the new target population is broader than the initial population, conclusions can still be made about the initial population, if the members of the initial population are sufficiently represented in the sample.
 - a. **Examples of Narrower Population.** The initial desired population is all claims in a state. However, data from one claim processing center is found to be corrupt and cannot be repaired. The new population to be sampled then becomes all claims in a state, except those processed at the center producing the corrupt data. The subsequent sample indicates that 13 percent of claim files contain errors (+/- ‘x’ percent). The only valid generalization from this sample is that 13 percent of the claims from the centers sampled, not 13 percent of all claims in the state, contain errors. Nothing can be meaningfully said, based on the sample, of the processing center that was excluded from the initial population.
 - b. **Examples of Broader Population.** The initial target population was all *paid claims*, but the data elements relating paid claims failed numerous data integrity checks and the problems could not be remedied. Because the data fails to reliably distinguish claims closed with payment from claims closed without payment, the population may be redefined as all *closed claims*. Paid claims, of course, are an element of the new population. If paid claims appear in the subsequent sample in sufficient numbers, generalizations about correlates associated with paid claims can still be valid. However, the confidence interval and margin or error for the subpopulation (paid claims) must be calculated separately based on their numbers in the sample, error rate and population size. This procedure is not uncommon, and the reader has no doubt seen polls in the popular press that provide estimates for subpopulations in an overall sample such as those defined by ethnicity or gender.
2. If data is corrupt and the population cannot be meaningfully redefined in a way to effectuate the purposes of an examination, no valid sampling can occur. This chapter does not recommend any form of non-random sampling from a given population. As discussed throughout this chapter, departures from randomness can introduce significant statistical biases into the sample, rendering the sample unrepresentative of the general population. In addition, since the probabilities of non-random sampling outcomes are unknown, no calculable level of confidence can be attached to conclusions.

Even in this instance, the regulator is not totally without recourse. Every effort should be made to investigate essential insurer processes—even in those instances when valid sampling cannot be performed. However, a strong caveat is that generalizations or extrapolations from findings will be invalid. Evidence of error is strictly limited to the actual errors identified, and no claims about overall error rates can be made. If 10 violations are identified in 20 files that are non-randomly selected, the examinee can only be meaningfully cited for 10 discrete violations, not for 50 percent of the entire population of files.

There may be many situations suitable for non-random investigative techniques. Random sampling is unnecessary for processes in which each discrete violation is the target of the investigation, rather than an overall violation rate in a defined population. For example, it may not be possible to obtain data for a population consisting of all advertising materials used in a state over a specified time period, and thus there may be no way to randomly sample from this population. However, if 7 violations are identified among the advertising materials that are available, the examinee is noncompliant in seven known instances, even though no knowledge is gained about the overall rate of noncompliance.

The examination process is heavily reliant on random sampling, since market conduct audits are generally tailored to identify systemic process failures rather than discrete or incidental violations. Nevertheless, there may still be many instances in which other investigative techniques are appropriate. The caveats repeated throughout this chapter are intended to alert regulators to the lack of validity of generalized conclusions derived from non-random samples. Nothing in this chapter, however, precludes non-random investigative techniques, so long as generalizations are avoided.

G. Sample Sizes

As with the example of the coin, larger sample sizes lend themselves to greater confidence in conclusions. One would feel less confident basing conclusions about the fairness of a coin after only 5 flips as compared to 50. Because probabilities are known, a precise level of confidence can be calculated for any given sample size, if the sample is produced by a random process. Generally, statisticians accept a 95 percent confidence level as sufficient to support scientific findings. Very rarely are confidence levels below 90 percent considered “statistically significant.”

The term confidence, in the statistical sense, is always related to a specified level of precision (or margin of error) of an estimate calculated from a sample. Confidence and precision are inversely related: other things being equal, less confidence is associated with more precise estimates. For example, in many popular presentations of sample results, an estimate is presented with a confidence of ‘x’ percent and a margin of error (or confidence interval) of $\pm y$ percentage points. That is, the real (and unknown) population proportion is known to lie within the margin of error with a probability of ‘x’ percent. Conversely, the probability that the true value lies outside of the margin of error is (100 – ‘x’ percent), since the two outcomes are mutually exclusive and jointly exhaustive (i.e., the proportion must either lie inside or outside of the interval). A given sample will support a conclusion with a narrower margin of error, but with *less* confidence. For example, for a sample size of 500 for which a proportion is calculated at 50 percent, one is more confident that the population proportion is between 45 and 55 (or ± 5 percentage points) than between 49 and 51 (± 1 percentage point). Both precision and confidence are governed by sample size.

The sample size, confidence level and margin of error are always calculated in the context of a specific target population, and are not applicable to any specific subpopulation within the target population. For example, if an EIC attempts to sample 500 fire claims of 20XX for a company on a countrywide basis, and even if a rather large sample of 500 files is selected, very few files for any one jurisdiction will likely be present. Let’s assume only 7 files were reviewed for Jurisdiction A. Although a regulator can make generalized statements about the overall claims practices of the company countrywide, very little can be said of its practices in Jurisdiction A on the basis of only 7 files. To make accurate statements on the procedures in Jurisdiction A, a much larger sample of Jurisdiction A claims must be reviewed.

Large, all-purpose samples, intended to give blanket coverage over a wide range of variables, will usually fail in testing specifics. When gross categories are used (countrywide), little can be deduced about specifics. The same is also true of time sampling for a 3-year period, then discussing a single year, and category “sampling” for all fire coverage, then attempting a discussion of homeowners policies. Thus, the regulator should carefully delineate the target population prior to the adoption of a particular sampling strategy. If necessary, a particular subpopulation can be oversampled or specifically targeted to produce sample sizes necessary to support conclusions, as per the discussion of stratified sampling.

H. Initial Sample

A minimum confidence level of 95 percent is used to make inferences from the small first-stage sample. Due to the relatively small sample size, the estimate made from the first-stage sample has a wide confidence interval (or margin of error). Thus, the small sample is insufficient to produce an accurate “point estimate,” or a precise estimate of the true population proportion. Instead, the first-stage sample is designed to rule out the possibility that a given error rate is above a specified threshold. If this possibility cannot confidently be ruled out, the regulator proceeds to the larger second-stage sample capable of supporting more precise estimates with a high degree of confidence.

The sample sizes indicated in the Acceptance Samples Table (AST) will produce a one-tailed lower 95 percent confidence limit of no more than 4.5 percentage points for claims, and 5 percent for non-claims. In some instances, the samples were adjusted somewhat to reduce the likelihood of “false positives,” or instances in which a process that is in compliance will still trigger a second sample. In addition, sample sizes for non-claims processes are larger than the corresponding samples for claims.²⁴

The “p-values” in columns E and J are equal to (100 percent confidence level), and represent the probability that the number of errors found in the sample would have occurred if the true or population error rate were at least equal to the tolerance level (i.e., 7 percent of claims, 10 percent of non-claims). For example, in a sample of 76 drawn from a population of 200, the probability of finding two or fewer errors is 4.8 percent if the sample were taken from a population with an error rate of 7 percent. A second sample is triggered when the p-value exceeds 5 percent. This is the point at which the confidence level (100 percent p-value) is less than 5 percent, and the process error rate is below the critical threshold. Column F indicates when an additional sample is necessary for tests utilizing a 7 percent tolerance level, while Column K uses 10 percent. The p-values are cumulative probabilities derived from the hypergeometric distribution.

The AST represents the generally recommended sample size for most applications. However, the regulator has some discretion in the selection of the initial sample size. There may very well be instances in which greater precision is desired, particularly if examining a critical issue or process likely to represent a high probability of consumer harm. If sample sizes significantly different from those listed in the AST are selected, the regulator should be prepared to provide explicit justification with respect to the substantive issues being investigated.

Slightly larger samples can reduce the likelihood that an initial sample fails to detect a practice that is noncompliant (i.e., “false negatives”). Ideally the likelihood of false positives, where a compliant process fails the first round of sampling, should also not be high. Increased precision associated with larger sample sizes can reduce the likelihood of both types of inference errors (sometimes referred to as “false alarms” or “failed alarms”). If the regulator is less concerned about the risk of false positives, significantly smaller samples can be used.

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	% Error	% Error	P-Value Pop=.07	Add for Claims	Sample (n)	% Error	% Error	P-Value Pop=.10	Add for Other

²⁴ The 95 percent confidence limits become wider as the true population proportion increases, and are at their widest when the population proportion is at 50 percent. The value of the interval is symmetrical for proportions greater or less than 50 percent (i.e., the margin of error or confidence interval will be the same for proportions of 30 and 70 percent, 20 and 80 percent, etc.) This result may seem counterintuitive but it is attributable to the fact that the sampling variability of a proportion is greatest when the population proportion is 50 percent, and at its minimum when the true proportion is 0 or 100 percent (in which case, there would be no variability in the sample estimate across different samples, all of which would precisely replicate the population). Thus, a slightly larger sample is required for a tolerable error of 10 percent compared to 7 percent.

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	% Error	% Error	P-Value, Pop=.07	Add for Claims	Sample (n)	Error	% Error	P-Value, Pop=.10	Add for Other
200	76	0	0.0%	0.1%	No	79	0	0.0%	0.0%	No
200	76	1	1.3%	1.0%	No	79	1	1.3%	0.0%	No
200	76	2	2.6%	4.8%	No	79	2	2.5%	0.3%	No
200	76	3	3.9%	14.9%	Yes	79	3	3.8%	1.4%	No
200	76	4	5.3%	32.6%	Yes	79	4	5.1%	4.0%	No
200	76	5	6.6%	54.9%	Yes	79	5	6.3%	12.2%	Yes
400	82	0	0.0%	0.1%	No	84	0	0.0%	0.0%	No
400	82	1	1.2%	1.1%	No	84	1	1.2%	0.1%	No
400	82	2	2.4%	4.8%	No	84	2	2.4%	0.4%	No
400	82	3	3.7%	13.6%	Yes	84	3	3.6%	1.6%	No
400	82	4	4.9%	28.3%	Yes	84	4	4.8%	4.8%	No
400	82	5	6.1%	47.0%	Yes	84	5	6.0%	11.4%	Yes
500	83	0	0.0%	0.1%	No	86	0	0.0%	0.0%	No
500	83	1	1.2%	1.2%	No	86	1	1.2%	0.1%	No
500	83	2	2.4%	4.9%	No	86	2	2.3%	0.4%	No
500	83	3	3.6%	13.5%	Yes	86	3	3.5%	1.5%	No
500	83	4	4.8%	27.9%	Yes	86	4	4.7%	4.5%	No
500	83	5	6.0%	46.0%	Yes	86	5	5.8%	10.6%	Yes
1,000	105	0	0.0%	0.0%	No	113	0	0.0%	0.0%	No
1,000	105	1	1.0%	0.3%	No	113	1	0.9%	0.0%	No
1,000	105	2	1.9%	1.5%	No	113	2	1.8%	0.0%	No
1,000	105	3	2.9%	5.0%	Yes	113	3	2.7%	0.2%	No
1,000	105	4	3.8%	12.0%	Yes	113	4	3.5%	0.7%	No
1,000	105	5	4.8%	23.4%	Yes	113	5	4.4%	2.0%	No
1,000	105	6	5.7%	38.2%	Yes	113	6	5.3%	4.8%	No
1,000	105	7	5.7%	53.0%	Yes	113	7	6.2%	9.8%	Yes
2,000	107	0	0.0%	0.0%	No	114	0	0.0%	0.0%	No
2,000	107	1	0.9%	0.3%	No	114	1	0.9%	0.0%	No
2,000	107	2	1.9%	1.5%	No	114	2	1.8%	0.0%	No
2,000	107	3	2.8%	4.9%	No	114	3	2.6%	0.2%	No
2,000	107	4	3.7%	11.7%	Yes	114	4	3.5%	0.7%	No
2,000	107	5	4.7%	22.5%	Yes	114	5	4.4%	2.1%	No
2,000	107	6	5.6%	36.7%	Yes	114	6	5.3%	5.0%	No
2,000	107	7	6.5%	52.2%	Yes	114	7	6.1%	10.0%	Yes
3,500	108	0	0.0%	0.0%	No	115	0	0.0%	0.0%	No

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	% Error	% Error	P-Value, Pop=.07	Add for Claims	Sample (n)	% Error	% Error	P-Value, Pop=.10	Add for Other
3,500	108	1	0.9%	0.3%	No	115	1	0.9%	0.0%	No
3,500	108	2	1.9%	1.5%	No	115	2	1.7%	0.0%	No
3,500	108	3	2.8%	4.8%	Yes	115	3	2.6%	0.2%	No
3,500	108	4	3.7%	11.5%	Yes	115	4	3.5%	0.7%	No
3,500	108	5	4.6%	22.1%	Yes	115	5	4.3%	2.1%	No
3,500	108	6	5.6%	35.9%	Yes	115	6	5.2%	4.9%	No
3,500	108	7	6.5%	51.2%	Yes	115	7	6.1%	9.8%	Yes
5,000	108	0	0.0%	0.0%	No	115	0	0.0%	0.0%	No
5,000	108	1	0.9%	0.3%	No	115	1	0.9%	0.0%	No
5,000	108	2	1.9%	1.6%	No	115	2	1.7%	0.0%	No
5,000	108	3	2.8%	4.9%	Yes	115	3	2.6%	0.2%	No
5,000	108	4	3.7%	11.6%	Yes	115	4	3.5%	0.8%	No
5,000	108	5	4.6%	22.2%	Yes	115	5	4.3%	2.1%	No
5,000	108	6	5.6%	36.0%	Yes	115	6	5.2%	4.9%	No
5,000	108	7	6.5%	51.2%	Yes	115	7	6.1%	9.8%	Yes
10,000	109	0	0.0%	0.0%	No	116	0	0.0%	0.0%	No
10,000	109	1	0.9%	0.3%	No	116	1	0.9%	0.0%	No
10,000	109	2	1.8%	1.5%	No	116	2	1.7%	0.0%	No
10,000	109	3	2.8%	4.8%	No	116	3	2.6%	0.2%	No
10,000	109	4	3.7%	11.3%	Yes	116	4	3.4%	0.7%	No
10,000	109	5	4.6%	21.6%	Yes	116	5	4.3%	2.0%	No
10,000	109	6	5.5%	35.2%	Yes	116	6	5.2%	4.7%	No
10,000	109	7	6.4%	50.2%	Yes	116	7	6.0%	9.5%	Yes
20,000	109	0	0.0%	0.0%	No	116	0	0.0%	0.0%	No
20,000	109	1	0.9%	0.3%	No	116	1	0.9%	0.0%	No
20,000	109	2	1.8%	1.5%	No	116	2	1.7%	0.0%	No
20,000	109	3	2.8%	4.8%	No	116	3	2.6%	0.2%	No
20,000	109	4	3.7%	11.3%	Yes	116	4	3.4%	0.7%	No
20,000	109	5	4.6%	21.7%	Yes	116	5	4.3%	2.1%	No
20,000	109	6	5.5%	35.2%	Yes	116	6	5.2%	4.8%	No
20,000	109	7	6.4%	50.2%	Yes	116	7	6.0%	9.6%	Yes
50,000	109	0	0.0%	0.0%	No	116	0	0.0%	0.0%	No
50,000	109	1	0.9%	0.3%	No	116	1	0.9%	0.0%	No
50,000	109	2	1.8%	1.6%	No	116	2	1.7%	0.0%	No
50,000	109	3	2.8%	4.8%	No	116	3	2.6%	0.2%	No
50,000	109	4	3.7%	11.4%	Yes	116	4	3.4%	0.8%	No

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	% Error	P-Value, Pop=.07	Add for Claims	Sample (n)	% Error	P-Value, Pop=.10	Add for Other		
50,000	109	5	4.6%	21.7%	Yes	116	5	4.3%	2.1%	No
50,000	109	6	5.5%	35.2%	Yes	116	6	5.2%	4.8%	No
50,000	109	6	5.5%	48.8%	Yes	116	7	6.0%	9.6%	Yes

I. Additional Sample

If the initial acceptance sample indicates that an additional sample is necessary to more precisely estimate the level of error in the field of files from which the sample was drawn, several options are available. There are a variety of ways to select such an additional sample. The sampling method selected should be described in the examination report. In conformity with generally accepted practice, the report should also include the confidence limits associated with any estimate.

J. Sampling Topics and Tables

1. **Sample Sizes.** Numerous software packages can easily calculate necessary sample sizes. Alternatively, sample sizes can be estimated with the formula presented in Section M of this chapter, although the formula is only an approximation to the more complex algorithm used to produce the table, and which is implemented in most auditing software.²⁵

Sample size for testing proportions, such as error rates in a population of files, is governed entirely by the following four parameters:

- a. **Population size.** The larger the population, the larger the necessary sample. When the population is sufficiently large, further population increases have minimal impact on sample size.
- b. **Desired margin of error or precision.** Sample size is inversely related to the margin of error. The smaller the desired margin, the larger the necessary sample.
- c. **Confidence level.** More confidence requires larger samples.
- d. **The (unknown) error rate or proportion in the population to be estimated.** Necessary sample sizes are largest when the actual error rate in a population to be sampled is 50 percent and declines as the error rate approaches 0 percent and 100 percent (see below).

Of these four parameters, values for only two parameters are established by the regulator: the “desired margin of error or precision” and the “confidence level.” These two parameters can have a significant impact on necessary sample sizes. Regulators should carefully weigh the costs and benefits when making sampling decisions, such as whether gains in precision or higher confidence or merited by the cost of producing and investigating a larger sample of files.

In selecting a sample size, the regulator must estimate the true population proportion, or the actual percentage of files in the population that that contain errors. Differences in the sampling variability

²⁵ The table was produced in SAS via an iterative algorithm that employed the cumulative hypergeometric probability function (SAS function “*probypr*”). Most auditing software generates sample sizes using the same or closely similar probability distributions. Because the hypergeometric calculations are complex and labor intensive, the normal approximation to the hypergeometric is often employed when the sample sizes must be calculated manually. This is the formula presented below following the table. Since the formula is only an approximation, sample sizes produced by it will differ somewhat from those displayed in the table, as well as sample sizes generally returned by computer software.

associated with different proportions can be substantial. For example, when sampling from a population of 5,000 files, a sample size of 200 is necessary to obtain a margin of error of 3 percent when the population proportion is 5 percent. However, the necessary sample size to achieve the same margin of error increases to 917 when the true proportion is 50 percent. If the initial guess about the population proportion is far off, the resulting estimates produced from the sample may have a significantly wider margin of error than anticipated. One conservative approach is to always select the sample size associated with a proportion of 50 percent. However, a significant amount of labor can be saved by using any information available that indicates that the true population proportion is greater than or less than 50 percent. For example, the estimate produced from the initial acceptance sample may be used in calculating the subsequent sample size. Final confidence limits must be calculated *after* the sample is obtained, using the sample proportion as a substitute for the (unknown) actual proportion.

K. Considerations for Selecting Sample Sizes

The rationale for the two-stage acceptance sampling technique discussed in this handbook is that the possibility that a process exceeds a specified error rate can be ruled out without having to draw a large sample in every case. In some instances, a small sample can effectively identify insurer processes that are likely to be compliant, even though the sample cannot produce very precise point estimates of the actual population proportion since the confidence interval or margin of error will be large. For example, the recommended first-stage sample sizes in the AST are designed to accommodate a confidence level of 95 percent, with a corresponding (one-sided) confidence limit (or margin of error) of 4.5 percent for claims and 5 percent of non-claims.²⁶

However, there is an additional decision risk associated with the first-stage sample. While a regulator can be reasonably confident that a process is compliant if the sample proportion is less than the lower boundary of the confidence limit, the converse is not true. The fact that a sample proportion exceeds the lower confidence limit does *not* indicate that a company process is *noncompliant*. Rather, all that is determined in this situation is that the possibility that the process is noncompliant cannot be ruled out with much certainty (let it is not thereby “ruled in,” as it were). The first-stage sample is, therefore, generally unsuitable for making a determination that a process is noncompliant.

There are, therefore, two types of risks associated with inferences based on the initial sample. First, the process may in fact be compliant, but the process fails the initial test, leading a regulator to draw the larger second sample. Alternatively, the process may be noncompliant, even though the sample indicates that it is compliant. This second probability is minimized by use of the 95 percent confidence limits, but the risk is not reduced to zero. Statisticians call these types of incorrect conclusions *Type I* and *Type II* errors:

1. **Type I Error.** “False alarm” or “false positive.” A “null hypothesis” is rejected when it should be accepted. For regulatory purposes, this error occurs when a regulator proceeds to the second larger sample when, in fact, the process is compliant.
2. **Type II Error.** “Failed alarm” or “false negative.” A “null hypothesis” is inappropriately accepted. For example, the insurer process passes the initial test and is not further investigated, even though the process is not compliant.²⁷

²⁶ A one-sided or “one-tailed” 95 percent confidence interval is essentially a one-sided interpretation of a two-sided 90 percent confidence interval. This is a valid interpretation since inferences are made only about whether the sample error rate exceeds the lower bound. The likelihood that the true value exceeds the upper bound is not relevant to the decision at hand.

²⁷ Strictly speaking, the “null hypothesis” in this handbook is that “the true proportion is greater than 7 (or 10) percent” rather than “the true proportion is less than or equal to 7 percent.” Thus, the terms “Type I” and “Type II” above should really be reversed. For expository reasons, a terminology consistent with the verbal meaning of the terms “false alarm” or “false positive” is adopted to avoid conceptual confusion. In reality, a Type I error or “false positive” in this context is the erroneous rejection of the hypothesis that a process is noncompliant (or $H_0: p > .07$), though this might be better thought of conceptually as a Type II error (“false negative” or “failed alarm”).

A Type I error results in wasted time and resources, in the sense that a large sample is gathered to investigate a company process that was, in fact, compliant. A Type II error leads to a failure of regulatory oversight, in that problem areas of company operations will remain uninvestigated. Unfortunately, there is a strict trade-off associated with the two categories of inference errors: *for a given sample size, minimizing the risk of a Type I error maximizes the risk of a Type II error, and vice versa*. However, inference risks are calculable, and can be managed by altering decision rules for a given sample size. Alternatively, the risk of both types of errors can generally be reduced by increasing sample sizes. If the initial sample size is substantially increased, the whole rationale of two-stage sampling is defeated.

The trade-off between Type I and Type II risks might be clarified by a more mundane example. If the sensitivity of a smoke alarm is calibrated too high, there is a high probability of “false alarms.” The alarm may sound in the presence of normal environmental smoke, such as that produced from cooking. Clearly, it is unlikely that the alarm will fail in the event of a house fire, but it is also very likely that a high number of false alarms will reduce the alarm’s efficacy. In response, a frustrated homeowner might decide to remove the battery, thus reducing the risk of a Type I error to zero. In the event of a real fire, the probability of a Type II error is thereby increased to one, since the now powerless alarm will necessarily fail to detect a hazardous fire.

A rational sampling approach should carefully balance the costs and benefits associated with each type of risk, such as regulatory resources diverted from noncompliant areas or additional expense associated with unnecessary sampling versus the potential consumer harm resulting from regulatory oversight failures. Indeed, regulators may rationally adopt differing sampling strategies to alter Type I and Type II trade-offs depending on the context. For example, given a company process for which failure would entail a high risk of consumer harm, a regulator may tolerate an elevated Type I risk in order to reduce a Type II risk.

Researchers are generally concerned with Type I risks, an element that Type II risks are commonly ignored in a wide variety of research fields. When Type II risks are made an explicit part of research design, a level of 20 percent is generally considered acceptable, although often a much higher level is tolerated (compared to a 5 percent maximum for Type I risks).

Regulators, however, are much more concerned with Type II risks, or the risk of failing to detect a noncompliant process (a “failed alarm”). Therefore, the risk trade-off associated with permitting a larger number of errors in the sample is generally unacceptable. As such, it is generally preferable to negotiate inference risks by adjusting sample sizes rather than altering decision rules for a given sample size. In many instances, efficiency gains can be obtained with modest sample size increases, which can reduce the risk of *both* types of inferences.

Use of Smaller Samples. One method used by some auditors (see, for example, the *Financial Condition Examiners Handbook*) utilizes much smaller samples than the sample sizes recommended by this handbook. A process is deemed reliable if zero errors are found in the sample. Given the decision rule, a sample size is selected that reduces the probability of zero sample errors to less than 5 percent when the true error rate equals the tolerable level or critical threshold. Thus, the Type I risk of the method equals that of the method prescribed in this chapter.

For example, if zero errors were found in a sample size of 38 drawn from a population of 200, a regulator could be at least 95 percent confident that the true error rate is not greater than or equal to 7 percent (p-value is 4.7 percent). Similarly, with a sample size of 27 taken from the same population, zero errors would occur only 4.7 percent of the time if the true error rate was 10 percent.

However, Type I risk is significantly greater than risks associated with larger samples. For claims, the Type I risk for each population size exceeds 71 percent for processes that have an actual error rate of only 3 percent, which is well below the 7 percent critical threshold. Similarly, the Type I risk for non-claims processes is more than 83 percent for processes with a 6 percent error rate. Large Type I risks are inherent in small samples due to a large margin of error.

This method is not recommended for general use, since it does not finely discriminate between compliant and noncompliant processes, except when the true error rate is well below 3 percent.²⁸ As such, significant efficiency gains—which constitute the rationale of two-stage sampling—are unlikely to be realized, since a second-stage sample will be triggered in most instances. Regulators should use this method only in those instances in which they have reason to believe that the true error rate is low.

L. ACL and Sampling

One common auditing software package widely used by regulators is audit command software (ACL). This section discusses the sampling routines available in ACL.

ACL employs the same one-tailed confidence methodology for acceptance sampling that is described in this chapter, and it is, therefore, well-suited for examination and analysis purposes. Sample sizes in ACL are calculated by entering a confidence level (e.g., 90 percent or 95 percent), the population size, the upper error limit (or tolerance level) and an “expected error rate.” The expected error rate is a way to establish a margin of error, and is *not* the population proportion assumed in calculating the sample size. Rather, the sample size is calculated assuming that the population proportion equals the tolerance level, or “upper error limit.” ACL returns a sample size large enough to produce a maximum margin of error of (tolerance level – expected error rate).

For example, the ACL manual describes the following scenario:²⁹

Population = 40,000
Confidence = 95%
Upper Error Limit = 5%
Expected Error Rate = 2%

ACL returns a sample size of 184, with a margin of error of no more than 3 percent (5% – 2%). The maximum allowable errors in the sample is four, such that if the sample contains four or fewer errors, the hypothesis that the true error rate is greater than 5 percent can be rejected with at least 95 percent confidence.

The following table displays the probability distribution for these results in a form similar to the AST table shown previously in this chapter. The cumulative probability column displays the percentage of samples (if taken over time) that would contain the corresponding number of errors or fewer, if the population error rate equaled the tolerable error, or 5 percent. For example, six or fewer errors could be obtained in 18.2 percent of samples. The 95 percent confidence limit is the point at which this probability falls below 5 percent (100 – 95), which occurs when the number of errors is less than or equal to four. Thus, with four errors in the sample, it can be concluded with 95.6 percent (100 – 4.4) confidence that the true error rate is less than 5 percent, and does not exceed the critical threshold.

²⁸ A point made in Aron, Herbert. 1992. *Sampling Methods for the Auditor: An Advanced Treatment*. New York: McGraw-Hill.

²⁹ *ACL for Windows Command Reference*. 1996. Vancouver: ACL Software, page 451.

Probability Distribution if Population Proportion is 5%				
Population	Sample	Errors	% Errors	Cumulative Probability
40,000	184	0	0.0%	0.0%
40,000	184	1	0.5%	0.1%
40,000	184	2	1.1%	0.5%
40,000	184	3	1.6%	1.6%
40,000	184	4	2.2%	4.4%
40,000	184	5	2.7%	9.8%
40,000	184	6	3.3%	18.2%
40,000	184	7	3.8%	29.4%
40,000	184	8	4.3%	42.5%
40,000	184	9	4.9%	56.0%
40,000	184	10	5.4%	68.8%

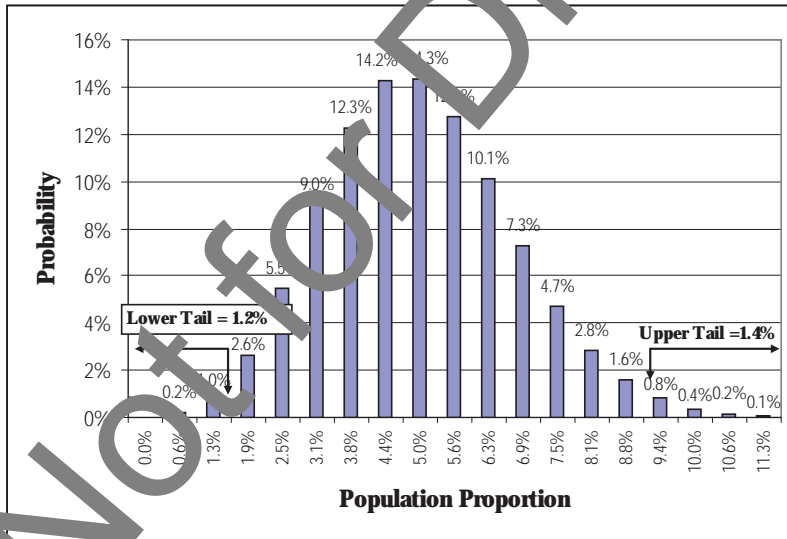
To generate sample sizes roughly equivalent to those contained in the AST, enter a confidence level of 95 percent, and the upper error limit for claims or non-claims processes (7 percent or 10 percent). Since the AST was initially constructed using a 4.5 percent margin of error for claims, the “expected error rate” for ACL is 2.5 percent (upper error limit—margin of error) = (7% – 4.5%) = 2.5%. ACL’s sample sizes will not exactly duplicate those listed in the AST, since the sample sizes in the AST were adjusted for Type I risks.

Because the ACL routine is a one-tailed test appropriate for acceptance sampling, confidence limits must be modified for the second stage sample, which generally employs a two-tailed test. That is, during the second-stage sampling, the concern is generally not whether the population proportion exceeds some specified value. Instead, the second-stage sample is designed to establish *upper and lower* bounds within which the true value may lie.

For example, assume that eight errors are discovered in a sample size of 160. Substituting the sample error rate of five percent for the unknown population error rate, the following probability distribution is obtained. To obtain a confidence level of *at least* 95 percent that the true proportion lies within an interval around 5 percent, the sum of the probabilities of both upper and lower bounds cannot exceed 5 percent (100 – 95 percent confidence level = 5 percent). The minimum of a 95 percent confidence interval around 5 percent is, thus, 1.3 percent and 8.8 percent. The actual confidence limit is the sum of the probabilities of the upper and lower tails, or the areas that fall outside of the confidence interval. $[100 - \text{lower tail probability} - \text{upper tail probability}] = [100 - 1.2 - (100 - 98.5)] = (100 - 1.2 - 1.5) = 97.3\%$.

Probability Distribution if Population Proportion is 5%				
Population	Sample	Errors	Errors %	Probability
40,000	160	0	0.0%	0.0%
40,000	160	1	0.6%	0.3%
40,000	160	2	1.3%	1.2%
40,000	160	3	1.9%	3.9%
40,000	160	4	2.5%	9.3%
40,000	160	5	3.1%	18.4%
40,000	160	6	3.8%	30.7%
40,000	160	7	4.4%	44.9%
40,000	160	8	5.0%	59.3%
40,000	160	9	5.6%	72.0%
40,000	160	10	6.3%	82.1%
40,000	160	11	6.9%	89.4%
40,000	160	12	7.5%	94.1%
40,000	160	13	8.1%	97.0%
40,000	160	14	8.8%	98.5%
40,000	160	15	9.4%	99.3%
40,000	160	16	10.0%	99.7%
40,000	160	17	10.6%	99.9%
40,000	160	18	11.3%	100.0%

The probabilities are displayed graphically below. In this chart, probabilities are non-cumulative, and represent the probability of a single proportion. The confidence interval is the area of the graph excluding the upper and lower tails, or between 1.9 percent and 8.8 percent inclusive. Alternatively, the normal approximation formula given in Section M yields a confidence interval of 1.6 percent and 8.4 percent, which is very close to the more exact hypergeometric limits. The normal approximation works well because, as reader will note, the shape of the distribution in the graph approximates the normal or “bell-shaped” curve.



To estimate a sample size sufficient for a two-tailed test, the confidence level entered into ACL's one-tailed test must be increased. To calculate a sample for a 95 percent confidence interval for a two-tailed test, enter a confidence level of 97.5 percent, such that $[2 * (100 - 97.5) = 5\%]$.

The sample sizes produced by ACL are somewhat larger than those produced by the hypergeometric distribution, since the ACL algorithm utilizes a slightly different probability distribution.

M. Sampling Formulas

1. Formulas:

A formula for approximating the required size of the second-stage sample to produce estimates with a given level of confidence and precision is:

$$S = \frac{Nz^2P(1-P)}{(N-1)e^2 + z^2P(1-P)}$$

where:

- N = Size of the population from which the sample will be taken
- S = Sample size
- Z = Standard normal deviate (or standard deviation). For a desired confidence level of 95 percent confidence, use $z=1.96$.
- P = The unknown population proportion to be estimated. Regulators should use their best judgment, as well as evidence from the initial sample, to select a value for P .
- E = Margin of error or degree of accuracy of the sample estimate expressed as a proportion (for example, use .05 instead of 5 percent)

The desired outcome is to produce a sample of sufficient size to support a conclusion with 95 percent confidence that the true proportion is within $\pm E$ or the margin of error, of the sample proportion. The actual margin of error depends on the accuracy of the initial guess for the population proportion. As discussed above, the margin of error increases as the true proportion approaches 50 percent. If the initial guess was 10 percent, but the resulting sample proportion was 30 percent, the confidence limits will be significantly wider than initially anticipated. Confidence limits, therefore, must be calculated after the analysis of the sample is complete.

2. Confidence interval formula:

$$E = Z \sqrt{\frac{P(1-P)}{S}} \sqrt{\frac{N-S}{N-1}}$$

where:

- E = Margin of error
- Z = The standard deviation of the sampling estimate. Use $z=1.96$ for a 95 percent confidence interval.
- P = The sample proportion (as a substitute for the unknown population proportion)
- S = Sample size
- N = Population size

The formulas for sample size and confidence interval are for samples taken from small populations. The term $\sqrt{\frac{N-S}{N-1}}$ is the population correction factor. As populations increase in size, the term has less impact on the resulting estimate. For example, with a sample size of 300 and population size of 500, the term reduces to .63. If the population size is increased to 5,000, the term is .96, and it quickly approaches 1 at

50,000 (or .997). Thus, for populations greater than 50,000, the term can safely be dropped from the equation, since further increases in population have little impact on the margin of error, or the necessary sample size. In other words, a sample sufficient for sampling from a population of 50,000 will also be sufficient for sampling from a population of 50 million. In each case, the population is “large enough,” and the formula for “large populations” can safely be used, which calculates a sample size without reference to the population size.

3. Skip interval formula:

$$I = \left(\frac{2N}{S}\right) - 1$$

where:

I = Skip interval
 N = Population size
 S = Sample size

4. Procedure:

- a. Determine the sample size.
- b. Determine the skip interval.
- c. Using a table of random numbers, or a random number generator, select the sample indicated.
- d. Apply test(s) to sample and tabulate raw frequency expressing each frequency as proportion.
- e. Using the 95 percent confidence interval formula, calculate an interval for each population proportion.

5. Calculation example:

From a population of 20,000 homeowners insurance policy files, investigate the accuracy of rating procedures. Using the sampling formula, find sample size as follows:

$$S = \frac{(20,000)(1.96^2)(.5)(1-.5)}{(20,000-1)(.05^2) + (1.96^2)(.5)(1-.5)}$$

$$S = 376.9, \text{ or } 377$$

After the sample size is determined, the skip interval formula for a sample size of 400 yields:

$$I = \frac{2(20,000)}{400} - 1 = 99$$

From a random number table, select 400 numbers between 1 and 99 (ignore those numbers that fall outside the range of 1 to 99; e.g., disregard 138, 191, 295, 0, etc.) For sake of illustration, suppose the first 10 numbers are:

K1 – 03	K2 – 16
K3 – 12	K4 – 55
K5 – 56	K6 – 33
K7 – 57	K8 – 18
K9 – 25	K10 – 23

Begin the selection process by skipping the first three files and selecting the fourth file, then skip the next 16 files and select the 21st file and so on.

Suppose the following results were tabulated from the sample of 400 files.

Category	(a) Count	(b) Percent (P) (Column a ÷ sample size)	(c) 95% Confidence Interval
Policies with rate overcharge	21	5.25	2.16
Polices with rate undercharge	14	3.50	1.78
Policies with non-premium error	10	2.50	1.51
Policies with insufficient information	10	2.50	1.51
Total rated incorrectly	55	13.75	3.34

Using the 95 percent confidence interval formula, the confidence interval for 5.25 would be:

$$1.96 \sqrt{\frac{(5.25)(94.75)}{400} \left(\frac{20,000 - 400}{20,000 - 1} \right)}$$

$$1.96 \times 1.115 = 2.16 \text{ (rounded)}$$

Thus, a regulator can be 95 percent confident that the proportion of policies with a rate overcharge is between 3.09 (column b - 2.16) and 7.41 (column b + 2.16).

Not for Distribution

Chapter 15—Writing the Examination Report

This chapter explains how to prepare an examination report and record examination findings so that a company's performance can be assessed and any recommended actions can be made. This chapter also provides guidance regarding an insurance department's policy on review and distribution of an examination report. Regardless of the number of jurisdictions participating in an examination, whenever possible, a single report should be issued.

A. General

1. Objectivity

The language of the report should reflect the same objectivity as was used in the fact finding and information gathering processes of the examination. Phrases such as "random sample" may be used to emphasize objectivity. When the scope of the examination is to target certain areas, that should be indicated in the report. The report must be a factual recording of the findings. The use of words such as "some, many, several and few" must be minimized.

2. Privacy

When providing individual file numbers that were found to contain exceptions, be mindful of not violating the confidentiality of individual policyholders.

3. Use of Jargon

Keep the needs of the various individuals who will review and utilize the report in mind. Whenever possible, the use of insurance industry jargon within the report should be either avoided or explained.

4. Report Types

There are two approaches to report writing: the report by exception and the report by test. The two report types are not mutually exclusive.

a. Report by Exception

The report by exception has been the accepted method of examination reporting since the inception of market conduct examinations. In this type of report, only exceptions or errors are noted. The advantage of this type of report is that it can be relatively brief. One concern that has been expressed regarding this type of report is that it is not possible to tell which tests have been applied during the examination. Another concern is that items considered insignificant or resolved by the examiners are not reflected and other readers may place a different value on the unreported information.

b. Report by Test

The report by test is a recent development wherein each test applied during the examination is stated and the results are reported, whether good or bad. Exceptions are noted as part of the comments for the applicable test. The advantage of this type of report is that it is clear what tests have been applied. The report format tends to reduce report production time. The principal concern with this type of report is that it is likely to be lengthier than the traditional report by exception. There is also concern that entities being examined may use the report for advertising purposes; however, this may be addressed by stating in the report, if necessary, that it may not be used for such purposes.

B. Content of the Report

1. Preliminary Information

This information should be contained in the first few pages of the report.

a. Title Page

1. Type of examination;
2. Company name and home office address. If examined location is different, also include that address;
3. NAIC group and company code numbers;
4. NAIC Market Action Tracking System (MATS) action number;
5. An “as of” date, to indicate the end of the examination time period covered; and
6. List of participating jurisdictions.

b. Table of Contents

c. Salutation

Addressed to the director, superintendent or commissioner of the jurisdictions participating in the examination, stating that pursuant to their instructions, an examination of the company has been performed.

d. Foreword

A statement that the report is

1. By exception—only that additional practices, procedures and files subject to review during the examination were omitted from the report, if no improprieties are indicated; or,
2. By test—and that all tests applied during the examination are reported.

e. Scope of Examination

1. Cite specific statutory authority;
2. List the time period covered by the examination;
3. Briefly outline the examination purpose(s);
4. Cite error tolerance used and that any error which appears to be a pattern error or general business practice has been included;

5. List areas to be covered, such as company operations/management, underwriting, policyholder service, claims, marketing and sales, producer licensing and complaint handling; and
6. Failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

2. Profile Facts

This section should contain a brief profile of the company that may include, but is not limited to, the following:

- a. Company history or U.S. Securities and Exchange Commission (SEC) Form 10-K information;
- b. Affiliated companies;
- c. Jurisdictions where company does business. Indicate if certificates of authority are reviewed as part of the examination;
- d. Premium volume;
- e. Major lines of business;
- f. Market share comparison in major lines of business, citing source of statistics, and
- g. Market approach, e.g., agents, brokers and direct response.

3. Executive Summary

The executive summary should highlight the principal areas of concern noted in the examination report without repeating the findings of the examination. It should be a brief and simpler version of the original report. The executive summary should provide an overview to the reader of the significant results of the examination without requiring the reader to review the report in its entirety.

The executive summary is usually no longer than 10 percent to 20 percent of the original report. Particular attention may be given to those activities that involve significant consumer harm or that relate specifically to the reason for the calling of the examination. After presenting a summary of the report, an executive summary may conclude with a paragraph explaining the recommendations for regulatory enforcement action.

The executive summary should contain the following language:

Various noncompliant practices were identified, some of which may extend to other jurisdictions. The company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the [insert state] insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

4. Previous Examination Findings

Previous examination findings are a summary of pertinent results of prior examinations, company responses and disciplinary action taken (which have become public record), as they relate to the current examination results.

5. Pertinent Factual Findings

Depending on the size and content of the report, separate sections may be appropriate for: company operations/management; complaint handling; marketing and sales; producer licensing; policyholder service; underwriting; and claims. Recommended corrective action to deal with significant problem areas may follow finding descriptions or may be included in the summary section. If a general problem is cited which has subsequently been corrected, the report should clearly state that the correction has been made to the satisfaction of the examiner.

a. Report by Exception

If there are no exceptions to note in particular areas, that section may be eliminated from the report. The report should include the sample size and number of files in error for each area examined. Errors would include inconsistencies with the company's manuals and filings. The error ratio (percentage of files reviewed that were in error) for the jurisdiction's statutes, rules and regulations or generally accepted practices should be provided. Brief explanations of particular statutes, rules and regulations that have been violated may help keep the report less technical and easier to follow. Specific areas of performance that were evaluated (in which exceptions were found) should be identified.

b. Report by Test

Each test utilized should be stated with the statutory, rule or regulatory basis noted. The results of each test should be listed with comments pertinent to the examinee's performance under the test. One advantage of the report by test is that information which may not be useful in preparing one aspect of a report may change the focus of an examination or may be helpful for other regulatory purposes. For example, an examiner might find insufficient "errors" in marketing to give rise to an exception report, but then discover that the errors arose in connection with a particular producer. The nature of the inquiry into the insurer may shift to an analysis of its supervision of its agents; while the information also becomes useful for evaluating disciplinary proceedings against the individual.

6. Summarization

- a. Examiners' comments may be presented to emphasize significant problem areas found during the examination and/or to emphasize company noncompliance with recommendations of prior examinations;
- b. Summary of recommendations, if applicable;
- c. A report submission page, listing all examiners who participated in the examination and all signatures of Examiners-in-Charge (EICs) for each jurisdiction participating. If the EIC wishes, a brief acknowledgment of the courtesy and cooperation of the officers and employees of the company may be included; and
- d. A statement of verification where required, signed by the EIC, which attests to the truth and accuracy of the report.

Appendices

Appendices may include time studies and other necessary documentation.

C. Review of the Report

The insurance department should advise the company examined of its policies and procedures for:

1. Conducting informal meetings or conferences with the company to discuss findings and corrective action programs.
2. Reviewing the report with the company before it is printed in final form.
3. Mailing the report to the company and receiving the company's comments.
4. Filing the report and any company comments.
5. Finalizing and filing the report, and determining whether or not it will become a public document.
6. Providing formal rebuttals or conducting formal hearings to review company objections to official filing of the report after it is printed in final form.
7. Advising who will be responsible for printing the report and how many copies will be needed.
8. The submission of a post-examination questionnaire (optional).

D. Distribution of the Findings

1. Any distribution of the filed report may include the examiner's report, the company's comments and objections, and any results of insurance department comments and orders or stipulations.
2. Examination results are to be entered in the appropriate NAIC database.
3. Final (adjudicated) actions should be entered into the appropriate NAIC database.

E. Information on Examinations Conducted by Other States

1. A report of market conduct examinations, as well as summarized examination findings of past examinations conducted in other jurisdictions, can be obtained via MATS.
2. Examiners may wish to contact either the EIC or the individual identified in MATS for further information regarding particular examinations.
3. The RIRS contains a history of regulatory actions taken by individual jurisdictions on reported companies and agents.

Not for Distribution

Chapter 16—General Examination Standards

The examination of the insurance operations of a regulated entity may involve reviewing one or more of the following business areas:

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the regulated entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. Many states have executed an agreement to share complaint information with one or more of these federal or state agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal or state agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

This chapter contains examination standards that are relevant to nearly all types of examinations. Chapters 17 through 28 contain standards that are specific to various product lines and specialized entities.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the regulated entity is and how it operates. It is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate a financial examination review, but is important in providing the market conduct examiner with an understanding of the examinee. Many troubled companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. The areas to be considered in this kind of review include:

- a. History;
- b. Profile;
- c. Subcontractor oversight;
- d. Internal audits;
- e. Antifraud initiatives;
- f. Certificates of authority;
- g. Disaster recovery plan;
- h. Computer systems;
- i. Minutes from all meetings attended by the board of directors; and
- j. Privacy.

2. Techniques

Typically, the items to be reviewed here can be prepared by the regulated entity and provided at the pre-examination conference. Supplemental information, including history and profile may be available in the insurance department files. Other items suggest an active review of regulated entity files relating to managing general agent (MGA) or subcontractor oversight, internal audits, procedure manuals, record management, computer systems controls and antifraud plans. The latter category of items should have substantial supporting documentation.

The absence of subcontractor oversight, internal audit functions, written procedures or an antifraud plan should be specifically noted when preparing the examination report.

a. History

The examiner should prepare for the examination report a very brief history of the regulated entity, including its formation; its type; its structure, including the parent corporation and other members of the group; and any major changes that are relevant to the current examination.

b. Profile

The profile includes an overview of the regulated entity's operations, including management structure, type of carrier, states where the regulated entity is licensed and the entity's major line(s) of business. A total change in the management team may generate the need to review the regulated entity on an abbreviated time cycle.

The examiner should review Market Action Tracking System (MATS) findings from prior examinations, Regulatory Information Retrieval System (RIRS) results, complaint index reports and reports from other NAIC applications and databases to determine if other regulators have expressed concerns that may require additional attention during the examination. RIRS and MATS information should not be included in the examination report.

The total written premiums for the major lines of business should be compared to the total writing in a given state to determine the market share. The loss, expense and combined ratios can be obtained from the response exhibit attached to the annual statement or the NAIC Financial Analyst Workbench (FAW) system and may be calculated for the specific jurisdiction. Review IRIS ratios, which can be an indicator of market conduct problems. The surplus ratio should also be examined and noted for the period under review. Substantial shifts in the geographical area of operation and kinds of business written and volume should be noted, questioned and described.

c. Subcontractor Oversight

The jurisdiction's statutes on MGAs and other subcontractors are sources of tests for this oversight. The aim is to ensure that a regulated entity using subcontractors engages in a realistic review of oversight. Contracts should be reviewed to ensure compliance with the MGA statutes governing contract content and oversight features. The focus is on the oversight impacting records and actions considered in a market conduct examination such as, but not limited to, trade practices, claims practices, policy selection and issuance, rating, complaint handling, etc. Examiners should pay particular attention to a subcontractor's dealings with policyholders and claimants.

d. Internal Audits

A regulated entity that has no internal audit function lacks the ready means to detect structural problems until after problems have occurred. Any questionable findings about the internal audit function should be referred to the Examiner-in-Charge.

e. Antifraud Plans

The regulated entity should have antifraud plans which are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. In addition, insurers may be required by law to establish antifraud plans, and examiners should be aware of any state-specific legal requirements pertaining to antifraud measures.

The guidelines set forth in the *Antifraud Plan Guideline* (#1690), adopted by the NAIC in March 2011, are intended to provide a road map for state fraud bureaus, insurers' Special Investigative Units (SIU)s or contracted SIU vendors for preparation of an antifraud plan.

Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meet state compliance standards. The *Antifraud Plan Guideline* does not preempt other state laws or preempt or amend any guidance previously published by the NAIC Antifraud (D) Task Force or in the *Fraud Prevention Model Act* (#680).

f. Certificates of Authority

The examiner should determine if the regulated entity's operations conform with the regulated entity's certificates of authority.

g. Disaster Recovery Plan

It is essential that the regulated entity has a formalized disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster. The examiners should determine if the regulated entity maintains separate backups of all records and facilities to continue operations.

h. Computer Systems

The examiners should determine the types of controls, safeguards and procedures for protecting the integrity of the computer information. The focus in this case is on those records subject to a market conduct examination that are maintained in electronic format, such as, but not limited to, underwriting files, claim files, rate and form filings, complaint files, statistical data used to support rates, etc.

The regulated entity should identify the location(s) of all websites maintained by or for and authorized by the regulated entity and all approved producer sites.

In addition, an Internet search using the regulated entity's name should be conducted using a search engine such as Yahoo, Google or a metasearch (aggregator) search engine such as WebCrawler. If any additional sites are located that the regulated entity did not identify, it should be specifically noted when preparing the examination report. The examiner should be mindful that some searches may produce a large volume of "hits." In such a situation, the examiner should employ sampling techniques to determine the regulated entity's general practices on the Internet.

i. Minutes from All Meetings Attended by the Board of Directors

A review of the minutes of meetings with the board of directors should be conducted to ensure the board has proper oversight of the company's operations and activities. Note: When a credit company is the subject of an examination, examiners should be aware that there may be statutes, rules, and regulations with specific requirements regarding the organization and structure of credit organizations.

j. Privacy

The NAIC has adopted several sets of privacy requirements, and examiners will need to determine which requirement(s) the state imposes to conduct an examination. The first is the *NAIC Insurance Information and Privacy Protection Model Act* (#670) (hereinafter, the 1982 Model Act). The second NAIC approach was the *Health Information Privacy Model Act* (#55), which, according to NAIC records, as of April 2015 had not been adopted by any state, although a few states have related laws.

The NAIC then adopted a model titled *Privacy of Consumer Financial and Health Information Regulation* (#672) (hereinafter, the 2000 Model Privacy Regulation) to assist states with promulgation of regulations to comply with certain requirements of Title V of the federal Gramm-Leach-Bliley Act (GLBA) (PL 102-106), enacted by Congress in 1999. And, in 2002, the *Standards for Safeguarding Customer Information Model Regulation* (#673) (hereinafter, the 2002 Model Information Security Regulation) was adopted to assist states in establishing standards for development and implementation of safeguards by insurers to protect customer information, also required by Title V of GLBA.

In some cases, a state may have one or more of these measures, or a combination thereof, in force. NAIC records indicate that as of April 2015, 39 states plus the District of Columbia and Puerto Rico have enacted regulations/laws based on the 2000 Model Privacy Regulation.

1982 Model Act (#670)

The 1982 Model Act is focused primarily on the insurance application process, underwriting, policy issuance and related transactions. It requires various disclosures to applicants regarding the insurer's practices (e.g., that an investigative consumer report may be obtained and that information may be disclosed to insurance support organizations which, in turn, may retain and later re-disclose the information to others) and the applicant's rights (e.g., that the applicant has a right to obtain a copy of an investigative consumer report and that the applicant has the rights of access to and correction of information about him/her).

Notices providing these disclosures may be required at application and whenever there is a "change of status"—e.g., at renewal or reinstatement—if new or additional information is to be collected from a source other than the applicant. There is no requirement for annual notices. If an insurer intends to disclose information for the marketing of a product or service, the customer must be given an opportunity to opt out. Operations/Management Examination Standards #10 and #11 in this chapter are applicable only for those states that have enacted the 1982 Model Act or substantially similar privacy requirements.

2000 Model Privacy Regulation (#672)

The 2000 Model Privacy Regulation was adopted to implement certain privacy provisions of the Gramm-Leach-Bliley Act. Title V of GLBA addressed the confidentiality of information about customers of "financial institutions," a term that includes insurance companies, banks and depository institutions, broker-dealers, investment companies, registered investment advisors and a variety of other kinds of businesses. Title V, as further implemented by the 2000 Model Privacy Regulation, requires that financial institutions establish and implement a privacy policy and

provide notices to customers describing such policies and the customer's rights to opt out of disclosures other than those allowed by the exceptions in Sections 14 through 16 (Section 17B of the 2000 Model Privacy Regulation sets forth exceptions for the customer authorization requirement for certain health information disclosures). The adoption of regulations and guidelines was delegated to the functional regulators of the various financial institutions.

The federal functional regulators (including, among others, the Securities and Exchange Commission, the Office of the Comptroller of Currency and the Federal Trade Commission) and the NAIC have taken substantially similar positions in their regulations regarding the disclosure of customer personal information and notices. The federal regulations are nearly identical to each other, with very minor differences to reflect the different financial products and services involved and related business practices. The 2000 Model Privacy Regulation is very similar to the federal regulations with respect to the treatment of financial information, with appropriate changes for insurance products and services, as well as established business practices and relationships.

The notices required by the 2000 Model Privacy Regulation include initial, revised and annual privacy notices, which must reflect the privacy policy, including financial information disclosure practices, of the insurance regulated entity or other licensee. It should be noted that privacy policies differ from insurer to insurer, from insurer to other licensee, etc. There is no set format required for privacy notices, although they must be "clear and conspicuous" as that term is defined in the regulation. The regulation does, however, list the topics that the privacy notice must address. Since a privacy notice reflects a specific insurer's or other licensee's own particular financial information privacy practices, notices will legitimately differ.

The 2000 Model Privacy Regulation differs from the federal agency regulations in that the model includes protections for certain health information. In general, a licensee must get an individual's approval (opt-in) prior to disclosing nonpublic personal health information, unless the disclosure falls under an exception listed in Subsection 17B or the licensee is in compliance with the health privacy regulation promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to the federal Health Information Portability and Accountability Act (HIPAA). Even if the licensee is not subject to HIPAA, the 2000 Model Privacy Regulation allows the option of complying with the HHS standards as an alternative to the NAIC standards.

Operations/Management Examination Standards #12, #13, #14, #15 and #16 in this chapter are applicable for examination of compliance with the 2000 Model Privacy Regulation regarding the disclosure of customer information.

2002 Model Information Security Regulation (#173)

The 2002 Model Information Security Regulation was adopted to establish standards regarding safeguarding of customer information, also required by Title V of GLBA. It should be noted that the 2002 Model Information Security Regulation requires that a licensee establish an information security program "appropriate to the size and complexity of the licensee," as well as appropriate to the "nature and scope of (the licensee's) activities." The regulation provides illustrative examples of various factors that a licensee may consider when developing its information security program.

Operations/Management Examination Standard #17 in this chapter is applicable for examination of compliance with the 2002 Model Information Security Regulation for security standards.

3. Tests and Standards

The operations and management review includes, but is not limited to, the following standards addressing various aspects of a regulated entity's operations. The sequence of the standards listed here does not indicate priority of the standard.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 1
The regulated entity has an up-to-date, valid internal or external audit program.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Audit plan and regulated entities' procedural manuals
- _____ Audit reports and results

Others Reviewed

- _____
- _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 12
Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies
(#751), Section 11
Best Practices Organizations White Paper

Review Procedures and Criteria

Review audit reports to determine if the function is providing meaningful information to management. If external, obtain an explanation.

Determine how management is using the reports.

Determine if the regulated entity responds to internal audit recommendations to correct, modify and implement procedures.

Determine if accuracy of internal statistical data and information systems is periodically tested by the regulated entity's audit program.

Determine if the regulated entity conducts periodic reviews of creditors with respect to their credit insurance business with such creditors.

Determine if the regulated entity has adopted edit and audit procedures to screen and check data submitted by the regulated entity's statistical agent.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the regulated entity has taken appropriate corrective action.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 2
The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Electronic records control, recovery/backup plan and regulated entity's procedural manuals; whether the records are electronic

_____ Negotiated contracts

Others Reviewed

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)

Health Information Privacy Model Act (#55)

Standards for Safeguarding Consumer Information Model Regulation (#673)

Review Procedures and Criteria

Review regulated entity records, records recovery and backup procedures. The plan and procedures should be valid and up-to-date.

Review computer security procedures.

If the regulated entity permits changes to be made to policies either electronically or verbally, check what security procedures the regulated entity has established to permit these changes. These may include who has authority to make those changes, and what verification is done by the regulated entity with the insured after changes are made.

Ensure there is adequate security of applicant/insured data during the electronic transference of information. Identify any areas where the applicant's/insured's privacy is not properly protected.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 3

The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity antifraud plan and procedural manuals

Others Reviewed

NAIC Model References

Insurance Fraud Prevention Model Act (#680)

Antifraud Plan Guideline (#1690)

Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Review the regulated entity's antifraud initiatives in conjunction with applicable statutory requirements. Antifraud initiatives may include fraud investigators, who may be insurer employees or independent contractors, and an antifraud plan.

Verify that the insurer, if required by applicable state statutes, rules and regulations, submits its antifraud plan to the insurance commissioner:

- Within ninety days of receiving a certificate of authority;
- Every five years thereafter; and
- Within thirty days of a material change made to the antifraud plan.

Determine if the plan is adequate, up-to-date and in compliance with statutes, rules and regulations.

Review the regulated entity's implementation (staffing, support, etc.) of its plan and, if necessary, discuss with management.

Note: An SIU antifraud plan may cover several insurer entities within a regulated entity, if one SIU has the fraud investigation mission for all entities.

Verify that the insurer's antifraud plan includes the following five sections:

1. General Requirements

- An acknowledgment that the SIU has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer;
- An acknowledgment that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the insurance department or other applicable state regulatory agency within a specific time frame;
- A provision stating whether the SIU is an internal unit or an external or third-party unit;
- If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments;
- A written description or chart outlining the organizational arrangement of the insurer's antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts:
 - If the SIU is an internal unit, the insurer shall provide general contact information for the company's SIU;
 - If the SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU company; and
 - If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented;
- A provision where the insurer provides the appropriate NAIC individual and group code numbers;
- A statement as to whether the insurer has implemented a fraud awareness or outreach program. If the insurer has an awareness or outreach program, a brief description of the program shall be included; and
- If the SIU is a third-party unit, a description of the insurer's policies and procedures for ensuring that the third-party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third-party vendor.

Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

2. Prevention, Detection and Investigation of Fraud

- A description of the insurer's corporate policies for preventing fraudulent insurance acts by its policyholders;
- A description of the insurer's established fraud detection procedures (i.e. technology and other detection procedures);
- A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by the SIU;
- A description of the SIU investigation program (i.e. by business line, external form claims adjustment vendor management Statement of Positions (SOPs); and
- A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from its claims or underwriting departments to the SIU.

3. Reporting of Fraud

- A description of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations;

- A description of the insurer's criteria or threshold for reporting fraud to the insurance commissioner; and
- A description of the insurer's means of submission of suspected fraud reports to the insurance commissioner (e.g., the NAIC Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system or other).

Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

Note: The examiner should be aware of any applicable state statutes, rules and regulations regarding state antifraud mandatory reporting methods.

4. Education and Training

- If applicable, a description of the insurer's plan for antifraud education and training initiatives or any personnel involved in antifraud related efforts. This description shall include:
 - The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.;
 - If the training will be internal and/or external;
 - Number of hours expected per year; and
 - If training includes ethics, false claims or other legal-related issues.

5. Internal Fraud Detection and Prevention

- A description of insurer's internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.; and
- A description of the insurer's internal fraud reporting system.

Determine if the regulated entity has procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.

Determine if the regulated entity has procedures in place to provide information regarding fraudulent insurance acts to the insurance commissioner and in a manner prescribed by the insurance commissioner.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 4 The regulated entity has a valid disaster recovery plan.
--

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Description of the regulated entity’s disaster recovery plan, procedural manuals and controls
- _____ Description of protective devices for various hazards and procedures/controls for protection from those hazards
- _____ Negotiated contracts

Others Reviewed

- _____
- _____

NAIC Model References

Market Conduct Record Retention and Production Model Regulation (#910)

Review Procedures and Criteria

Determine that the regulated entity’s database(s) are protected from various hazards, including environmental hazards.

Review the regulated entity’s documents. Any additional areas or lack of information should be discussed with the regulated entity’s management. The disaster recovery plan should be valid, specific and operational, with procedures for implementation and should also be current. Failure of the regulated entity to adequately plan for the future means the standard was not met.

Failure of the regulated entity to adequately (on an ongoing basis) provide for off-site backup, failure of the regulated entity to provide adequate controls and, in the case of a catastrophe, failure to provide for recovery, means the standard was not met.

Operations/Management Examination Standard #2 in this chapter also addresses disaster recovery issues.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 5
Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and management agreements, must comply with applicable licensing requirements, statutes, rules and regulations.

Apply to All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

Others Reviewed

NAIC Model References

Service Contracts Model Act (#685)

Managing General Agents Act (#225)

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1079)

Third Party Administrator Statute (#90)

Review Procedures and Criteria

Review the contract to determine compliance with state statutes and rules.

The contract should specify the responsibilities of the subcontractor regarding recordkeeping and responsibilities of the regulated entity for conducting audits.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 6

The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

_____ Audit reports

Others Reviewed

NAIC Model References

Managing General Agents Act (#225), Section 5
Registration and Regulation of Third-Party Administrators: An NAIC Guideline (#1090)
Third Party Administrator Statute (#90), Section 6
Consumer Credit Insurance Model Regulation (#270), Section 12
Variable Life Insurance Model Regulation (#770)

Review Procedures and Criteria

Entities can include an MGA, GA or TPA. Suppliers of consulting, investment, administrative, sales, marketing, custodial or other services with respect to variable life insurance operations are also considered entities (*Variable Life Insurance Model Regulation (#270), Section 3E*).

Review entity contracts to determine compliance with statutes, rules and regulations. The contract should specify the responsibilities of the MGA, GA and TPA concerning recordkeeping and responsibilities of the regulated entity for conducting audits.

Review audit reports to determine whether the regulated entity is adequately monitoring the activities of the contracted entity.

Review activities of entities to ensure compliance with applicable statutes and rules.

For credit insurance, each insurer is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business. The review should ensure compliance with statutes, rules and regulations. Written records of the reviews must be maintained by the insurer.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 7
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All records, files and documents

Others Reviewed

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)

Market Conduct Record Retention and Production Model Regulation (#910)

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Model Law on Examinations (#390), Section 4

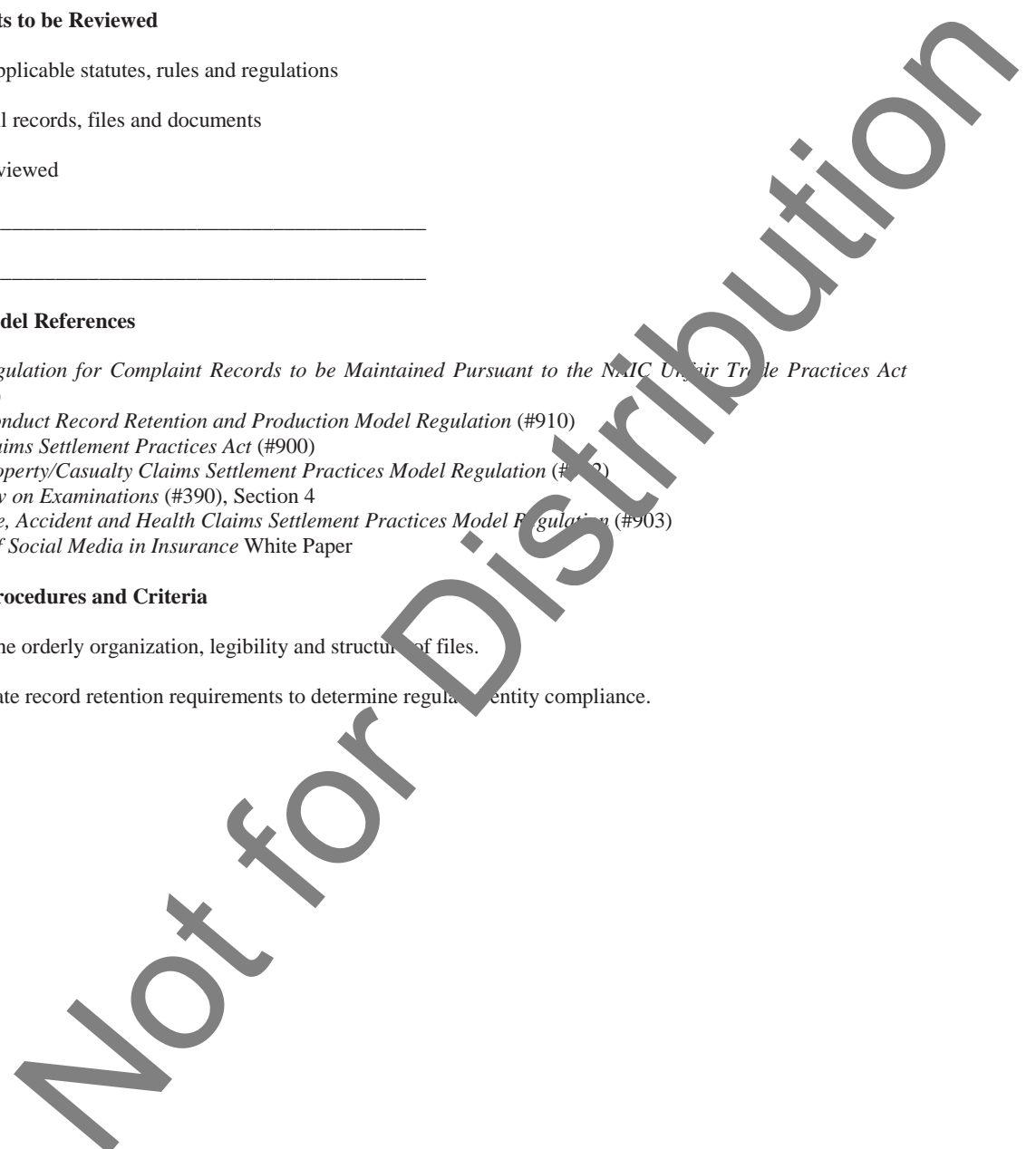
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Evaluate the orderly organization, legibility and structure of files.

Review state record retention requirements to determine regulatory entity compliance.



**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 8 The regulated entity is licensed for the lines of business that are being written.
--

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Certificate of authority or other similar documents
- _____ Access NAIC financial system
- _____ Regulated entity system

Others Reviewed

- _____
- _____

NAIC Model References

- Service Contracts Model Act (#685)*
- Nonadmitted Insurance Model Act (#870)*
- Unauthorized Transaction of Insurance Criminal Model Act (#890)*

Review Procedures and Criteria

- Review certificates of authority; compare writings with authorized lines.
- Review financial annual statements submitted to the NAIC; compare writings with authorized states.
- Obtain explanation of any discrepancies.
- Access regulated entity system to verify that writings are in line with written premium reported in the financial annual statement.

Automation Tip:

The Financial Applications section of NAIC iSite+ contains the annual statement financial information for insurance companies that report to the NAIC. The most useful for market conduct examiners would be the annual statement Pick-a-Page. The State Page Exhibit displays the direct written premiums in any particular state for any particular year.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 9
The regulated entity cooperates on a timely basis with examiners performing the examinations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ All records, files and documents

Others Reviewed

NAIC Model References

Model Law on Examinations (#390)

Review Procedures and Criteria

Monitor regulated entity's cooperation during the course of the examination; this may be noted in the examination report.

Automation Tip:

Requests for information or "crits" can be monitored using either a database or spreadsheet. The information that should be captured includes: area of review, type of request, contact person, date given, date due and date received. Databases and spreadsheets contain functions that will calculate the number of days between two dates. The information can be easily sorted and reviewed to see what is still outstanding and if the regulated entity is responding in a timely fashion.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 10

The regulated entity has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Written procedures of regulated entity for maintaining personal information and privileged information of applicants and policyholders
- _____ The “Notice of Information Practices” required to be provided to applicants and policyholders
- _____ Disclosure authorization forms
- _____ Written procedures for the correction, amendment or deletion of regulated personal information

Others Reviewed

- _____
- _____

NAIC Model References

- NAIC Insurance Information and Privacy Protection Model Act (#670)*
- Health Information Privacy Model Act (#55)*
- Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act (#898)*
- Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)*
- Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)*
- The Use of Social Media in Insurance White Paper*

Review Procedures and Criteria

- Determine if the regulated entity appropriately provides a “notice of information practices” that contains the required information.
- Determine if the content of disclosure authorization forms meet content standards.
- Determine if the regulated entity properly handles the use of investigative consumer reports.
- Determine if the regulated entity’s procedures appropriately limit access to personal information.
- Determine if the regulated entity provides specific and accurate reasons for adverse underwriting decisions.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 11

The regulated entity has developed and implemented written policies, standards and procedures for the management of insurance information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity procedure manual
- _____ Regulated entity training manual
- _____ Internal regulated entity claim audit procedures
- _____ Regulated entity bulletins regarding insurance information
- _____ Contractual arrangements between the carrier and a person other than the covered person

Others Reviewed

- _____
- _____

NAIC Model References

Health Information Privacy Model Act (#55), Section 5
NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 4-9

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state law.

Review contractual arrangements between the regulated entity and other persons to determine if the contracts address privacy procedures and standards for the person with whom the regulated entity is contracting.

Review the regulated entity's methods for handling, disclosing, storing and disposing of insurance information. The examiners should determine whether there are procedures in place to ensure proper authorization is obtained prior to disclosure of insurance information.

Review the regulated entity's training manual to determine whether the regulated entity's employees are properly trained on the handling of insurance information.

Verify that the regulated entity provides a "Notice of Information Practices" to all applicants or policyholders or has procedures in place for the producer to deliver the notice. The examiner should determine whether the notice contains all information required by applicable state law.

Verify that the regulated entity specifies those questions designed to obtain information solely for marketing or research purposes.

Verify that the regulated entity has implemented reasonable procedures to address investigative consumer reports and personal interviews.

Verify that the regulated entity has established procedures to address access to, correction, amendment or deletion of recorded personal information.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 12

The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Other regulated entity manuals/instruction books
- _____ Communication provided by the regulated entity to employees and producers subject to the regulated entity's privacy policies
- _____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the regulated entity's policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers, to verify that they comply with applicable state laws regarding privacy.

Review employee procedures regarding the treatment of nonpublic personal information to verify that they comply with the regulated entity's privacy policies, practices and procedures and with applicable state laws regarding privacy.

As applicable, verify that the regulated entity licensee has provided a copy of its privacy notice to its producers.

Determine that the regulated entity does not unfairly discriminate against customers and consumers who are not customers who (1) have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties; and (2) have not authorized disclosure of nonpublic personal health information, if applicable.

Review all privacy-related consumer complaints and inquiries.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 13

The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Sample notices to customers: initial, annual, revised and simplified, if applicable
- _____ Sample notices to consumers that are not customers, if applicable: initial (standard and short-form) notices and revised notice
- _____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the content of the regulated entity's initial, annual and revised notices.

Verify that these notices are clear and conspicuous and accurately reflect privacy policies and practices.

Notices should include the following:

- Identification of the regulated entity, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The categories of nonpublic personal financial information that the regulated entity discloses, if applicable;
- The categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;
- The categories of nonpublic personal financial information about the regulated entity's former customers that the regulated entity discloses and the categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information about the regulated entity's former customers, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;

- If a regulated entity discloses nonpublic personal financial information to a nonaffiliated third party under Section 14 of Model #672, a separate description of the categories of information the regulated entity discloses and the categories of third parties with whom the regulated entity has contracted;
- An explanation of the consumer's right to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right, if applicable;
- Any disclosures that the regulated entity may make under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. Section 1681a(d)(2)(A)(iii) (i.e., notices regarding the ability to opt out of disclosures of information among affiliates, other than transaction and experience information);
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- If a regulated entity only discloses nonpublic personal financial information as authorized under Sections 15 and 16 of Model #672, a statement that indicates the regulated entity makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

Review the content of the regulated entity's simplified notice, if applicable, which shall include:

- Identification of the regulated entity and affiliates or subsidiaries, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- That the regulated entity only discloses nonpublic personal financial information to affiliates and nonaffiliated third parties, as applicable, as authorized under Sections 15 and 16 of Model #672.

Review the content of the regulated entity's short-form notice for consumers who are not customers, if applicable, which shall state that the regulated entity's privacy notice is available upon request and provide a reasonable means by which the consumer may obtain a full notice.

Verify that the regulated entity's process for delivery of notices includes:

- Initial notice, if applicable, to consumers who are not customers;
- Initial notice to all customers, as required;
- Annual notice to all customers, as required;
- Revised notice to customers and consumers who are not customers entitled to notice, if applicable;
- Where applicable, simplified notices to customers and former customers to affiliates and nonaffiliated third parties as authorized under Sections 15 and 16 of Model #672 (or the applicable sections under state law regarding privacy); and
- Short-form notices to consumers who are not customers in lieu of initial notices, if applicable.

Verify that a notice is delivered to the regulated entity's customers at or prior to the time the regulated entity establishes a customer relationship (initial notice), and at least once in any period of 12 consecutive months or once in each calendar year thereafter (annual notice) during the continuation of the customer relationship, if appropriate. If initial notice was provided to customers after the customer relationship was established, verify that the notice was delivered within a reasonable time after the customer relationship was established and (1) establishing the customer relationship was not at the customer's election; or (2) providing notice at or prior to the establishment of the relationship would have substantially delayed the customer's transaction and the customer agreed to receive the notice at a later time.

Verify that if the regulated entity discloses any consumer's nonpublic personal financial information to any nonaffiliated third party, other than as authorized under Section 15 or 16 of Model #672 (or the applicable sections under state law regarding privacy), the regulated entity delivers a notice before disclosing the information.

Verify that individuals deemed consumers under applicable law are provided with an initial notice where applicable (such as where a licensee discloses a claimant's nonpublic personal financial information outside Sections 14 through 16 of Model #672 or its equivalent under state laws regarding privacy).

Verify that a notice was delivered to the regulated entity's customers and, if applicable, to consumers who are not customers in a manner that can reasonably be expected to provide actual notice. Verify that a notice was provided to the regulated entity's customers and, if applicable, to consumers who are not customers, in writing, or, if the licensee provides and if the consumer has agreed, electronically.

Verify that the regulated entity has provided customers with clear and conspicuous initial, annual and revised notices in a manner that allows the customer to retain the notices or obtain them later in writing or, if the customer has agreed, electronically.

If the regulated entity is an excess lines insurer and does not disclose nonpublic personal financial information to nonaffiliated third parties, except as authorized under Sections 15 and 16 of Model #672, verify that the notice set forth in Section 4Q(3)(ii) of Model #672 has been delivered to all customers at the time the regulated entity established ongoing relationships with the customers. If the regulated entity makes disclosures other than as authorized under Sections 15 and 16 of Model #672, the regulated entity is required to comply with applicable initial, annual and revised notice requirements and the opt-out requirements.

Review the regulated entity's notice content and notice delivery procedures to verify that the regulated entity complies with applicable statutes, rules and regulations regarding privacy.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 14

If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Sample notices to customers: initial, annual and, if applicable, revised
- _____ Sample notices to consumers who are not customers, if applicable
- _____ Sample opt-out notice, if applicable
- _____ Regulated entity records of consumers and other customers who have opted out, if applicable
- _____ Communication of customers' and consumers who are not customers' opt-out selections to producers of record
- _____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Determine whether the regulated entity discloses nonpublic personal information relating to customers or consumers who are not customers beyond the scope permitted under Sections 14, 15 and 16 of Model #672.

- Verify that consumers who may be affected by such disclosures have been offered the opportunity to opt out before the disclosures are made. Continue with Steps 1 through 5 below.
- If not, verify that any communications the regulated entity makes regarding opt-out rights are accurate and are in compliance with applicable law.
 1. If applicable, verify that the regulated entity has policies and procedures in place so that consumers and other affected consumers may opt out of the disclosure of their nonpublic personal

financial information to nonaffiliated third parties, except to the extent such disclosure is permitted under Sections 14, 15 and 16 of Model #672.

2. If applicable, review the regulated entity's policies and procedures to verify that the regulated entity has the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out.
3. If applicable, verify that the regulated entity does not disclose, directly or through any affiliate, unless authorized or permitted by applicable federal and/or state law or regulations, nonpublic personal financial information about a consumer or to a nonaffiliated third party except when:
 - The regulated entity has provided a notice to the consumer;
 - The regulated entity has provided an opt-out notice to the consumer;
 - The regulated entity has given the consumer a reasonable opportunity to opt out of the disclosure before the regulated entity discloses the consumer's nonpublic personal financial information to a nonaffiliated third party; and
 - The consumer does not opt out.
4. As applicable, determine that the regulated entity's initial, annual, revised and short-form notices accurately explain the consumer's right to opt-out, including the methods by which the consumer may exercise that right at any time, in accordance with applicable law and the regulated entity's policies and procedures.
5. If applicable, review the content of the regulated entity's opt-out notice to determine if it is clear and conspicuous and includes, either on the form or on the initial privacy notice:
 - A statement that the regulated entity discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;
 - A statement that the consumer has the right to opt out of that disclosure; and
 - A reasonable means by which the consumer may exercise the opt-out right.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 15

The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Joint marketing agreements, if any
- _____ Sample service agreements, if any, with nonaffiliated third parties involved in the regulated entity's marketing activities
- _____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If the regulated entity discloses nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes, verify that all such disclosures are in compliance with Model #672:

- Verify that the regulated entity has provided initial notices to its customers and other affected consumers that include the required information regarding the regulated entity's joint marketing and servicing activities; and
- Review joint marketing agreements, where applicable, to verify that they prohibit the nonaffiliated third party from disclosing or using the nonpublic personal financial information received from the regulated entity other than to carry out the purposes for which the regulated entity disclosed the information, including use under an exception in Sections 15 or 16 of Model #672.

Verify that the regulated entity does not disclose nonpublic personal financial information that it receives from a nonaffiliated financial institution, except in compliance with Model #672.

Review sample service agreements under which a third party markets a licensee's own products and services, if any, to verify compliance with non-disclosure requirements.

Verify that the regulated entity prohibits disclosure of policy numbers or similar forms of access numbers or access codes for a consumer's policy or transaction account to any nonaffiliated third party, except as permitted by applicable law or regulation regarding privacy.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 16

In states promulgating the health information provisions of the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity privacy policies and procedures
- _____ Sample authorizations used by the regulated entity to permit disclosure of nonpublic personal health information, if applicable
- _____ Regulated entity records of customer and other consumer authorizations
- _____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If applicable, verify that the regulated entity has policies and procedures in place to secure authorizations from its customers and consumers who are not customers before disclosing their nonpublic personal health information to nonaffiliated third parties, except to the extent such disclosure is permitted under Subsection 17B of (Model #672).

If applicable, verify that the regulated entity has obtained valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information, except to the extent such disclosures are permitted under Subsection 17B of (Model #672). A valid authorization shall include:

- The identity of the consumer who is the subject of the nonpublic personal health information;
- A general description of the types of nonpublic personal health information to be disclosed;
- A general description of the parties to whom the licensee discloses nonpublic personal health information;
- A general description of the purpose of the disclosure of the nonpublic personal health information;
- A general description of how the nonpublic personal health information will be used;

- The signature of the consumer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant disclosure authority and the date signed;
- A notice of the length of time for which the authorization is valid; and
- A notice that the consumer may revoke the authorization at any time, and an explanation of the procedure for making a revocation.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 17

Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity written materials describing its information security program
- _____ Regulated entity policies, procedures and other materials it uses to implement its information security program
- _____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

- _____
- _____

NAIC Model References

Standards for Safeguarding Customer Information Model Regulation (659)

Review Procedures and Criteria

Review the regulated entity's written information security program to determine whether the security program includes administrative, technical and physical safeguards.

Determine whether, when developing safeguards, the regulated entity took into consideration the:

- Size and complexity of the regulated entity; and
- Nature and scope of regulated entity's activities.

In making the assessment above, consider factors such as: (1) the products and services offered by the regulated entity; (2) the methods of distribution of the products and services; (3) the types of information maintained by the regulated entity; (4) the size of the regulated entity (which may include the number of employees and the volume of business, etc.); (5) the marketing arrangements; and (6) the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.

Evaluate whether the regulated entity's information security program is designed to:

- Ensure the security and confidentiality of customer information;
- Protect against any anticipated threats or hazards to the security or integrity of the information; and
- Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to a customer.

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 18

All data required to be reported to departments of insurance is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Claim files
- _____ Underwriting files
- _____ Regulated entity's medical professional liability closed claim reports (if applicable)
- _____ Regulated entity's Market Conduct Annual Statement (MCAS) submission
- _____ Regulated entity's responses to state-specific data requests

Others Reviewed

Statutory or regulatory authority for state-specific data requests

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Medical Professional Liability Closed Claim Reporting Model Law (#77)
Market Conduct Surveillance Model Law (#693)

Review Procedures and Criteria

Interview the regulated entity's personnel who prepare loss statistical reports, medical professional liability loss reports, MCAS data and state-specific data requests; analyze regulated entity's internal communications between various departments which report same.

Determine that the regulated entity reviews data errors and subsequent changes are made.

Determine if the regulated entity's medical professional liability closed claims reports are accurate and reported within the required time frame.

Request that the regulated entity reconcile closed claims reports, state-specific data requests and MCAS data with the State Page of the annual statement to include payments, case reserves, and defense cost containment expenses, and explain differences.

Request that the regulated entity reconcile closed claims reports to data provided on the standardized data request.

B. Complaint Handling

1. Purpose

The NAIC definition of a complaint is “any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state’s insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose.” The examiner should review the regulated entity’s procedures for processing consumer or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the regulated entity’s operation.

If a regulated entity is using social media, the examiner should review the regulated entity’s policies and procedures with regard to regulated entity handling of complaints received via social media, in which the regulated entity is active.

2. Techniques

A review of complaint handling should incorporate both consumer direct complaints to the regulated entity and those complaints filed with the insurance department. The examiner should reconcile the regulated entity’s complaint register with a list of complaints from the insurance department. A random sample of complaints should be selected for review from the regulated entity’s complaint register. If such a register is not maintained, alternative methods of isolating complaints may be implemented.

The examiner should review the frequency of similar complaints and be aware of any pattern of specific type of complaints. The examiner should take into consideration the increase of complaints that typically follows a catastrophe. Should the type of complaints generated be cause for undue concern, specific measures should be instituted to investigate other areas of the regulated entity’s operations. This may include modifying the scope of examination to examine specific regulated entity behavior.

The examiner should review the NAIC Complaints Database System (CDS) to determine the regulated entity’s complaint index, along with any adverse trends in complaint volume. The examiner may wish to review complaint trends and the complaint index for the preceding three years.

The examiner should review the final disposition of complaints and determine if the regulated entity has taken adequate steps to finalize the complaint. The examiner should determine if the actions taken are in compliance with statutes, rules and regulations.

In states that have established a statutory or regulatory standard of promptness, a study should be conducted to determine how promptly the regulated entity responds to complaints, the adequacy of the responses and what, if any, actions were taken to resolve the problems.

If the examination involves a depository institution or their affiliates, it may also be regulated by a federal agency, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. If the state has signed an agreement to share complaint information with these agencies, any adverse trends or pattern of concern to the examiners may be identified and relayed to the agency.

3. Tests and Standards

The complaint handling review includes, but is not limited to, the following standards addressing various aspects of the regulated entity’s operations. The sequence of the standards listed here does not indicate priority of the standards.

**STANDARDS
COMPLAINT HANDLING**

Standard 1
All complaints are recorded in the required format on the regulated entity’s complaint register.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity complaint register
- _____ Insurance department’s complaint records
- _____ Direct consumer complaints
- _____ Complaints received electronically (i.e., via Internet or email)

Others Reviewed

- _____
- _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Consumer Complaints White Paper
Unfair Trade Practices Act (#880), Section 4K

Review Procedures and Criteria

All of the above should be reviewed to make sure the regulated entity is:

- Recording all complaints (both consumer direct and insurance department); and
- Recording required information in the regulated entity complaint register.

Determine if the regulated entity complaint register meets minimum standards as required by law. At a minimum, the complaint register should include:

- Line of business;
- Function (underwriting, marketing and sales, claims, policyholder services or miscellaneous); and
- Reason for complaint (underwriting, application, cancellation, rescission, nonrenewal).

Automation Tip:

Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Do not specify which data to be supplied, but instead go with exactly what the regulated entity tracks. A review can be made to see if they contain the information that should be collected from each complaint. Then, a sample can be pulled to review individual complaints to see if the regulated entity’s procedures are being followed.

Obtain complaint data file from the insurance department (in whatever format available; e.g., ASCII text file, Microsoft Access, etc.). Convert the data file to a format compatible to the spreadsheet/database from the regulated entity. Compare the complainant name, claim number, policy number, etc., in both files to determine if all of the insurance department complaints were correctly logged by the regulated entity.

Not for Distribution

**STANDARDS
COMPLAINT HANDLING**

Standard 2
The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint handling procedure manuals

_____ Policy files

Others Reviewed

NAIC Model References

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Consumer Complaints White Paper

Review Procedures and Criteria

Review the regulated entity's manuals to verify that complaint procedures exist.

Determine whether there are sufficient procedures in place to require satisfactory handling of complaints received, as well as internal procedures for analysis in areas developing complaints.

Determine whether there is a method for distribution of and obtaining and recording responses to complaints. This method should be sufficient to allow response within the time frame required by state law.

The regulated entity should provide a telephone number and address for consumer inquiries.

Not for Distribution

**STANDARDS
COMPLAINT HANDLING**

Standard 3

The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Regulated entity complaint register

_____ Complaint letter or email and regulated entity complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Regulated entity correspondence

Others Reviewed

NAIC Model References

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints documentation to determine if the regulated entity response fully addresses the issues raised. If the regulated entity did not properly address/resolve the complaint, the examiner should ask the regulated entity what corrective action it intends to take.

Criteria for reviewing complaint responses:

- The response is timely;
- The response is complete and responds to all issues raised;
- The response includes adequate documentation to support the respondent's position;
- The respondent's actions are appropriate from a business practice standpoint;
- The respondent's actions comply with all applicable statutes, rules and policy or contract provisions; and
- The appropriate remedies for the consumer are identified.

**STANDARDS
COMPLAINT HANDLING**

Standard 4
The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Complaint letter or email
- _____ Regulated entity response and supporting documentation
- _____ Regulated entity complaint register

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Complaints White Paper*

Review Procedures and Criteria

Review complaints to ensure regulated entity is maintaining adequate documentation.

Determine if the regulated entity's response is timely. The examiner should refer to state laws for the required time frame.

Automation Tip:

Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Using either an Excel spreadsheet or a Microsoft Access database, calculate the number of days between the date the complaint was received and the date a final resolution was sent to the complainant. Use the features of either application to identify those complaints where the number of days to resolve the complaint exceeds the statutory standard.

C. Marketing and Sales

1. Purpose

The Marketing and Sales portion of the examination is designed to evaluate the representations made by the regulated entity about its product(s) or services. It is not typically based on sampling techniques. The areas to be considered in this kind of review include all media (radio, television, videotape, electronic medium, social media, etc.), written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every regulated entity is required to have procedures in place to establish and, at all times, maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained for or for the regulated entity and authorized by the regulated entity are the responsibility of the regulated entity.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (# 30)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a regulated entity's Internet advertisements, it is important to also review the safeguards implemented by the regulated entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
MARKETING AND SALES**

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ All regulated entity advertising and sales materials, including radio and audio visual items such as television commercials, telemarketing scripts, pictorial materials, social media or other electronic medium
- _____ Policy forms as they coincide with advertising and sales materials
- _____ Producer’s own advertising and sales materials
- _____ Regulated entity policies and procedures

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Trade Practices Act* (#880)
- Advertisements of Life Insurance and Annuities Model Regulation* (#570), Section 3B
- Risk-Based Capital (RBC) for Insurers Model Act* (#312), Section 8B
- Life Insurance Disclosure Model Regulation* (#580), Section 8C
- Life and Health Insurance Guaranty Association Model Act* (#520), Section 19A
- Long-Term Care Insurance Model Act* (#640)
- Life Insurance Illustrations Model Regulation* (#582)
- Small Employer and Individual Health Insurance Availability Model Act* (#35)
- Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Model Act* (#171), Section 7(H)(1)(c)-(d)
- Advertisements of Accident and Sickness Insurance Model Regulation* (#40)
- Individual Health Insurance Portability Model Act* (#37), Section 5
- Title Insurers Model Act* (#528)
- Title Insurance Agent Model Act* (#230)
- Home Service Disclosure Model Act* (#920)
- Marketing Insurance Over the Internet White Paper*
- Group Health Insurance Standards Model Act* (#100)
- Medicare Supplement Insurance Minimum Standards Model Act* (#650)
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651)
- The Use of Social Media in Insurance White Paper*

IIPRC Uniform Standard References

IIPRC Standards for Individual Long-Term Care Advertising Materials (applicable to individual long-term care products and associated advertising materials submitted and/or approved by the IIPRC)

Review Procedures and Criteria

Review advertising materials in conjunction with the appropriate policy form. If statistics are included, proper citation should be included in the documentation.

Materials should not:

- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of the surplus previously paid on the policy;
- Misrepresent any policy as being shares of stock;
- Misrepresent policy benefits forms or conditions by failing to disclose limitations, exclusions or reductions or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, regulated entity or organization in the conduct of insurance business; and
- Offer unlawful rebates or inducements.

Materials should:

- Disclose the name and address of insurer;
- Comply with applicable statutes, rules and regulations; and
- Cite the source of statistics used by the regulated entity.

Determine if the regulated entity approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Review the regulated entity's and producer's websites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the regulated entity/entities?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run an inquiry with the regulated entity's name.
- Review the regulated entity's home page;
- Identify all lines of business referenced on the regulated entity's home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the regulated entity's procedures related to producers advertising on the Internet and ensure the regulated entity requires prior approval of the producer pages, if the regulated entity name is used.

For the review of social media:

- Perform a search of social media sites with the regulated entity's name;
- Identify social media sites in which the regulated entity is active;
- Review identified social media sites and verify any product information provided by the regulated entity is accurate;
- Review the regulated entity's policies and procedures to identify the personnel involved in monitoring the regulated entity's marketing and sales-related social media activity;
- Review the regulated entity's policies and procedures for tracking marketing and sales-related social media requiring regulated entity review; and
- If the regulated entity requires preapproval of producer advertising on the Internet, review the regulated entity's preapproval procedures to determine whether the regulated entity identifies marketing and sales-related social media as also requiring regulated entity preapproval.

Automation Tip:

Enter a summary of all marketing materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as Internet or direct mail. Include fields to note exceptions, such as unsupported statistics or possible misleading statements. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one "piece" of marketing material. It is also possible that one piece of marketing material will contain more than one violation/exception.

The spreadsheet will make it easier to track any repeated statements and to identify any marketing material containing apparent multiple violations/exceptions.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 2
Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's producer training manuals, videos and sales scripts

Others Reviewed

NAIC Model References

Producer Licensing Model Act (#218)

Life Insurance Disclosure Model Regulation (#580), Section 5A(2)

Advertisements of Life Insurance and Annuities Model Regulation (#570)

Small Employer and Individual Health Insurance Availability Model Act (#35)

Individual Health Insurance Portability Model Act (#37), Sections 11D and 11E

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#230)

Advertisements of Accident and Sickness Insurance Model Regulation (#41)

Group Health Insurance Standards Model Act (#100)

Long-Term Care Insurance Model Act (#640)

Medicare Supplement Insurance Minimum Standards Model Act (#650)

Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review all producers' training materials for compliance with state statutes, rules and regulations.

Review materials for references to employing unfair discrimination tactics or avoiding statutory compliance.

Determine whether producers' prepared materials are permitted and, if so, under what conditions and controls.

The examiners should be aware of the results of the review of common consumer complaints against the regulated entity, as that could point toward problems in this area.

Automation Tip:

Enter a summary of all training materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as video, sales script, etc. Include fields to note exceptions, such as incomplete disclosure or possible misleading statements. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one "piece" of training material. It is also possible that one piece of training material will contain more than one violation/exception.

The spreadsheet will make it easier to track any repeated statements and to identify any training material containing apparent multiple violations/exceptions.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 3
Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Bulletins, newsletters and memos

_____ Organizational chart of marketing division

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

Small Employer and Individual Health Insurance Availability Model Act (#35)

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#230)

Group Health Insurance Standards Model Act (#100)

Long-Term Care Insurance Model Act (#640)

Medicare Supplement Insurance Minimum Standards Model Act (#640)

Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review written and electronic communication between the regulated entity and producers in accordance with applicable statutes, rules and regulations.

Determine if communication includes references to new rates, rules and regulations.

Determine if communication conforms to Marketing and Sales Examination Standard #1 in this chapter when referencing advertising and sales.

Determine if the regulated entity uses email to communicate with producers. The examiner should ask to review saved, stored or archived email that was broadcast to the sales force.

Automation Tip:

Enter a summary of all producer communications of whatever description in an Excel spreadsheet. Capture the regulated entity's title or subject line for the communication, the date of the communication, source of the communication, etc. Include fields to note exceptions, such as misleading statements or instructions to producers that are in conflict with statutes or regulations. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one regulated entity communication. It is also possible that a single regulated entity communication will contain more than one violation/exception.

The Excel spreadsheet will make it easier to track any repeated statements and to identify any regulated entity communications containing apparent multiple violations/exceptions.

Not for Distribution

D. Producer Licensing

1. Purpose

The producer licensing portion of the examination is designed to test a regulated entity's compliance with state producer licensing laws and rules. The focus of the standard relating to producer accounts current is to aid in the detection of fraud or misuse of funds held by the producer in a fiduciary capacity.

2. Techniques

The examiner should review and compare information obtained from insurance departments and regulated entity records pertaining to licenses held by individuals or entities soliciting business on behalf of the regulated entity. Information related to producer licensing may be obtained from the NAIC State Producer Licensing Database (SPLD). In addition to aggregate listings of licensed/appointed/terminated producers, compliance with producer licensing statutes should be verified during the review of individual policy files, which take place during other portions of the examination (see Section F Underwriting and Rating in this chapter).

The examiner should compare information obtained from insurance departments and regulated entity records pertaining to the licenses held by individuals or entities soliciting business on behalf of the regulated entity. Insurance department records may be obtained through the NAIC SPLD, if the state is actively submitting information to the database. The SPLD contains information about a producer's license and any appointments they have with a regulated entity.

3. Tests and Standards

The producer licensing review includes, but is not limited to, the following standards related to producer licensing. The sequence of the standards listed here does not indicate priority of the standard.

Not for Distribution

**STANDARDS
PRODUCER LICENSING**

Standard 1

Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with insurance department records.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department listing of producers and, if applicable, adjusters for the SPLD (State Producer Licensing Database)

_____ Regulated entity listing of currently licensed and/or appointed producers and, if applicable, adjusters

_____ Regulated entity listing of commissions

Others Reviewed

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)

Producer Licensing Model Act (#218)

Title Insurance Agent Model Act (#230)

Independent Adjuster Licensing Guidelines (#1924)

Review Procedures and Criteria

Reconcile above regulated entity records with corresponding insurance department lists to determine any discrepancies. If the state is actively participating in the State Producer Licensing Database (SPLD), the examiner should validate the producer's or adjuster's licensure status through the SPLD in lieu of obtaining a hardcopy of the producer's or adjuster's license.

Determine that any producer writing business in connection with a mass marketing plan is appropriately licensed.

Refer discrepancies to appropriate divisions within the insurance department.

Automation Tip:

Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period, and, where applicable, all company or contracted independent adjusters licensed at any time during the examination period. Include the producer's or adjuster's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a similar list. Obtain from the regulated entity a list of all producers who received commission during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, date first commission received and internal regulated entity or employee number for the producer. Obtain from the regulated entity a list of all new business written during the examination period. Include the date the policy was issued and the producer's internal regulated entity or employee number.

- Compare the regulated entity's producer and adjuster licensing list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list;
- Compare the regulated entity's commissions list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare commission first earned dates to the insurance department's license/appointment dates to see if commissions were earned prior to license/appointment date; and
- Compare the regulated entity's new business written list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers or internal regulated entity/employee numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare policy issued date to the insurance department's license/appointment dates to see if policies were written prior to license/appointment date. This may need to be cross-referenced with the regulated entity's licensed producer list to correlate the producer's National Producer Number (NPN) and the internal regulated entity/employee number.

**STANDARDS
PRODUCER LICENSING**

Standard 2

The producers are properly licensed and appointed and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business application
- _____ Insurance department listing of licensed and/or appointed producers for the State Producer Licensing Database (SPLD)
- _____ Copy of producer's license or electronic verification of producer's license via the State Producer Licensing Database (SPLD)
- _____ Regulated entity listing of all currently licensed and/or appointed producers
- _____ Notice of appointment
- _____ Regulated entity procedures for appointing a producer
- _____ Regulated entity list of commissions paid by line of business

Others Reviewed

- _____
- _____

NAIC Model References

- Producer Licensing Model Act (#218)*
- Title Insurance Agent Model Act (#230)*
- Unfair Trade Practices Act (#280)*
- Long-Term Care Insurance Model Act (#640)*

Review Procedures and Criteria

Review the regulated entity's procedures for the appointment of producers.

Review the producer's license and the appointment records. Determine if the appointment was effective within 15 days of the producer writing business on behalf of the regulated entity.

Review the producer's authority for the types of business he/she is eligible to solicit. Determine if the producer is acting within the scope of that authority.

Determine that the producer has met continuing education requirements and, if appropriate, has met the producer training requirements for selling long-term care insurance.

Identify the producer of each selected policy and determine proper licensure and appointment (if required).

Automation Tip:

Obtain from the regulated entity a list of all producers licensed and appointed at anytime during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, type of license and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, applicable jurisdictions and type of license. Obtain from the regulated entity a list of all applications taken during the examination period. Include the date the application was taken, the producer's internal regulated entity or employee number and the jurisdiction where the application was taken. Compare these files using National Producer Numbers (NPN) or, if unavailable, Social Security numbers or Federal Employer Identification numbers and internal regulated entity/employee number for the producer and jurisdictions. Extract any producers who took applications from jurisdictions where they were not licensed/appointed.

Not for Distribution

**STANDARDS
PRODUCER LICENSING**

Standard 3
Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity/agency contracts
- _____ Regulated entity listing of producer terminations for examination review period
- _____ Regulated entity listing of commissions
- _____ Insurance department listing of terminations
- _____ Copies of individual termination notifications sent to terminated producers
- _____ Copies of individual termination notifications sent to insurance department

Others Reviewed

- _____
- _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Reconcile the regulated entity's listing of producer terminations with the listing of commissions paid to determine if payouts are being made properly to terminated producers.

Review individual termination notices from the regulated entity to producers to determine compliance with termination notification periods and allowance for renewal commissions.

Refer any discovery of terminated producers still submitting new business to appropriate divisions within the insurance department.

Review the regulated entity's contract with producers to determine how commissions are paid to producers who have been terminated (e.g., vesting provisions).

Compare the regulated entity's listing of producer terminations with the National Insurance Producer Registry (NIPR) to ensure accuracy in reporting.

**STANDARDS
PRODUCER LICENSING**

Standard 4

The regulated entity's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Listing of appointments and terminations for examination review period
- _____ Listing of producer appointments by line of business (if applicable) by producer's business ZIP code
- _____ Listing of terminations by line of business (if applicable) by producer's business ZIP code
- _____ Regulated entity market plan or synopsis

Others Reviewed

- _____ _____
- _____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Compare the number of appointments/terminations for the current review period with previous review period and, if difference is significant, determine the reason(s).

Review the regulated entity's marketing plan.

Review ZIP code listings to determine the placement of producers and if there is evidence of under-served or over-served geographical areas.

Automation Tip:

Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, county, ZIP code, licensed date, appointed date, termination date, type of license and internal regulated entity or employee number for the producer. Extract a list of all producers that were licensed, appointed and/or terminated during the examination period. Run a count on the number of producers that were licensed, appointed by ZIP code or county and a count on the number of producers terminated by ZIP code or county. Also run a count on the original file by ZIP code or county. A comparison of the counts may show ZIP codes or counties that are under-served or over-served.

**STANDARDS
PRODUCER LICENSING**

Standard 5
Records of terminated producers adequately document reasons for terminations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity listings of terminated producers for examination review period
- _____ Regulated entity individual files of terminated producers
- _____ Insurance department's list of acceptable reasons for terminations

Others Reviewed

- _____
- _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine reasons for producer termination.

Review all or sample of individual terminated producer files.

Review above documents for inadequately or inaccurately documented termination reasons. If necessary, refer to the appropriate division within the insurance department.

Compare the regulated entity's listing of producer terminations with NIPR to ensure accuracy in reporting.

Determine if the insurance department is notified of termination for cause (if applicable).

Automation:

Obtain from the regulated entity a list of all producers terminated at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, termination date and reason for termination. Review the regulated entity's files for these producers to determine if the terminations were adequately documented.

**STANDARDS
PRODUCER LICENSING**

Standard 6
Producer account balances are in accordance with the producer’s contract with the insurer.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Listing of producer accounts current exceeding contract limits
- _____ Producer and/or agency contracts

Others Reviewed

- _____
- _____

NAIC Model References

- Producer Licensing Model Act (#218)*
- Title Insurance Agent Model Act (#230)*
- Unfair Trade Practices Act (#880)*
- Insurance Fraud Prevention Model Act (#680)*

Review Procedures and Criteria

- Review listing of producer accounts current.
- Discuss excessive balances with the regulated entity.
- Accounts current exceeding contract limits may indicate producer mishandling of funds.
- Refer to appropriate division within the insurance department.

Not for Distribution

E. Policyholder Service

1. Purpose

The policyholder service portion of the examination is designed to test a regulated entity's compliance with statutes regarding notice/billing, delays/no response, and premium refund and coverage questions.

2. Techniques

While larger companies may have a full staff to handle policyholder service, smaller companies may well do policyholder service as a function of the claims or underwriting department.

Policyholder service departments vary from regulated entity to regulated entity. Some companies do only what is required of them by state statute (i.e., notification of the toll-free number or policyholder complaint telephone number). In contrast, some actually contact policyholders that have had occasion to deal directly with the regulated entity, such as presenting a claim or requesting a policy change.

It is important that the examiner check with the examination coordinator to determine where the policyholder service function lies and then apply the following tests to determine the effectiveness of the unit.

3. Tests and Standards

The policyholder service review includes, but is not limited to, the following standards related to the adequacy and level of policyholder service provided by the regulated entity. The sequence of the standards listed here does not indicate priority of the standards.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 1
Premium notices and billing notices are sent out with an adequate amount of advance notice.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting files

_____ Underwriting procedure manuals

Others Reviewed

NAIC Model References

Improper Termination Practices Model Act (#915)

Property Insurance Declination, Termination and Disclosure Model Act (#729)

Automobile Insurance Declination, Termination and Disclosure Model Act (#725)

Universal Life Insurance Model Regulation (#585), Section 7F

Review Procedures and Criteria

Check renewal business to determine if the regulated entity's procedures for handling renewals are in accordance with state guidelines.

Check underwriting files to determine if premium notices and endorsements were sent timely, and not at audit or policy expiration.

Check mailroom for billings sent out by the regulated entity to ensure timeliness.

Automation Tip:

Obtain from the regulated entity a data file of all cancellations due to nonpayment. Include in the file the policy number, the date the notice was generated/mailed, and the effective date of the cancellation. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices, which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 2
Policy issuance and insured-requested cancellations are timely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

___ Applicable statutes, rules and regulations

___ Underwriting manuals

___ Insured's request for cancellation

___ Cancellation notices

___ Procedure manuals

___ Underwriting files

Others Reviewed

___ _____
___ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if insured-requested cancellations are handled in a timely manner without excessive paperwork requirements for the insured.

Perform a time study on policy issuance to determine that policies and endorsements are issued in a timely manner.

Not for Distribution

**STANDARDS
POLICYHOLDER SERVICE**

Standard 3
All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity correspondence files
- _____ Electronic correspondence
- _____ Policy/Underwriting files

Others Reviewed

- _____
- _____

NAIC Model References

- NAIC Insurance Information and Privacy Protection Model Act (#670)*
- Unfair Claims Settlement Practices Act (#990)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*

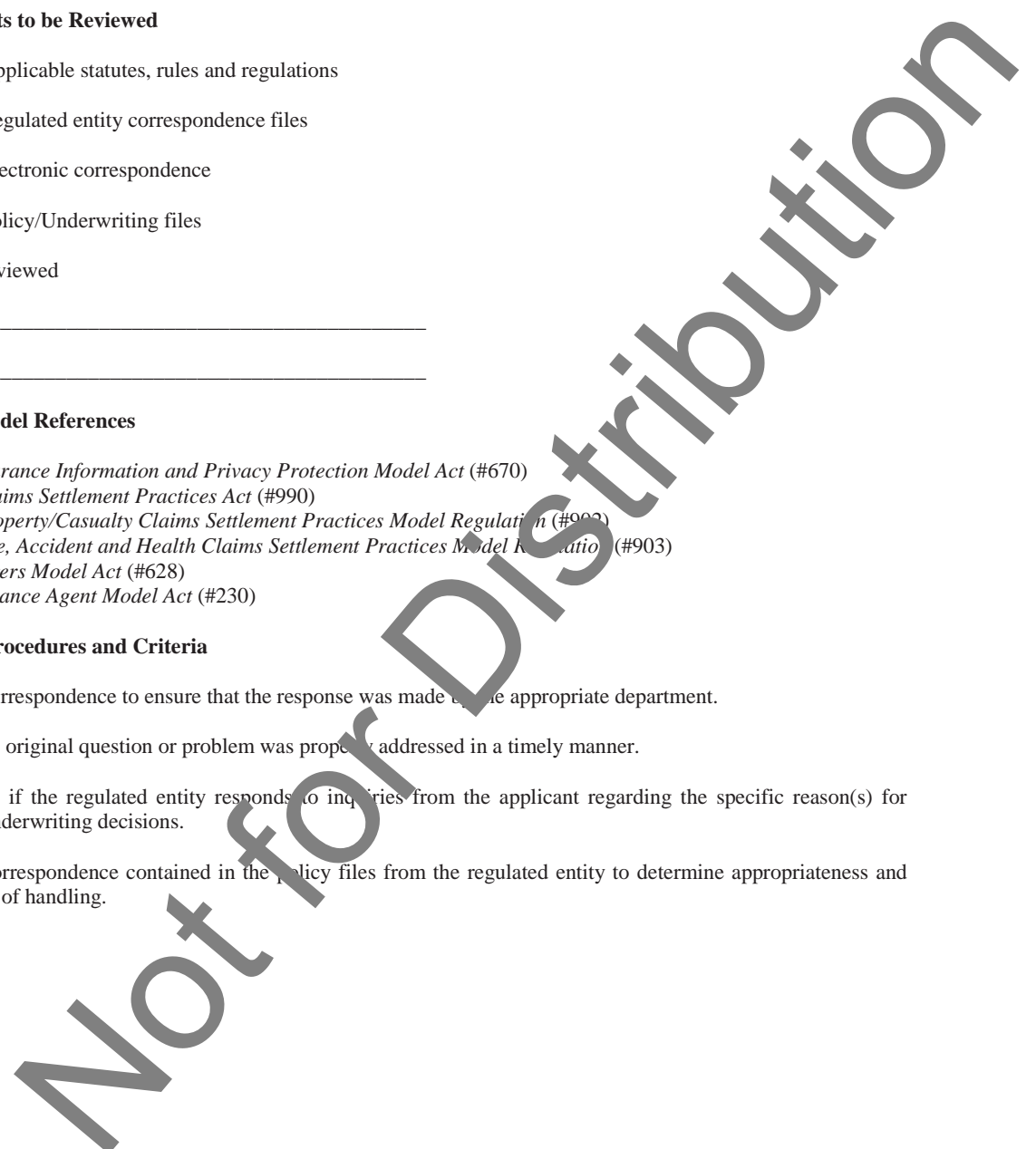
Review Procedures and Criteria

Review correspondence to ensure that the response was made by the appropriate department.

Ensure the original question or problem was properly addressed in a timely manner.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions.

Review correspondence contained in the policy files from the regulated entity to determine appropriateness and timeliness of handling.



**STANDARDS
POLICYHOLDER SERVICE**

Standard 4

Whenever the regulated entity transfers the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has gained prior approval of the insurance department, and the regulated entity has sent the required notices to affected policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Assumption reinsurance agreements
- _____ Order of insurance commissioner approving assumption reinsurance agreement
- _____ Notice of transfer sent to policyholders, producers and brokers
- _____ Response card sent to policyholders
- _____ Written regulated entity procedures for handling inquiries regarding the assumption transaction and for processing the policyholders' response cards

Others Reviewed

- _____
- _____

NAIC Model References

Assumption Reinsurance Model Act (#803)

Review Procedures and Criteria

According to the model act, "assumption reinsurance agreement" means any contract which both:

- Transfers insurance obligations and/or risks of existing or in force contracts of insurance from a transferring insurer to an assuming insurer; and
- Is intended to affect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer.

Determine if any assumption reinsurance agreements exist.

Obtain a list of policyholders covered by any assumption reinsurance agreements in order to determine sample.

Determine if the class of policyholder or type of product was covered by the assumption reinsurance agreement.

Determine if affected policyholders received the notice of transfer and the response card and that each includes appropriate language.

Determine whether the regulated entity appropriately handled a policyholder's right to reject the transfer.

Not for Distribution

**STANDARDS
POLICYHOLDER SERVICE**

Standard 5
Policy transactions are processed accurately and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Regulated entity correspondence files

_____ Policy underwriting files involving nonforfeiture, surrenders, benefit changes, existing policy changes and other post-issue transactions

Others Reviewed

NAIC Model References

Modified Guaranteed Annuity Model Regulation (#255), Section 6B(1)(b)
Consumer Credit Insurance Model Act (#360)

Review Procedures and Criteria

Ensure proper documentation is maintained for the following:

- Cash surrenders;
- Policy loans;
- Bank draft acceptance and clearance; and
- Beneficiary changes.

Ensure that policyholder requests are processed as soon as reasonably possible.

Ensure that matured payments are processed when due. Determine if the regulated entity takes appropriate steps to notify policyholders of guaranteed options to purchase additional insurance.

Premium refunds for modified guaranteed life products. Special requirements may exist, under policy provisions or state law, for calculation of refunds involving “10-day right to return” periods for life products, which include a separate account.

For credit insurance, if a debt is refinanced prior to the scheduled maturity date, the in force insurance must be terminated before any new insurance is issued.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 6
Reasonable attempts to locate missing policyholders or beneficiaries are made.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Schedule F of the annual statement
- _____ Policies scheduled for matured endowments
- _____ Underwriting files
- _____ Unpaid payees of returned benefit checks

Others Reviewed

- _____
- _____

NAIC Model References

Review Procedures and Criteria

Determine if the regulated entity has made reasonable attempts to locate beneficiaries, policyholders and recipients of unclaimed properties.

Not for Distribution

**STANDARDS
POLICYHOLDER SERVICE**

Standard 7

Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Refund check or complete documentation of refund, if canceled check information is maintained on the computer system

Others Reviewed

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)

Universal Life Insurance Model Regulation (#560)

Review Procedures and Criteria

Calculate the unearned premium (short rate, pro rata or sum of digits method) in accordance with policy provisions or state law.

Verify that refunds provided to producers are properly distributed.

Verify that unearned premiums were returned to the insured in a timely manner.

Verify that the regulated entity adheres to applicable “free look” periods.

For credit insurance:

- If the creditor has opened a line of credit for a debtor and is charging for the line of credit rather than the amount of debt (i.e., credit cards), at the debtor’s death the insured amount due is the amount of established credit against premium was last charged;
- If a debtor prepays the debt in full, any credit insurance shall be terminated and an appropriate refund of premium shall be paid or credited to the debtor; and
- In the event of termination, no charge may be made for the first 15 days of a month and a full month may be charged for over 16 days.

F. Underwriting and Rating

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies.

The underwriting portion of the examination is designed to provide a view of how the regulated entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- a. Rating practices;
- b. Underwriting practices;
- c. Use of correct and properly filed and approved forms and endorsements;
- d. Termination practices;
- e. Unfair discrimination;
- f. Use of proper disclosures, buyers' guides and delivery receipts;
- g. Reinsurance; and
- h. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Symbol manuals or tables;
- Rating systems filed with regulators;
- Payment plans;
- Minimum premiums;
- Policy fees;
- Discounts;
- Dividend rating plans;
- Regulated entity automated rating systems;
- Rating materials provided to producers;
- Reinsurer policies/treaties;
- Reinsurer guidelines and manuals;
- Documentation of required disclosures and delivery receipts;
- Premium statements and billing statements;
- Premium refund documentation;
- Replacement and conservation materials;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Issued and renewed policy and certificate files;
- Canceled and non-renewed policy and certificate files;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;

- Rescission files;
- Underwriting guidelines;
- Sample of premium audit files;
- Applicable policy forms and endorsements and summaries;
- Producer licensing information;
- Group trust and association arrangements where applicable;
- Producer compensation agreements where applicable;
- Statistical reporting requirements; and
- Underwriting files content and structure.

For purposes of this chapter, “underwriting file” means the file or files containing the new business application; renewal application; rate calculation sheets; billings; audits, including binder, engineering reports; inspection reports; risk or hazard investigative or evaluation reports; motor vehicle reports (MVRs); credit reports; all underwriting information obtained or developed; policy declaration page; endorsements; premium finance agreements with regulated entities; cancellation or reinstatement notices; correspondence; and any other documentation supporting selection, classification, rating or termination of the risk.

In selecting samples for testing, personal lines should generally not be combined with commercial lines. These two areas are generally not homogeneous, and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between personal lines and commercial lines as respects the various tests to be developed. Then examiners also should be familiar with the process for gathering and processing underwriting information, and the quality controls for the issuance of policies, endorsements and premium statement/billings. The list of files from which a sample is to be drawn may be generated through a computer run or in some cases through a policy register covering the period of time selected in the notice or call of examination.

Determine the regulated entity’s policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as being from the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems or development of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner responses should maximize objectivity; the examiner should avoid replacing examiner judgment for regulated entity judgment.

a. Rating Practices

It is necessary to determine if the regulated entity is in compliance with rating systems that have been filed with, and, in some cases, approved by the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the regulated entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a regulated entity may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a regulated entity is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a regulated entity varies between personal lines and commercial lines. There can also be considerable variation by kind of insurance. The examiner should become familiar with the regulated entity's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached. If policies are issued by an automated system, the examiner should manually rate policies based on a selection of various classes and various territories to verify that the computer has been programmed correctly. Once this has been established, the examiner should check only the input data for other policies against the information included in the inspection report or from information obtained from other sources in order to determine that they have been rated correctly. If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

Rating practices of renewal policies, as well as newly issued policies, should be reviewed. By reviewing renewal policies, the examiner can verify whether the regulated entity is updating rating components, such as vehicle identification number (VIN) symbol changes or property protection class changes. The examiner should look for cases where initial year premium rates were set at artificially low levels for competitive reasons.

The complexity of rating systems varies greatly from line to line. Some lines require little in the way of documentation focused on the appropriate use of the rating system. Some systems are so complex that appropriate documentation is difficult if a worksheet is not maintained. This is generally more true of commercial lines than it is for personal lines. The examiner should ensure that the underwriting files contain sufficient information to support the rates that have been applied to a policy. Aherent in the more complex systems is the concern for unfair discrimination.

Examiners may wish to review situations involving multiple related companies under common underwriting management for issues involving unfair discrimination between similarly situated policyholders.

Restrictive practices also may be involved if there are indications of two or more unrelated companies attempting to conspire to monopolize an insurance market.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the regulated entity's underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and regulated entity minutes, which may furnish evidence of anti-competitive behavior, may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also will use the above information to determine regulated entity compliance with its own manuals and guidelines. The examiner should confirm that the regulated entity's underwriters and producers consistently apply the regulated entity's guidelines for all business selected or rejected. The examination team should verify that the regulated entity has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the regulated entity the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of business.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Any practice suggesting anti-competitive behavior may have legal considerations that should be referred to insurance department counsel. Ultimately, the information so obtained may be useful in drafting legislation or regulations.

In some lines of business, a survey of nonstandard (e.g., surplus lines markets and consent-to-rate filings) and residual markets (e.g., FAIR—Fair Access to Insurance Requirements Plan, JUA—Joint Underwriting Association and high-risk health pools) may provide some insight into general industry underwriting practices.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

If the forms have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), the examiner should verify that the compacting state was included in the IIPRC-approved product filing and the form being marketed has a prefix of "ICCxx" (where "xx" represents the appropriate year the form was submitted for filing). If IIPRC-approved forms are being used or mixed and matched with forms approved by the compacting state, the examiner may wish to verify the forms approved by the compacting state were identified on the statement of intent schedule, which is required to be submitted, updated and maintained by the insurer in the product filing submitted to the IIPRC. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information.

d. Termination Practices

The examiner should review the regulated entity's declination, cancellation and nonrenewal of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules, guidelines and policy provisions.

The review of cancellation and nonrenewal practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of canceled policies. For nonrenewals, the examiner should select the sample from the expiration list. Cancellations of specific lines of business have unique requirements. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the cancellations comply with statutory provisions and policy provisions.

Cancellation processing for nonpayment of premium should include a formal notice to the insured. Some companies use the last billing notice as the cancellation notice. If this is the case, that billing notice must clearly state the effective date of termination of coverage, the insured's rights to an explanation, as provided by statutes where required, and a concise statement of the reason for termination of coverage. Make sure that the loss payee is receiving a copy of the same notice, or separate notice from the regulated entity, to advise that coverage is being terminated. Refer to the specific statute and rule that applies.

The accuracy of return premiums on canceled policies and, in particular, pro rata vs. short rate return of premiums should be verified. When coverage other than homeowner is canceled at the request of the insured, short rate methodology should be used. Cancellation initiated by the regulated entity and all homeowner cancellations should be pro rata.

The examination team should review reinstatement offers and determine what the regulated entity practice is for offering reinstatement. Additionally, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Declination Practices

The examiner should review the regulated entity's declination of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules and guidelines. Declination includes only refusal of an insurer to issue a policy upon receipt of a written nonbinding application or written request for coverage from a producer or an applicant, or the refusal of a producer or broker to transmit to an insurer a written nonbinding application or written request for coverage.

Insurers should maintain declination files and producers should maintain files on declinations made on behalf of the regulated entity. The applicant must be provided with a written, specific reason for the declination.

The review of declination practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of declinations. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the declinations are in compliance with the applicable rules and regulations and in conformance with the rules and guidelines for the specific line of business.

f. Reinsurance

Most state statutes include a feature that for many lines of business the regulated entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files utilized for other tests.

Adherence to the requirement is easy to test but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the regulated entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than \$10 million). It may also reflect on the care the regulated entity's management places on its selection of business, and represent a danger to the financial health of the regulated entity. Errors in this area should result in alerts to the insurance department's financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 1

The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business application
- _____ All underwriting information obtained
- _____ Rating manuals
- _____ Policy declaration page
- _____ Underwriter's file or notes on a system log

Others Reviewed

- _____
- _____

NAIC Model References

Property and Casualty Model Rating Law Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Law Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Stop Loss Insurance Model Act (#92)
Individual Health Insurance Portability Model Act (#37), Sections 5A–H, 5J, 5K, 7 and 9
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1970)

Review Procedures and Criteria

Verify all rating factors, including class, territory, symbol assignment, surcharges, deductible factors and increased limit factors.

If no source document application exists, review what procedures the regulated entity has in place to determine the accuracy of the information that was given to issue the policy.

Calculate the premium to verify it is in accordance with filed rates.

Verify that the proper rules are being used.

Verify that the filed implementation date is used uniformly, including at different branches.

Confirm that rates in use were filed and approved prior to use, where required.

Confirm that rates in use have been submitted as required, if system is other than prior approval.

Verify the basis of premium is correct.

Verify that the protection classes and other rating factors are correct.

Verify that the rating rules are properly utilized. The examiner should be alert for incorrect interpretation of rating rules.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:

Obtain from the regulated entity a data file that contains new business written during the examination period. The file should contain policy number, policy form, address, territory code, and any other rating factor that is standardized by the regulated entity. Obtain from the regulated entity a data file that contains these standardized rating factors. For example, if the regulated entity underwrites by county, then obtain a data file that contains the county codes and a new business file that contains the policyholder's county. Compare the two files to see if the appropriate rating code is being applied. Since variations can happen, ask for explanations only in areas where the error rate is unacceptable.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 2

All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting or policy files

_____ Lapsed policies

_____ Rating/Quote information provided electronically

Others Reviewed

NAIC Model References

Cancer Insurance Shopper's Guide

Model Regulation to Implement the Small Employer Insurance Portability Model Act (#119)

Small Employer and Individual Health Insurance Availability Model Act (#155)

Accident and Sickness Insurance Minimum Standards Model Act (#170), Section 5

Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), Sections 8A(10) and 8A(11)

Consumer Credit Insurance Model Act (#360)

Individual Health Insurance Portability Model Act (#37), Section 1

Unfair Trade Practices Act (#880)

Long-Term Care Insurance Model Act (#640)

Long-Term Care Insurance Model Regulation (#640)

Life Insurance Disclosure Model Regulation (#580), Section 5A(1)

Life Insurance Illustrations Model Regulation (#580)

Consumer Credit Insurance Model Regulation (#370)

Charitable Gift Annuities Model Act (#100)

Charitable Gift Annuities Exemption Model Act (#241)

Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to Meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act

Group Life Insurance Definition and Group Life Insurance Standard Provisions Model Act (#565)

Military Sales Practices Model Regulation (#568)

Group Health Insurance Standard Model Act (#100)

Medicare Supplement Insurance Minimum Standards Model Act (#650)

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that written notice of Medicare supplement replacements are provided to applicants and existing insurers and that appropriate buyer's guides are used.

Verify that appropriate notices regarding credit-related coverages are documented.

Verify that notices regarding the existence of health insurance pools are provided, where applicable.

Review other notices and disclosures required by various jurisdictions.

Determine if state law requires that telephone help numbers be provided, including state insurance department telephone numbers and addresses.

Determine if changes in coverage are disclosed in a timely manner.

Determine if the regulated entity underwriting guidelines comply with applicable statutes, rules and regulations.

Determine if mandated optional coverages are disclosed and documented.

Verify that quotations are made accurately and in a timely manner.

Verify that delivery receipts are obtained where necessary.

Verify that changes in rates are disclosed in a timely manner and in accordance with applicable statutes, rules, regulations and policy provisions.

Determine if the regulated entity is in compliance with rules related to fair marketing.

Verify that the *Shopper's Guide to Consumer Insurance* complies with required disclosures and policy limitations.

Ensure disclosures to consumers represent the applicable consumer protections required by state law, including:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed renewals for all policies, with certain exceptions;
- Limits on the factors that can be used to establish and change premium rates; and
- Descriptive information about all available health benefit plans.

Ensure the regulated entity maintains complete and detailed descriptions of its rating and underwriting practices for individual and small groups at its principal place of business.

Where required, individual accident and sickness insurance policies shall include with delivery or application an outline of coverage, in a prescribed format. Outlines of coverage delivered in connection with individual hospital confinement indemnity, specified disease or limited benefit health insurance coverages to persons eligible for Medicare by reason of age shall contain language that indicates "This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the regulated entity."

Insurers shall give any person applying for specified disease insurance a buyer's guide approved by the insurance commissioner. Direct response insurers shall provide the buyer's guide upon request, but not later than the time the policy is delivered.

Credit disability income products

Ensure the debtor is provided a disclosure with the following information prior to the election to purchase insurance:

- That the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;
- If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately or the multiple coverages only as a package;
- The conditions of eligibility;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;
- That within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, only in those instances where insurance is a requirement for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;
- A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package; and
- That, if the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

Long-term care products

Verify that written notice of long-term care replacements are provided to applicants and existing insurers, suitability worksheets are completed and submitted and that appropriate buyer's guides and contract or policy summaries are used.

Ensure the entity maintains, at its home office or principal office, a complete file containing one specimen copy of each disclosure document authorized and used by the entity (e.g., buyer's guide, contract, outline of coverage, statement of policy information for applicant, etc.). The file should contain one copy of each authorized form for a period of 3 years following the date of its last authorized use. Many jurisdictions have repealed the requirement for policy summaries if the product is declared to be marketed with an illustration that meets the requirements of statutes, rules and regulations.

Workers' compensation products

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

IIPRC-approved products

If the forms and advertisements have been approved by the Interstate Insurance Product Regulation Commission (IIPRC), please note that the notices and disclosures required to be included within the approved forms and advertisements are governed by the IIPRC uniform standards and not state law. State law that requires notices and disclosures during the sale, underwriting and claims processes are still applicable to products and advertisements approved by the IIPRC, provided such state law requirements do not pertain to or affect the content or approval of the IIPRC-approved products and advertisements.

**STANDARDS
UNDERWRITING AND RATING**

Standard 3

The regulated entity does not permit illegal rebating, commission-cutting or inducements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint files/logs

_____ Underwriting files

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

Producer Licensing Model Act (#218)

Interest-Indexed Annuity Contracts Model Regulation (#225)

Consumer Credit Insurance Model Regulation (#300)

Individual Health Insurance Portability Model Act (#301), Section 11

Title Insurers Model Act (#628)

Title Insurance Agent Model Act (#236)

Medicare Supplement Insurance Minimum Standards Model Act (#650)

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Check commission schedule for inappropriate variances.

Determine that producer commissions adhere to the commission schedule and, if not, verify that the file documentation reflects reasons for the variance.

Check billings and invoices for varying commission percentages.

Check regulated entity advertising for indications of illegal commission-cutting or inducements.

**STANDARDS
UNDERWRITING AND RATING**

Standard 4

The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business and renewal applications
- _____ All underwriting information obtained
- _____ Regulated entity underwriting guidelines
- _____ Underwriting bulletins
- _____ Declination procedures
- _____ Agency agreements and correspondence with producers
- _____ Interoffice memoranda and regulated entity minutes
- _____ Policy declaration page
- _____ Underwriter's file or notes on a system log

Others Reviewed

- _____
- _____

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)*
- Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)*
- Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)*
- Unfair Trade Practices Act (#880)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Military Sales Practices Model Regulation (#568)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Group Health Insurance Standards Model Act (#100)*
- Stranger-Originated Life Insurance Transactions (STOA) NAIC Sample Bulletin*

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Ensure that the regulated entity does not discriminate against individuals by using any of an individual's past lawful travel or future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure that the regulated entity's procedures are in compliance with the Genetic Information Nondiscrimination Act (GINA).

Some indication of industry underwriting practices may be obtained by a survey of residual markets (FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intended, can result in unfair discrimination, including requests for supplemental information.

Examine new business and renewal applications for the required fraud warning statement.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their applicable jurisdiction.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 5

All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ New business application
- _____ Policy or contract determination page
- _____ Regulated entity's approval register
- _____ Insurance department's approval for all forms, including policies, contracts, riders, amendments, endorsements and certificates (Note: All forms submitted to the IIPRC for approval in an applicable compacting state can be verified through the NAIC System for Electronic Rule and Form Filing (SERFF) or by contacting the designated IIPRC representative(s) within the compacting state)

Others Reviewed

- _____
- _____

NAIC Model References

Health Policy Rate and Form Model [Act] [Regulation] (#165)
Individual Health Insurance Portability Model Act (#37), Sections 7 and 9
Insurance Fraud Prevention Model Act (#680)
Unfair Trade Practices Act (#880)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#195)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed. Where required, determine that either prior approval has been obtained or that applicable waiting periods following the filing have been met.

Determine if the regulated entity lists, on the summary page, all forms that constitute a part of the contract.

Examine new business applications for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 6

Policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting files

_____ Application

_____ Underwriting procedure manuals

_____ Underwriting and binding guidelines

Others Reviewed

NAIC Model References

Anti-Arson Application Model Bill (#715)

Improper Termination Practices Model Act (#915)

Property Insurance Declination, Termination and Disclosure Model Act (#720)

Automobile Insurance Declination, Termination and Disclosure Model Act (#725)

Consumer Credit Insurance Model Regulation (#370)

Consumer Credit Insurance Model Act (#360)

Health Policy Rate and Form Model [Act] [Regulation] (#165)

Uniform Individual Accident and Sickness Policy Provision Law (#180), Sections 2A(7), 2B(5) and 5C

Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act (#171), Sections 6G and 8A(2)

Administrative Procedure Relative to Renewability and Cancellation Provisions in the Approval of Accident and Health Policies Drafted In Accordance with the Uniform Individual Accident and Sickness Provision Law, Section 8

Individual Health Insurance Portability Model Act (#37), Sections 6, 7, 8 and 11

Medicare Supplement Insurance Minimum Standards Model Act (#650)

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Small Employer and Individual Health Insurance Availability Model Act (#35)

Group Health Insurance Standards Model Act (#100)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)

Guidelines for Regulation and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if policies and endorsements are issued in appropriate time frames.

Verify how much time elapses between completion of the application and issuance of coverage.

Note that this standard may need flexibility or special application when dealing with assigned risk plans, joint insurance arrangements, anti-arson applications, FAIR (Fair Access to Insurance Requirements) plans or other involuntary business.

Review new issues prior to mailing to ensure correct procedures, forms, disclosures, etc., are used.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 7 Rejections and declinations are not unfairly discriminatory.
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Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy contract
- _____ Notice of declination
- _____ Regulated entity guidelines for cancellation/nonrenewal/declination
- _____ Producer records/issued policies and declinations

Others Reviewed

- _____ The Genetic Information Nondiscrimination Act (GINA)
- _____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670), Section 10-12
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#50)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the regulated entity provides valid reasons for rejection/declination when required.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions. Was the adverse underwriting decision based on previous adverse underwriting decisions?

Determine if the regulated entity uses valid reasons for rejection/declination and documents these reasons.

Review the regulated entity's procedures for rejection/declination to determine if the regulated entity is following its own guidelines.

Determine if the regulated entity monitors agency rejection/declination for appropriate practices.

Review for any unfairly discriminatory practices.

Verify appropriate refund has been made to the applicant.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 8

Cancellation/nonrenewal, discontinuance and declination notices comply with policy and contract provisions, state laws and the regulated entity's guidelines.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)
- _____ Policy contract
- _____ Notice of cancellation/nonrenewal
- _____ Agent's/MGA's/Underwriter's file or notes on a system log
- _____ Producer records/notices issued
- _____ Insured's request (if applicable)
- _____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

- _____
- _____

NAIC Model References

- Property Insurance Declination, Termination and Disclosure Model Act (#720)*
- Automobile Insurance Declination, Termination and Disclosure Model Act (#725)*
- Improper Termination Practices Model Act (#915), Section 8A*
- Unfair Trade Practices Act (#880)*
- Group Coverage Discontinuance and Replacement Model Regulation (#110)*
- Individual Health Insurance Portability Model Act (#70), Section 11*
- Long-Term Care Insurance Model Act (#649)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Small Employer and Individual Health Insurance Availability Model Act (#35)*
- Group Health Insurance Standards Model Act (#100)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1956)*

Review Procedures and Criteria

Determine if the reason for cancellation/nonrenewal or declination was valid according to policy provisions and state law.

Review the regulated entity's procedures for cancellation/nonrenewal and declinations to determine if the regulated entity is following its own guidelines.

Review regulated entity-initiated cancellations and consider a separate sample for insured-initiated cancellation.

Determine if the regulated entity monitors agency cancellation, declination and nonrenewals for appropriate practices.

Review for any unfairly discriminatory practices.

Review declinations, including declinations made by producers on behalf of the regulated entity. Declinations shall, as required, include the specific reasons for the declination.

Review notice of cancellation/nonrenewal to determine that it was mailed and delivered by the insurer to the first named insured's last known address.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:

Obtain from the regulated entity a data file of all cancellations/nonrenewals and declinations during the examination period. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices which appear to fail to comply with state requirements and submit to the regulated entity for explanations.

**STANDARDS
UNDERWRITING AND RATING**

Standard 9
Rescissions are not made for non-material misrepresentation.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ List of rescinded policies
- _____ Underwriting files and supporting documentation, including claim files

Others Reviewed

- _____ Case law for state impacted
- _____
- _____

NAIC Model References

- Improper Termination Practices Model Act (#915)*
- Unfair Trade Practices Act (#880)*
- Long-Term Care Insurance Model Act (#640)*
- Medicare Supplement Insurance Minimum Standards Model Act (#650)*
- Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*
- Group Health Insurance Standards Model Act (#100)*

Review Procedures and Criteria

- Determine if rescinded policies indicate a trend toward positive claim underwriting practices.
- Determine if decisions to rescind policies are made in accordance with applicable statutes, rules and regulations.

Not for Distribution

G. Claims

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies. The claims portion of the examination is designed to provide a view of how the regulated entity treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims.

For purposes of this chapter, “claim file” means the file or files containing the notice of claim, claim forms, proof of loss, medical records, health facility pre-admission certification or utilization review documentation, settlement demands, accident reports, police reports, adjusters’ logs, claim investigation documentation, inspection reports, supporting bills (including electronic payment records, estimates and valuation worksheets), correspondence to and from insureds and claimants or their representatives, complaint correspondence, copies of claim checks and/or check numbers and amounts, releases, all applicable notices and correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, and any other documentation necessary to support claim-handling activity.

The review is concerned with the regulated entity’s claims practices by line of business for compliance with statutes, rules and regulations and policy provisions. The areas to be considered in this kind of review include:

- a. Time studies to measure acknowledgment, investigation and settlement times;
- b. General handling study;
- c. Total loss valuation survey;
- d. Closed without payment survey;
- e. Subrogation survey;
- f. Litigation survey;
- g. Unfair claims practices survey;
- h. Claims form review;
- i. Loss statistical reporting survey;
- j. Time study on cashed checks; and
- k. Review of other procedures, as deemed necessary.

2. Techniques

Each area of claim review involves selecting a sample of claims (open, closed without payment, closed, denied). However, it is not necessary to use different samples to review timeliness of payment, conformity to policy language or adequacy of proof.

A general approach to examination would be to:

- Define the scope of the examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage.
- Become familiar with the regulated entity’s claim handling procedures for the line of business identified. Review corresponding policy forms for coverage, exclusions and nonstandard provisions. Review the methods for processing claims from notification to conclusion. Review with the claim manager or other appropriate personnel the maintenance of claim records and draft and settlement authority.
- Select a representative sample of files to be reviewed. Chapter 14—Sampling of this handbook should be reviewed. If field sizes are relatively small and the regulated entity’s records appear

complete, representative samples or a census should be selected. In the case of large field sizes and incomplete or complicated records, the use of audit software should be considered. Care should be taken that no adverse selection occurs.

- a. Time studies to measure acknowledgment, investigation and settlement times

Record the date of loss/claim, the date reported to the producer or regulated entity, the date sufficient information was available to determine the regulated entity's liability and the date the regulated entity accepted or rejected the claim. Record identifying data, such as the claim/policy number and the claimant's name.

Determine for each claim the number of days the regulated entity took to accomplish each category. Compare days required by regulated entity to appropriate state standards and document those claims that exceed standards for inclusion in the report. Delays beyond the control of the regulated entity should be excluded; e.g., a delay caused by an uncooperative insured. Establish a mean and median time to acknowledge, investigate and accept/deny claims, if necessary, to determine a business practice.

Caution: If a file has a violation of a standard with multiple tests, and the standard is the item measured, the file can only fail one time. If the individual test is the item measured, the file can fail each test. If failure of a standard or of a test ensures failure of another standard or test under another standard, then no substitution of the file need occur. The relationship, however, should be explained.

- b. General handling study

Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed for adequate and accurate documentation. Correct application of deductibles, coinsurance and limits of coverage should be established. Mathematical accuracy should be determined. Reductions based on depreciation, obsolescence, etc., should be reviewed for fairness and accuracy.

Checks or drafts should be reviewed for correct payees. Files should be reviewed for specific state requirements. Compliance with the regulated entity's own standards should be established.

- c. Closed without payment review

This includes denied, rejected, incomplete and claims not paid for any other reason, including deductibles/waiting periods not met. Conduct tests similar to "General handling study" above. Record identifying data such as claim/policy number, date of loss and claimant name. Review specific state requirements for content and method of denial notification to the claimant. Note general handling by the regulated entity to determine validity of its action in the final disposition of these types of claims.

- d. Litigation survey

Determine the extent of suits against the regulated entity. Separate first- and third-party actions. If review is deemed appropriate, select a representative sample or census.

Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed to determine the basis for suit and the regulated entity's position for denial or settlement offer. Closed litigated files should be reviewed to determine accuracy, regulated entity position and if punitive or bad faith judgments were rendered. Recognition of attorney-client privileged documents or work products should occur during the file review. A principal focus is compliance with unfair claims practices statutes and regulations.

e. Unfair claims practices review

Record identifying data such as claim/policy number, date of loss and claimant name. Review selected files for violations of specific state unfair claims practices, such as misrepresentation of policy provisions or concealment of coverage.

Calculate error ratios for the sample and field sizes. This is especially important in this study, since most unfair claims practices statutes make reference to "business practices."

f. Claim forms

Request copies of all claim forms in use for the lines of business being examined. Forms should be reviewed for content and appropriate usage. Inappropriate forms should be documented and included in the report. Claim forms also may be reviewed as they are encountered in the file reviews.

g. Review of canceled drafts/checks

This review should be considered nonvoluntary is an issue, if the examiner determines delays in issuing a payment, or if consumer complaints indicated delays that are not supported by other time studies.

From the regulated entity's records, select a representative sample of the type of claims being reviewed. The selection should include drafts/checks reflecting a substantial payment amount on any one claim. Compare the date the regulated entity indicated the draft/check was forwarded to the claimant with the date the draft/check was presented for payment. If the review indicates significant and numerous delays in presenting drafts/checks for payment, additional investigation to determine the causes should be done.

Canceled checks should be reviewed to verify that the amount paid and the claim amount approved are the same, that payees are the same and that the information recorded in the computer system matches what is on the check (payee, amount, date of check, etc.).

h. Review of other procedures

Other review, as deemed necessary, should follow the same format for objectivity and sampling techniques as those already described. These reviews may be instituted by consumer complaints regarding specific claims practices and should be tailored to resolve specific issues.

3. Tests and Standards

The claims review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's claim handling practices. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
CLAIMS**

Standard 1

The initial contact by the regulated entity with the claimant is within the required time frame.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim files

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act* (#900)
- Unfair Property/Casualty Claims Settlement Practices Model Regulation* (#902)
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation* (#903)
- Title Insurers Model Act* (#628)
- Title Insurance Agent Model Act* (#230)
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs* (#1970)
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements* (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and bulletins to determine if regulated entity standards exist. Determine whether the regulated entity's standards comply with applicable statutes, rules and regulations.

Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.

Determine if initial contact with claimants meets required contract standards.

Determine if subsequent responses and claim handling delay notices comply with applicable statutes, rules and regulations.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 2 Timely investigations are conducted.
--

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manual
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Antifraud procedures

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Credit Insurance Model Act (#360)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if investigations are initiated and concluded in compliance with state statutes.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 3
Claims are resolved in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Review of canceled claim checks
- _____ Claim files

Others Reviewed

- _____
- _____

NAIC Model References

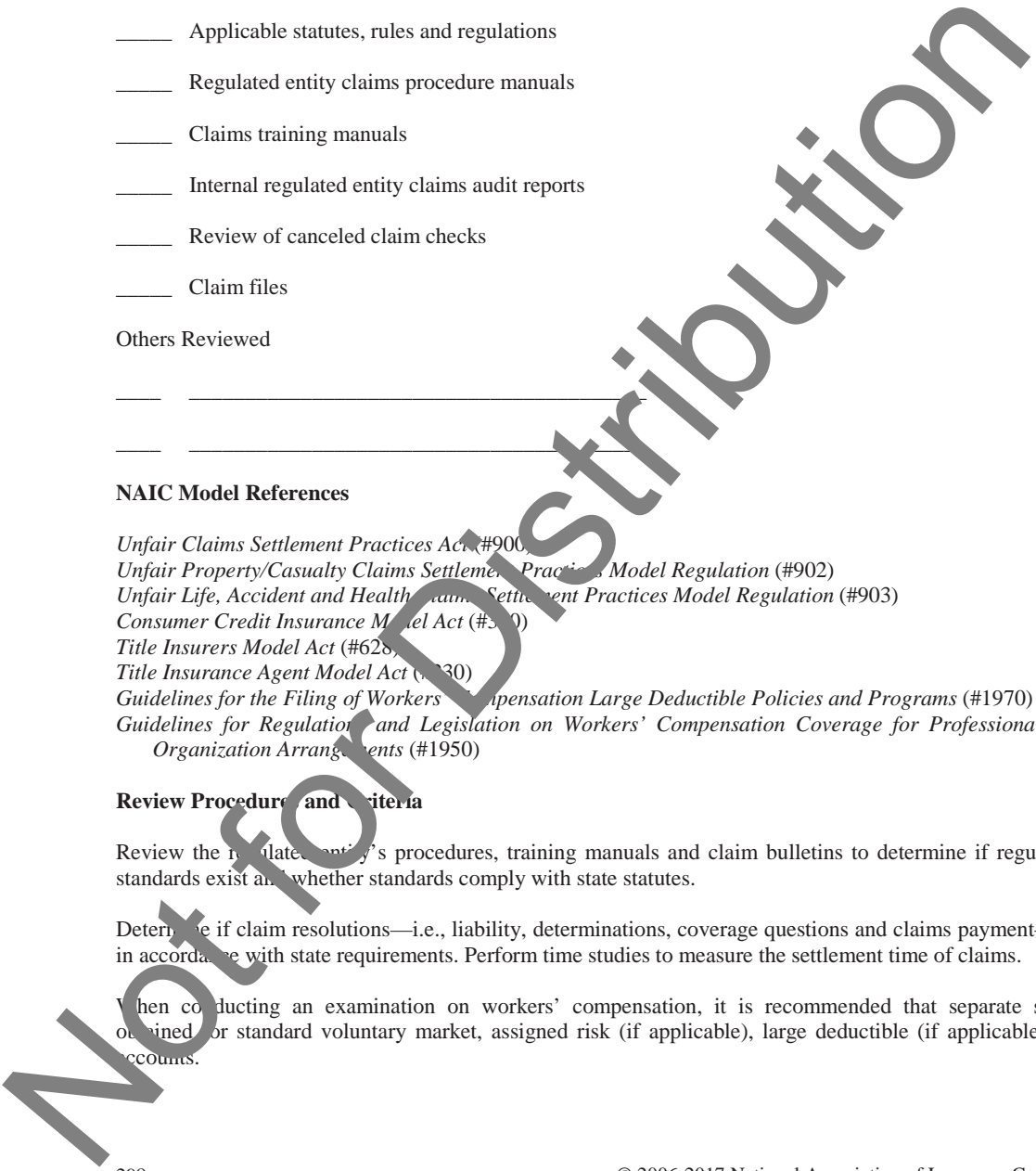
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Credit Insurance Model Act (#500)*
- Title Insurers Model Act (#625)*
- Title Insurance Agent Model Act (#630)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulation and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedure and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if claim resolutions—i.e., liability, determinations, coverage questions and claims payment—are made in accordance with state requirements. Perform time studies to measure the settlement time of claims.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.



Automation Tip:

Obtain from the regulated entity a listing of claims closed with payment or claims closed without payment by claim feature. Include in the file the claim number(s), date the claim was reported to the regulated entity, the first payment date (if applicable), and the date the claim feature was closed. Using ACL, a database or spreadsheet, calculate the number of days from the date the claim feature was closed to the date the claim was reported. Group the number of days in any appropriate time periods, for example, 1 to 15 days, 16 to 30 days, etc., and perform a count on each time period. Investigate any patterns of untimeliness.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 4
The regulated entity responds to claims correspondence in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Claim files
- _____ Electronic claims correspondence

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Consumer Credit Insurance Model Act (#500)*
- Title Insurers Model Act (#628)*
- Title Insurance Agent Model Act (#230)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1970)*

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if correspondence related to claims is responded to in accordance with state requirements.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 5
Claim files are adequately documented.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Electronic records of claims activities
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Claim files
- _____ Claim forms

Others Reviewed

- _____
- _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#195)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if quality of the claim documentation meets state requirements.

Determine if the retention/destruction program meets state requirements.

Determine if claim files documentation is sufficient to support or justify the ultimate claim determination.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 6

Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Regulated entity claim forms manual
- _____ Regulated entity subrogation and salvage logs
- _____ Claim files
- _____ Regulated entity depreciation schedules
- _____ Auto—total loss evaluation procedures

Others Reviewed

- _____
- _____

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)*
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Retained Asset Accounts Sample Bulletin (#573)*
- Consumer Credit Insurance Model Regulation (#360)*
- Long-Term Care Insurance Model Act (#640)*
- Coordination of Benefits Model Regulation (#120)*
- Off-Label Drug Use Model Act (#148), Section 4*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulation and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if the regulated entity’s procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the commissioner.

Determine if claim handling meets state-specific statutes and regulations as applied to total loss evaluations, sales tax payment, disposition of salvage, correct payees, improper release of claims, proper payment of non-disputed claims and proper referral of suspicious claims.

Determine if coverage was checked for proper application of deductible or appropriate exclusionary language.

When conducting an examination on workers’ compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 7
Regulated entity claim forms are appropriate for the type of product.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim forms for product being examined

_____ Electronic claims notification screens

_____ Claim files

Others Reviewed

NAIC Model References

Insurance Fraud Prevention Model Act (#680)

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Standardized Health Claim Form Model Regulation (#30)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)

Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if claim form(s) include appropriate content and are used appropriately. Use of inappropriate forms should be documented and included in the examination report.

Review claim forms as they are encountered in the file reviews.

Examine all claim forms for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 8
Claim files are reserved in accordance with the regulated entity’s established procedures.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal claims audit reports
- _____ Individual claim file
- _____ Average reserve data

Others Reviewed

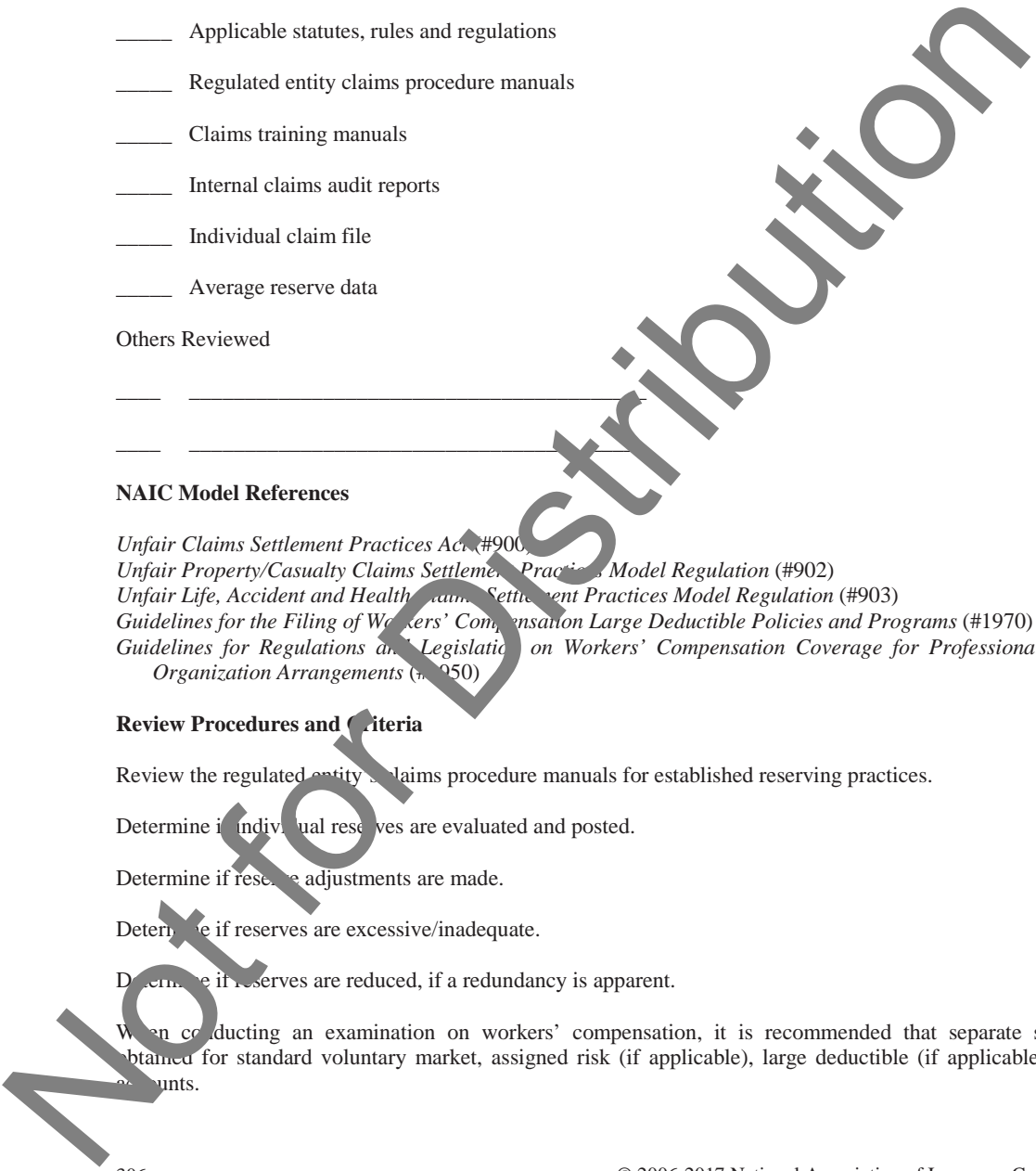
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NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)*
- Guidelines for the Filing of Workers’ Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers’ Compensation Coverage for Professional Employer Organization Arrangements (#950)*

Review Procedures and Criteria

- Review the regulated entity’s claims procedure manuals for established reserving practices.
- Determine if individual reserves are evaluated and posted.
- Determine if reserve adjustments are made.
- Determine if reserves are excessive/inadequate.
- Determine if reserves are reduced, if a redundancy is apparent.
- When conducting an examination on workers’ compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.



**STANDARDS
CLAIMS**

Standard 9

Denied and closed without payment claims are handled in accordance with policy provisions and state law.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity claims procedure manuals
- _____ Claims training manuals
- _____ Internal regulated entity claims audit reports
- _____ Claim bulletins
- _____ Claim files

Others Reviewed

- _____
- _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
*Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer
 Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if denied and closed without payment claims are based on policy provisions and applicable state statutes and regulations.

Determine if notices of claim denials reference specific policy provisions or exclusions.

Determine if the regulated entity provides claimants with a reasonable basis for the denial, when required by statutes, rules or regulations.

Where required, determine if claimants are provided with instructions for having rebuttals to denials reviewed by the insurance department or by the regulated entity.

Determine if the regulated entity refers suspicious claims to a regulatory authority/law enforcement agency, when appropriate.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 10
Canceled benefit checks and drafts reflect appropriate claim handling practices.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Cashed benefit checks and drafts

_____ Regulated entity claims procedure manuals

Others Reviewed

NAIC Model References

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Perform a time study on canceled claim checks or drafts to ascertain whether claim proceeds are being promptly mailed or delivered.

Determine if canceled checks include the correct payee and are for the correct amount.

Ascertain whether payment checks indicate the payment is "final" when such is not the case.

Ascertain whether checks or drafts purport to release the insurer from total liability when such is not the case.

Review endorsements to see if they are consistent with the payee name listed on the check.

If drafts are used, ascertain whether there is prompt clearance by the insurer.

**STANDARDS
CLAIMS**

Standard 11

Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Closed litigated claim files

_____ Regulated entity claims procedure manuals

Others Reviewed

NAIC Model References

Unfair Claims Settlement Practices Act (#900)

Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Review a sample or entire population of closed litigated claim files, if feasible. Determine if litigated files indicate problematic claim handling practices. If warranted, notify the insurance department's financial examination division.

Note: The examiner should review applicable state statutes to determine which particular claims should adhere to this standard. For example, bodily injury claims may not readily fit this standard.

Not for Distribution

Chapter 17—Conducting the Property and Casualty Examination

IMPORTANT NOTE:

The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting property/casualty insurance regulated entity examinations. Procedures for conducting life and health insurance regulated entity examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of property/casualty insurance operations may involve any review of one or a combination of the following business areas:

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the regulated entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

**STANDARDS
MARKETING AND SALES**

Standard 1
The regulated entity’s mass marketing of property/casualty insurance is in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business policy forms
- _____ Advertising materials
- _____ Disclosure materials
- _____ Marketing complaints
- _____ Underwriting guidelines

Others Reviewed

- _____
- _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Group Personal Lines Property and Casualty Insurance Model Act (#760)

Review Procedures and Criteria

Review documentation in new business policy files to determine a legitimate basis for the group. If not evident from the file, request additional documentation from the regulated entity to verify that the group is not fictitious.

Review underwriting guidelines, new business policy files, advertising materials, disclosure materials and complaints to verify:

- Compulsory participation not required for employment or group membership;
- Tie-in rules are not a condition of purchase; and
- Disclosures are provided, as required.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

Not for Distribution

**STANDARDS
POLICYHOLDER SERVICE**

Standard 1
Claims history and loss information is provided to the insured in a timely manner.

Apply To: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Regulated entity's procedures manuals

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880), Section 4(O)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)

Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review sample claim files to determine if the regulated entity is providing loss information for the three previous years to the first named insured within 30 days of receipt of the written request, including:

- On all claims, the date and description of occurrence and the total amount of payment; and
- For any occurrence not included above, the date and description of occurrence.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

F. Underwriting and Rating

1. Statistical Coding

In addition to the general standards, the examiner should review the regulated entity's statistical coding procedures. Coding on individual policies should be current and accurate. The examiner should determine to what statistical agencies the regulated entity reports its rating/underwriting data.

The examiner should confirm that the regulated entity is using the most current codes, classes, territories, town protection classes, ZIP codes, etc.

Errors should be noted with regard to overcharges or undercharges.

Additional introductory material is located in Chapter 16—General Examination Standards of this handbook.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 1
Credits, debits and deviations are consistently applied on a non-discriminatory basis.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Underwriting files and supporting documentation
- _____ Insurance department approval of deviations (if applicable)

Others Reviewed

- _____
- _____

NAIC Model References

- Property and Casualty Model Rating Guideline (File and Use Version) (#1775)*
- Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)*
- Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)*
- Unfair Trade Practices Act (#880)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1956)*

Review Procedures and Criteria

Credits and deviations should be filed, when required.

Determine if credits and deviations are applied consistently.

Determine if the reasons for use of credits and deviations are documented.

Verify proper handling of consent-to-rate or excess rate forms.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
UNDERWRITING AND RATING**

Standard 2

Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Underwriting files, including the Individual Risk Premium Modification (IRPM) worksheet
- _____ Schedule rating worksheet where IRPM worksheet is used

Others Reviewed

- _____
- _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that the application of the plan complies with limitations imposed by the state.

Verify that changes in the amounts of credit or debit are supported by documentation or an explanation that is consistent with the change. Also verify that the basis for use is appropriate (i.e., based on objective criteria, not on perceived competitive pressures).

Determine if the regulated entity is adjusting individual premiums to target premium levels for competitive reasons. Typically, the test for this is to review the documentation in the underwriting files.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
UNDERWRITING AND RATING**

Standard 3
Verification of use of the filed expense multipliers; the regulated entity should be using a combination of loss costs and expense multipliers filed with the insurance department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ National Council on Compensation Insurance (NCCI) pure premium tables
- _____ Regulated entity's filed multipliers that modify the NCCI's (or similar advisory organization) filed loss costs
- _____ Rate charts by classification codes (charts maintained at the regulated entity level)

Others Reviewed

- _____
- _____

NAIC Model References

- Property and Casualty Model Rating Guideline (File and Use Version) (#1775)*
- Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)*
- Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)*

Review Procedures and Criteria

Obtain from the regulated entity the filed expense multipliers which were applicable at the inception of the policy. (This filing should be stamped either "Approved" or "Filed" by the insurance department.)

Obtain the regulated entity's table of rates for each classification code. Check the sample's premium audit data (showing the actual rate charged to an employer for individual classification codes) against the table of rates, which includes the NCCI's (or similar advisory organization) loss costs and the filed expense multiplier, to verify accuracy.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

**STANDARDS
UNDERWRITING AND RATING**

**Standard 4
Verification of premium audit accuracy and the proper application of rating factors.**

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Insurance department approved and/or filed rating plans, including risk modification plans
- _____ Copies of cost containment certificates and loss improvement criteria to determine cost containment discount
- _____ Final rate manual tables by classification codes applicable to the period under examination (tables maintained at the regulated entity level)
- _____ Workers' Compensation Experience Modification Rating Sheets pertaining to the policy sample (experience modifiers as published by the NCCI and similar advisory organization)

Others Reviewed

- _____
- _____

NAIC Model References

- Property and Casualty Model Rating Guideline (File and Use Version) (#1775)*
- Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)*
- Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)*
- Guidelines for the Filing of Workers' Compensation Loss Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

The purpose of this review is to determine that the final premium charged to the employer is being applied correctly, fairly and consistently.

The sample's premium audits should contain specific information on each policy. The sample's information should be compared to the NCCI unit statistical report and to the company's rating plan, to verify accuracy in the application and reporting of the following factors when applicable:

- Premiums by classification code;
- Payroll exposure;
- Schedule rating;
- Cost containment discount;
- Premium discounting;
- Designated self-insured provider discount;

- Expense loading;
- Application of the correct experience modifier;
- Small employer discount;
- Discount for rehiring previously disabled employees; and
- Any other rating elements.

The company documents should be reviewed. Any additional areas or lack of information should be discussed with company management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 5 Verification of experience modification factors.
--

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Premium audit reports from the policy sample
- _____ Experience rating rules published by the NCCI (and similar advisory organizations)
- _____ Workers' compensation experience modification rating sheets pertaining to the policy sample, experience modifiers pertaining to the policy sample as published by the NCCI and similar advisory organizations.
- _____ Unit statistical reports pertaining to the policy sample and used to report the regulated entity's information (data) to the NCCI and similar advisory organizations

Others Reviewed

- _____
- _____

NAIC Model References

- Property and Casualty Model Rating Guideline (File and Use Version) (#1715)*
- Property and Casualty Model Rating Guideline (Prior Approval Version) (#1730)*
- Property and Casualty Commercial Rate and Policy Form (Local Law - Condensed) (#777)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

The experience modifier issued by the NCCI (and similar advisory organizations) should reflect the information reported to the NCCI (or similar advisory organization) using the unit statistical reports. Experience modifiers should be reconciled to what is reported on the unit statistical reports and what is shown on the workers' compensation experience modification rating sheets.

Net loss reporting should be properly applied to both large and small deductible policies.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

**STANDARDS
UNDERWRITING AND RATING**

Standard 6 Verification of loss reporting.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ NCCI (and similar advisory organizations') rules governing the reporting of losses on unit statistical reports
- _____ Loss data pertaining to the policy sample and maintained by the regulated entity
- _____ Unit statistical reports pertaining to the policy sample and used to report regulated entity information to the NCCI (and similar advisory organizations)

Others Reviewed

- _____
- _____

NAIC Model References

- Property and Casualty Model Rating Guideline (File and Use Version) (#1775)*
- Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)*
- Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Losses under each policy should be clearly and accurately maintained at the regulated entity, so that paid amounts, reserves and deductibles can be easily reviewed. The sample data should be compared to the unit statistical reports to verify accuracy of reporting of the following items:

- Paid losses
- Paid loss adjustment expenses;
- Net of deductible reporting on the unit statistical reports;
- Adjustments to reserves and revised unit statistical reports; and
- Any other adjustments, such as subrogation.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

**STANDARDS
UNDERWRITING AND RATING**

Standard 7
Verification of the regulated entity's data provided in response to the NCCI call on deductibles.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ The NCCI (or similar advisory organization) data call and resulting report made by the insurance regulated entity to the NCCI (or similar advisory organization)
- _____ Loss data pertaining to sample policies written on a deductible basis and maintained by the regulated entity
- _____ Unit statistical reports pertaining to sample policies written on a deductible basis and used to report regulated entity information to the NCCI (and similar advisory organizations)

Others Reviewed

- _____
- _____

NAIC Model References

- Property and Casualty Model Rating Guideline (File and Use Version) (#1775)*
- Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)*
- Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Note that a new sample (the "deductible sample") should be taken for this standard, sampling only policies with deductibles (both large and small deductibles).

During an examination, it should be verified that losses are reported on the unit statistical reports to the NCCI (or similar advisory organizations) net of deductibles. The Independent Deductible Data Call that the NCCI requests should be reported gross, including the deductibles. This must be verified with the policy sample, unit statistical reports and loss data maintained by the regulated entity.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable), and PEO accounts.

**STANDARDS
UNDERWRITING AND RATING**

Standard 8
Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Decisions should be based on information that reasonably should have been developed at the inception of the policy or during initial underwriting and not, through audit or other means, after the policy has expired.

Determine if the initial underwriting of a policy is based on the information obtained after a claim is submitted.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 9
Audits, when required, are conducted accurately and timely.

Apply to: All auditable personal policies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Premium audits pertaining to the policy sample

_____ Payroll records associated with the premium audits and with the policy sample

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Verify that all auditable commercial policies have a structured system for conducting payroll or other audits used to verify final premium.

Verify what is all auditable commercial policies' procedure for waiving audits. Verify that the basis is reasonable.

Determine what is all auditable commercial policies' time frame for completion of audits. Companies typically have a time frame for the completion of an audit following expiration.

Verify if all auditable commercial policies' auditors or independent auditors conduct audits.

Perform an independent verification to ensure that return premiums are received by insureds in a timely manner.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 10

The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and the regulated entity's guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business application
- _____ All underwriting information obtained
- _____ Regulated entity's underwriting guidelines
- _____ Underwriting bulletins
- _____ Declination procedures
- _____ Agency agreements and correspondence with producers
- _____ Interoffice memoranda and regulated entity minutes
- _____ Policy declaration page
- _____ Underwriter's file or notes on a system log

Others Reviewed

- _____
- _____

NAIC Model References

- Insurance Fraud Prevention Model Act (#680)*
- Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#837)*
- Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)*
- Unfair Trade Practices Act (#880)*
- Credit Reports and Insurance Underwriting White Paper*

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Some indication of industry underwriting practices may be obtained by survey of residual markets (e.g., FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination, including requests for supplemental information.

Examine new business applications for the required fraud warning statement.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 11

All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable).

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business application
- _____ Policy declaration page
- _____ Insurance department approval for forms and endorsements
- _____ Regulated entity's files or register of approved forms

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Registration of Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed.

Determine if the regulated entity lists all forms and endorsements that form part of the contract on the declaration page.

Examine new business applications for the required fraud warning statement.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
UNDERWRITING AND RATING**

Standard 12
Regulated entity verifies that the VIN number submitted with the application is valid and that the correct symbol is utilized.

Apply to: All automobile lines

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Underwriting files
- _____ Regulated entity's rating system
- _____ Regulated entity's symbol or Insurance Services Office (ISO) symbol manual

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Determine how the regulated entity checks the validity of the vehicle identification number (VIN) on the application. The regulated entity may use an automated program to verify the accuracy of the VIN.

Verify if the regulated entity is a member of or reports to any fraud detection bureau or organization. Some state statutes require reporting of suspected fraud.

Determine how a regulated entity handles updated symbols.

Determine if the correct symbol has been used.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 13 The regulated entity does not engage in collusive or anti-competitive underwriting practices.
--

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

Others Reviewed

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department legal counsel. This would include engaging in collusive underwriting practices that may inhibit competition; e.g., entering into an agreement with other companies to divide the auto market within the jurisdiction by territory.

The examiner should be aware of unlawful pricing and other prohibited anti-competitive acts or practices.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 14
The regulated entity’s underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in its application of mass marketing plans.

Apply to: All property and casualty companies with mass marketing plans

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy files

_____ Underwriting guidelines

_____ Canceled and nonrenewed policies

Others Reviewed

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#7)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Review documentation in new business policy files and underwriting guidelines to determine that the regulated entity does not apply underwriting standards to a mass marketing program that are more restrictive than those applied to an individually underwritten program.

Review underwriting guidelines, canceled and nonrenewed policy files to verify that failure of the employer or group to remit premium is not regarded as “nonpayment of premium” for the insured, unless the insured is sent appropriate notice and has failed to make timely payment.

Review underwriting guidelines and policy forms to verify that the employee or group member is given the right to continue coverage for 60 days after leaving employment or the group.

Review canceled and nonrenewed policies to verify that the notice of right to employee or member is given at cancellation or nonrenewal; allowing the employer or group to provide additional explanation why the individual should not be canceled.

**STANDARDS
UNDERWRITING AND RATING**

Standard 15
All group personal lines property and casualty policies and programs meet minimum requirements.

Apply to: Group personal lines property and casualty insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Master policy

_____ Program rules

_____ Certificates

Others Reviewed

NAIC Model References

Group Personal Lines Property and Casualty Insurance Model Act (#760)

Review Procedures and Criteria

Check for state jurisdictional requirements regarding group policies.

Verify that conversion options are included in notices of individual terminations.

Determine that conversion policies issued on an individual basis effective upon termination or ineligibility date have coverage and limits at least equal to the minimum coverage and limits required by statute.

Determine that program rules do not contain any provision making participation in the group program a condition of employment or membership in a group, nor subject employees or members to any penalty for non-participation.

Determine that group coverage is not contingent upon the purchase of any other insurance, product or service.

Confirm that any experience refund or dividend is applied for the sole benefit of the insured employee or member to the extent that any experience refund or dividend exceeds the policy or certificateholder's contribution to the premium for the period covered.

**STANDARDS
UNDERWRITING AND RATING**

Standard 16
Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy contract
- _____ Notice of cancellation/nonrenewal
- _____ Insurance department’s approval of forms
- _____ Underwriter’s file or notes on a system log
- _____ Insured’s request (if applicable)
- _____ Regulated entity’s cancellation/nonrenewal guidelines
- _____ Certificate of mailing
- _____ Producer records/notices issued

Others Reviewed

NAIC Model References

Guidelines for the Filing of Workers’ Compensation Large Deductible Policies and Programs (#1970)
*Guidelines for Regulations and Legislation on Workers’ Compensation Coverage for Professional Employer
 Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and state law.

Does the notice of cancellation include the specific reason for cancellation where required?

Are adverse underwriting decision notices provided where required?

Review cancellation notices and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the form, if necessary, has been approved by the insurance department.

Review the notice and the certificate of mailing to ensure that adequate notice of cancellation/nonrenewal was provided to the insured and any mortgagees or lien holders.

Does the regulated entity lull insureds into a false sense of security through use of misleading billing notices, grace period descriptions, reinstatement offers, lapse notices, etc.?

If cancellation was at the insured's request, ensure that there is proper documentation.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 17
All policies are correctly coded.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Regulated entity's rating system

_____ Regulated entity's coding manual

_____ Rating organization's coding manual

Others Reviewed

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)

Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine that the regulated entity confirms that the coding as reported by the producer is correct and current.

Determine that the regulated entity promptly updates all coding manuals and programs.

Determine that the regulated entity correctly codes all policies according to current codes.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable), and PEO accounts.

**STANDARDS
UNDERWRITING AND RATING**

Standard 18

Application or enrollment forms are properly, accurately and fully completed, including any required signatures, and file documentation adequately supports decisions made.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

___ Applicable statutes, rules and regulations

___ Application

___ Underwriting files

___ Electronic documentation

___ Policy

Others Reviewed

___ _____
___ _____

NAIC Model References

Review Procedures and Criteria

Application should be complete and signed where required (includes electronic signatures).

Determine that the underwriting file contains necessary information to tell the regulated entity what exposure it has.

Determine when and under what conditions the regulated entity requires a physical inspection, a motor vehicle report (MVR), an inspection report, a credit report or other underwriting information to confirm exposure or premium basis.

Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable state statutes and regulations.

G. Claims

In addition to the general examination techniques, the examiner should define the scope of the property/casualty claims examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage. Types of claims covered should differentiate between first-party and third-party claims or total losses and partial losses.

Claim procedure manuals, adjuster training manuals and claim bulletins should be reviewed. Regulated entity procedures for total loss settlement, salvage disposition and subrogation efforts should be determined. If the jurisdiction licenses company or independent adjusters, licensing records should be cross checked with claim adjustment records to ensure that assigned adjusters are properly licensed.

a. Total loss survey

Record identifying data, such as claim/policy number, date of loss and claimant's name. Review files for accuracy and adequacy of documentation. Review files for method of vehicle evaluation and compare with specific state requirements. Review reductions in value for appropriateness and accuracy. Review file for state-specific additions to value, such as sales tax or title fees.

Review file for correct disposition of salvage and compliance with specific state requirements for disposition of title and registration.

b. Subrogation survey

From the regulated entity's records, select a representative sample of the subrogated files with complete or partial recoveries. Record identifying data such as claim/policy number, date of loss and claimant name. Review files to determine if the subrogated amount included the insured's deductible. It should also be determined if the deductible was recovered and whether it was returned to the insured.

If a partial recovery was made, was a pro rata amount returned. Specific state requirements should be reviewed to determine the regulated entity's compliance. Determine if the insured's recovery was reduced by collection charges. Determine if the specific state law permits the reductions. Determine if recovery was reduced by written or oral agreement with other companies. Determine if such agreement is in compliance with specific state laws.

c. Loss statistical reporting

Determine to which statistical agency the regulated entity reports its loss data. Review claim drafts to determine if loss data is correctly coded as to the proper line of business. Review drafts to determine if claim expenses are separated from claim payments. If the review indicates significant errors in coding, the data should be included in the report.

**STANDARDS
CLAIMS**

Standard 1
Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity's claim procedure manuals
- _____ Claim training manuals
- _____ Claim files

Others Reviewed

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Review the regulated entity's procedures manual to determine if guidelines exist for the use of the reservation of rights letter and notice of excess of loss.

Claims where the regulated entity has reason to question coverage should have a reservation of rights letter sent to the insured.

Claims where it is apparent that the amount of loss will exceed policy limits should have an excess of loss letter sent to the insured.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 2
Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Subrogation register
- _____ Subrogation files
- _____ Review the regulated entity's subrogation and recovery procedures

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine if the regulated entity refunds deductibles from subrogation proceeds.

Determine if, upon complete recovery, the insured's deductible is promptly refunded.

Determine if refunds are made periodically or no less than a pro rata basis for long-term subrogation cases. Requirements may vary among states.

Determine if recovery payments are made to employees under workers' compensation, when applicable.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

**STANDARDS
CLAIMS**

Standard 3
Loss statistical coding is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Claim files
- _____ Regulated entity's claims coding manual
- _____ Regulated entity's coding system
- _____ Rating organization's coding manual

Others Reviewed

NAIC Model References

- Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)*
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*
- Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)*
- Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)*

Review Procedures and Criteria

Determine that the regulated entity codes the correct loss data onto the draft copies or system.

Determine that the regulated entity promptly updates all coding manual and programs.

Determine that the regulated entity accurately codes the loss amounts. Determine that the regulated entity separates loss amounts from loss expense amounts.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Chapter 18—Conducting the Title Insurance Company and Title Insurance Agent Examination

IMPORTANT NOTE:

The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a suggested format for conducting title insurance company and title insurance agent examinations. Procedures for conducting life and health insurance company examinations, property/casualty company examinations and other types of specialized examinations—such as managed care organizations, third party administrators and surplus lines brokers—may be found in separate chapters.

For the purpose of licensing standards, the term “producer” is used, instead of “title agent.” It will be necessary to refer to Chapter 16—General Examination Standards of this handbook relating to producer licensing.

The examination of title insurance operations may involve any review of one or a combination of the following business areas:

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims
- H. Escrow, Settlement, Closing or Security Deposit Funds
- I. Title Insurance Producer (Agent) Licensing and Relations
- J. Special Considerations for Title Insurance Companies and Title Insurance Agents
- K. Example Title Letter
- L. Example Title Interrogatory
- M. Sample Checklist

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the title insurance company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). In addition, banks may also be regulated at the state level. Many states have executed an agreement to share complaint information with one or more of these federal or state agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal or state agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 1
The title insurance company acts within the scope of its license.

Apply to: All title companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority

_____ Title insurance company system

Others Reviewed

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

No title insurance company may transact any class, type or kind of business other than title insurance.

Title insurance may not be transacted, underwritten or issued by a title insurance company transacting or licensed to transact any other class, type or kind of business.

The title insurance company shall do only title insurance business, reinsure title insurance policies and perform ancillary activities, including examining titles to real property and any interest in real property and procuring and furnishing related information and information about relevant personal property when not in contemplation of, or in conjunction with, the issuance of a title insurance policy.

A title insurance company shall not engage in the business of guaranteeing payment of the principal or the interest of bonds or mortgages.

The title insurance company is expressly authorized to issue closing or settlement protection to a proposed insured upon request, if the title insurance company issues a preliminary report, binder/commitment or title insurance policy.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 2

No member of the board of directors of the title insurance company may be a title insurance agent who wrote 1 percent or more of the direct premiums for the previous calendar year.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

This requirement does not apply if the relationship is covered by the state's insurance holding company act.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 3

The agency and all applicable employees have in place an errors and omissions policy, fidelity coverage, and/or a surety bond (or alternative financial arrangement, where permitted), if required by statutes, rules and regulations.

Apply to: All title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ Records of errors and omissions policy, fidelity coverage, surety or financial arrangement

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Some jurisdictions require fidelity coverage to cover all individuals who handle escrow, security deposits and/or closing funds.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 4
Business is diversified as required by statutes, rules and regulations.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Annual statement

Others Reviewed

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Business is diversified as required by statutes, rules and regulations. Prior written approval from the insurance department may override the following restrictions:

An independent title insurance agent's aggregate premiums may not exceed a percentage of the title insurance company's gross premiums written during the prior calendar year (as required by applicable statutes, rules and regulations).

Direct operations business may not be accepted from a single source in excess of the allowed percentage of the title insurance company's gross premiums written during the prior calendar year.

A single source means a person that refers business to the title insurance company and any other person that controls, is controlled by or is under common control with that person.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 5

There is a periodic review and testing of the title plant built, owned, controlled or maintained by a title agent.

Apply to: All title plants where a title insurance agent builds, owns, controls or maintains the title plant

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations, especially insurance examination law
- _____ Title insurance company or title insurance agent standards for title plant construction, use and maintenance
- _____ Title plant
- _____ Agency contract, if applicable
- _____ Claim files

Others Reviewed

- _____
- _____

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine if there are established title plant standards and periodic tests to see that standards are met.

Review claim files to determine if losses paid arise from faulty search of title.

Determine if adequate provisions concerning the title plant are in the agency contract, if applicable.

Note: In some instances, the title insurance company is responsible for overseeing the activities of its agents with respect to maintenance of the title plant. The examiner should be aware that in other instances, the title insurance company and the title insurance agent may be in direct competition with each other. In those situations, the title insurance agent is accountable for ensuring standards for appropriate maintenance of the title plant.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 1
Controlled business is handled in accordance with statutes, rules and regulations.

Apply to: All title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

The title insurance agent must advise customers prior to commencing a transaction of a controlled business arrangement, if required by statutes, rules and regulations.

If a referral is received from an individual who constitutes a controlled business arrangement, the person being referred must be notified that he or she is not required to use a specified title insurance agent or title insurance company, if required by statutes, rules and regulations.

Referrals must be in compliance with the provisions of applicable statutes, rules and regulations as it relates to controlled business.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 2

Inducements are not provided, directly or indirectly, in consideration of referral of title insurance business, escrow or other services provided by a title insurance agent.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Title insurance company's correspondence files

_____ Policy files

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

All transactions must be in compliance with the provisions of applicable statutes, rules and regulations as it relates to referrals.

Referrals may not be originated from a producer or other person that requires, directly or indirectly, placement of the title insurance through a particular agency or title insurance company as a condition precedent to providing a loan, credit, sale, property, contract, lease or service, if prohibited by statutes, rules and regulations.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 3

Affiliated business arrangements are organized and operated in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy files
- _____ Response(s) to pre-examination AfBA interrogatories
- _____ Accounting records, including but not limited to, copies of cancelled checks, front and back, and disbursements to owners from operating accounts
- _____ Ownership documents
- _____ Applications, reports and disclosures to the regulatory authority, if required
- _____ Documentation of disclosures to consumers, if required
- _____ Contracts and service agreements between affiliates

Others Reviewed

- _____
- _____

NAIC Model References

- Title Insurance Agent Model Act (#230)*
- Title Insurers Model Act (#628)*

Review Procedures and Criteria

All arrangements must be organized and operated in compliance with the provisions of applicable statutes, rules and regulations as they relate to referrals, financial kickbacks, and providing things of value to agency/company owners, referrers of business and potential referrers of business.

Core services are performed by in-house agency/company staff, including title examinations, determination of insurability, clearance of exceptions or objections, the issuance of preliminary commitment, issuance of title policies, and if normally performed by title agents in the state, conducting the title search and handling of the closing.

All contracted services provided by a party related to the affiliated business entity are obtained at fair market prices, including, for example, accounting, information technology, human resources, payroll, title search, title examination, providing preliminary commitment or issuing title policy. Review contracts, services agreements and disbursements to analyze such affiliate transactions.

Analyze performance of core services, including a review of employee activities and disbursements for contracted services.

Analyze the original source of business. Make note of common settlement producers and the amount of business being referred by each. If the majority of referrals are being submitted by a few persons or entities, examine the ownership/relationship of the referring settlement producer and the entity under examination. Review disbursements for marketing, sales and core service activities to analyze potential referral fees.

The agency/company must be capitalized in compliance with applicable statutes, rules and regulations.

If a referral is received from a person or entity who is part of the affiliated business arrangement, the agency/company and/or referrer must provide its customers in a timely manner with all disclosures required by statutes, rules and regulations, including, for example, disclosure of the affiliated business arrangement and notification that the person being referred is not required to use a specific agency/company. If documentation of disclosure is required, review such documentation. Consider contacting a sample of customers to verify that they received required disclosures.

Determine if reports, applications or disclosures of the affiliated business arrangement to the regulatory authority are required under state statutes, rules and regulations. If so, determine if such documents have been properly filed.

Not for Distribution

D. Producer Licensing

Not applicable.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

F. Underwriting and Rating**1. Purpose**

The underwriting portion of the examination is designed to provide a view of how the title insurance company treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- a. Rating practices;
- b. Underwriting practices;
- c. Use of correct and properly filed and approved forms and endorsements;
- d. Unfair discrimination;
- e. Use of proper disclosures, buyers' guides and delivery receipts; and
- f. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Rating systems filed with regulators;
- Policy fees;
- Discounts;
- Title insurance company automated rating systems;
- Rating materials provided to title insurance agents;
- Underwriting guidelines;
- Applicable policy forms and endorsements;
- Title insurance agent compensation agreements, where applicable;
- Statistical reporting requirements; and
- Underwriting/closing/escrow files content and structure.

For purposes of this chapter, "underwriting/closing/escrow file" means the file or files containing rate calculation sheets, billings, and audits, including binders/commitments, all underwriting information obtained or developed, policy schedules A and B, endorsements, the lender's written closing instructions, settlement statements (HUD-1) and Good Faith Estimate (HUD-GFE) forms (if available), correspondence, and any other documentation. In many cases, all applicable documentation will not be contained in one file, but rather will be found in separate underwriting and closing files. Additionally, it should be noted that, since HUD-GFE forms are not required to be given to the title entity, such forms might not be available in all circumstances.

In selecting samples for testing, residential coverages should generally not be combined with commercial coverages. These two areas are not always homogeneous and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between residential coverages and commercial coverages with respect to the various tests to be developed. The examiner also should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies and endorsements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice or call of examination.

Determine the title insurance company's policy population (policy count). Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the development of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for title insurance company judgment.

a. Rating Practices

It is necessary to determine if the title insurance company is in compliance with rating systems which have been filed with and, in some cases, approved by, the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the title insurance company's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a title insurance company may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate that a title insurance company is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a title insurance company may vary between residential coverages and commercial coverages. The examiner should become familiar with the title insurance company's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process.

Rating practices of policies and endorsements should be reviewed. The examiner should ensure that the underwriting/closing/escrow files contain sufficient information to support the rates that have been applied to a policy or endorsement. Inherent in the more complex systems is the concern for unfair discrimination.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the title insurance company's underwriting guidelines, underwriting bulletins, agency agreements and correspondence with title insurance agents. The examiner may review interoffice memoranda and title insurance company minutes for indications of anti-competitive behavior or unfairly discriminatory practices. The examination team also will use the above information to determine title insurance company compliance with its manuals and guidelines. The examiner should confirm that the title insurance company underwriters and title insurance agents consistently apply the title insurance company guidelines for all business selected. The examination team should verify that the title insurance company has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the title insurance company the opportunity to know what business it has selected through its underwriters and title insurance agents. Files should be reviewed for compliance with all written instructions provided by relevant parties. In most cases, this will apply to lenders' closing instructions. However, other written instructions, such as tax or escrow agreements, disbursement instructions, etc., should also be reviewed. The examiner should verify that properly licensed and appointed (where applicable) title insurance agents have been used in the production of business.

Any practice suggesting anti-competitive behavior may involve legal considerations which should be referred to insurance department legal counsel. Ultimately, the information so obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Unfair Discrimination

The examination team should be mindful of company underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted in the applicable jurisdiction also may prohibit specific underwriting practices.

e. Use of Proper Disclosures, Lenders' Guides and Delivery Receipts

The examiner should inquire into any reinsurance agreements or affiliated business arrangements or agreements with a third party whereby insurance is arranged, reinsured, purchased through or ceded on title business written on personal or commercial properties. Errors should be noted with regard to overcharges or undercharges.

f. Statistical Coding

The examiner should review the title insurance company's statistical coding procedures. Coding on individual policies should be current and accurate. The examiner should determine to what statistical agencies the title insurance company reports its rating/underwriting data.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the title insurance company's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 1
Re-issue and refinance credits are applied consistently in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ New business application
- _____ Policy schedules A and B
- _____ Settlement statement (HUD-1) forms
- _____ Good Faith Estimate (HUD-GFE) forms (if available)

Others Reviewed

- _____
- _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

A copy of the previously issued title insurance policy should be maintained on file, if necessary, pursuant to rate requirements.

Documentation should be maintained to ensure there was adequate inquiry made regarding the existence of a prior title insurance policy, if necessary, pursuant to rate requirements.

In cases where a prior policy is not required in the application of a re-issue or refinance rate, documentation should be maintained to ensure there was adequate inquiry and/or examination made regarding the applicability of discounts used in calculating rates.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 2
The title insurance company does not engage in collusive or anti-competitive underwriting practices.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting/closing/escrow files

Others Reviewed

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Any practice suggesting anti-competitive behavior may involve legal considerations which should be referred to insurance department legal counsel. This would include engaging in collusive underwriting practices that may inhibit competition.

The examiner should be aware of unlawful pricing and other prohibited anti-competitive acts or practices.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 3
Charges or fees other than premium for providing coverage are in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Applicable state fee filings
- _____ Underwriting/closing/escrow files
- _____ Settlement statement (HUD-1) forms
- _____ Good Faith Estimate (HUD-GFE) forms (if available)

Others Reviewed

- _____
- _____

NAIC Model References

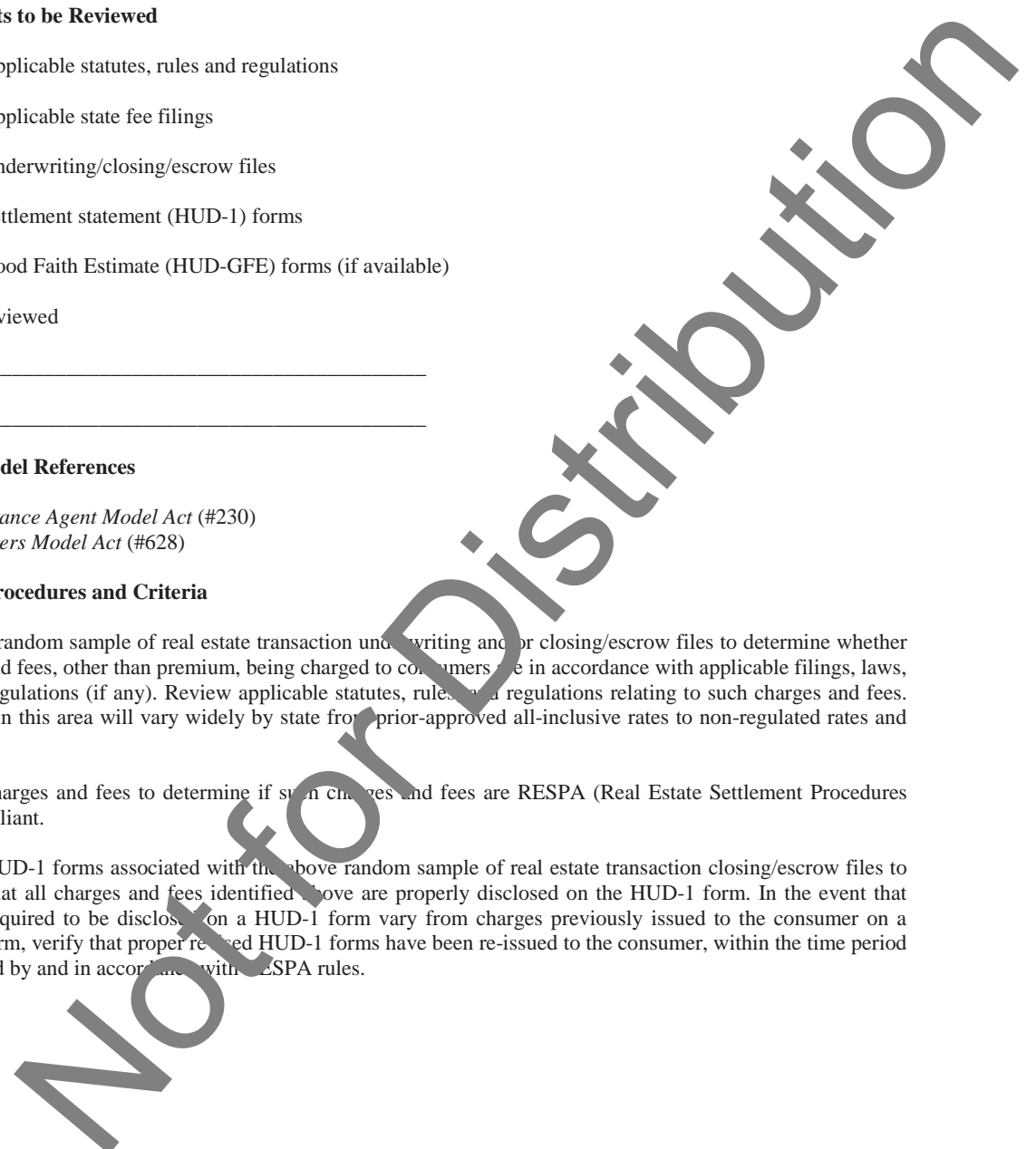
- Title Insurance Agent Model Act (#230)*
- Title Insurers Model Act (#628)*

Review Procedures and Criteria

Review a random sample of real estate transaction underwriting and/or closing/escrow files to determine whether charges and fees, other than premium, being charged to consumers are in accordance with applicable filings, laws, rules or regulations (if any). Review applicable statutes, rules and regulations relating to such charges and fees. The laws in this area will vary widely by state from prior-approved all-inclusive rates to non-regulated rates and fees.

Review charges and fees to determine if such charges and fees are RESPA (Real Estate Settlement Procedures Act) compliant.

Review HUD-1 forms associated with the above random sample of real estate transaction closing/escrow files to confirm that all charges and fees identified above are properly disclosed on the HUD-1 form. In the event that charges required to be disclosed on a HUD-1 form vary from charges previously issued to the consumer on a HUD-1 form, verify that proper re-issued HUD-1 forms have been re-issued to the consumer, within the time period established by and in accordance with RESPA rules.



If a settlement provider chooses to use average pricing as a means of calculating and disclosing settlement charges, review fee filings to verify that there is proper documentation of (1) all charges qualifying for average pricing and (2) the average pricing structure in effect at the time of closing, pursuant to applicable state statutes, rules and regulations.

Review closing/escrow files to determine if (1) any agreements between the lender and the title agent, or (2) any guarantees made by the title agent to the lender, guaranteeing any prices other than the title agent's filed fees or charges, have been made.

Review written documentation of the written instructions in the closing/escrow files to verify that all instructions provided by the relevant parties were followed. Review closing/escrow files to determine if transactions in escrow are ever closed in the absence of written instructions.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 4

Other than closing or settlement protection, the title insurance company does not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement or closing services.

Apply to: All title insurance companies

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Settlement statement (HUD-1) forms
- _____ Good Faith Estimate (HUD-GFE) forms (if available)

Others Reviewed

- _____ Case law for state impacted
- _____ _____
- _____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Review all coverage being offered and/or issued by the title insurance company to determine if it is within the definition of title insurance under the applicable statutes, rules and regulations.

Some jurisdictions require that all forms be filed and approved prior to use. In such jurisdictions, review forms to confirm that forms have been properly filed with the appropriate insurance department.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 5
The closing or settlement protection conforms to the terms of coverage and form of instrument as required by statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ Case law for state impacted

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

Where permitted or required, determine if closing or settlement protection is being offered by the company and/or agent.

Confirm that any closing or settlement protection being offered is in a form that complies with the applicable statutes, rules and regulations.

Some jurisdictions require that all closing or settlement protection forms be filed and approved prior to use. In such jurisdictions, review forms and confirm that forms have been properly filed with the appropriate insurance department.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 6
Reports and disclosures are made in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

The title insurance report and/or commitment shall be furnished to the purchaser-mortgagor or its representative as soon as reasonably possible prior to closing if the report includes an offer to issue an owner's policy covering the resale of the owner-occupied residential property.

Documentation of the reason for delay is maintained for title insurance reports, which are not delivered prior to the day of closing.

Required disclosures are made on reports not delivered prior to the day of closing:

“Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters, which are not covered under the terms of the title insurance policy and should be carefully considered.

It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects and encumbrances affecting title to the land.”

In accordance with applicable law, a written statement is provided or obtained when a lender's title insurance policy is issued in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan where no owner's title insurance policy has been requested.

The notice must be provided to the purchaser-mortgagor at the time the commitment is prepared.

The notice shall explain that a lender's title insurance policy is to be issued protecting the mortgage-lender and that the policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased.

The notice shall explain that a title insurance policy insures against through the purchase of an owner's policy.

The notice shall explain that the purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified or approximate cost, if the proposed coverages or amount of insurance is not known.

Copies of written notices prepared when a lender's title insurance policy is issued in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan where no owner's title insurance policy has been requested are maintained in the underwriting file for at least five years after the effective date of the policy.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 7
The title insurance company complies with statutes, rules and regulations regarding the recording, reporting and validation of revenue, loss and expense experience.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Rating organization's coding manual

Others Reviewed

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Validation may include certification by oath of the title insurance company's or title insurance agent's president, vice president or secretary.

Audits may be required by the insurance department. The audits should be conducted by an independent certified public accountant.

An actuarial certification is required to be filed with the title insurance company annual statement. The actuarial certification must conform to the NAIC annual statement instructions.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 8
All policies are correctly coded.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Underwriting files
- _____ Title insurance company’s rating system
- _____ Title insurance company’s coding manual
- _____ Rating organization’s coding manual

Others Reviewed

- _____
- _____

NAIC Model References

- Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)*
- Title Insurance Agent Model Act (#236)*
- Title Insurers Model Act (#628)*

Review Procedures and Criteria

- Determine that the title insurance company confirms the coding as reported by the title insurance agent is correct and current in accordance with applicable statutes, rules and regulations.
- Determine that the title insurance company promptly updates all coding manuals and programs.
- Determine that the title insurance company correctly codes all policies according to current codes.

Not for Distribution

G. Claims

1. Purpose

The claims portion of the examination is designed to provide a view of how the title insurance company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims. For purposes of this chapter “claim file” means the file or files containing the notice of claim; claim forms; settlement demands; claim investigation documentation; correspondence to and from insureds and claimants or their representatives; complaint correspondence; copies of claim checks or check numbers and amounts; releases; all applicable notices and correspondence used for determining and concluding claim payments or denials and any other documentation necessary to support claim handling activity.

The review is concerned with the title insurance company’s claims practices for compliance with statutes, rules and regulations and policy provisions. In addition to the general areas of review discussed in Chapter 16—General Examination Standards, a loss statistical reporting survey should also be performed.

Determine to which statistical agencies the title insurance company reports its loss data. Review claim drafts to determine if loss data is correctly coded as to the proper line of business. Review reports to determine if claim expenses are separated from claim payments. If the review indicates significant errors in coding, the data should be included in the report.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 1
Indemnification of a proposed insured solely against the loss of settlement funds may only be made for events as authorized by statutes, rules or regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Title insurance company's claim manuals

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

Where addressed by applicable statutes, rules and regulations, ensure that the closing or settlement protection only indemnifies against the following acts of a title insurance agent:

- Theft of settlement funds; and
- Failure to comply with written closing instructions by the proposed insured when agreed to by the title insurance agent relating to title insurance coverage.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 2
Loss statistical coding is complete and accurate.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Claim files
- _____ Title insurance company's claims coding manual
- _____ Title insurance company's coding system
- _____ Rating organization's coding manual

Others Reviewed

- _____
- _____

NAIC Model References

- Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)*
- Title Insurers Model Act (#628)*
- Unfair Claims Settlement Practices Act (#900)*
- Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)*

Review Procedures and Criteria

- Determine that the title insurance company codes the correct loss data onto the draft copies or system.
- Determine that the title insurance company promptly updates all coding manuals and programs.
- Determine that the title insurance company accurately codes the loss amounts.
- Determine that the title insurance company separates loss amounts from loss expense amounts.

Not for Distribution

H. Escrow, Settlement, Closing or Security Deposit Funds

1. Purpose

Title insurance companies, title insurance agents, approved attorneys and escrow companies provide services that reflect the unique nature of real estate transactions in our society. Services provided vary from one area of the country to another and may include acting as escrow agent, obtaining releases and conducting the actual closing or settlement. However, the essential purpose is the same; i.e., to assist the parties in real estate transactions by ensuring the acquisition or transfer of property interest can be effected with a maximum degree of efficiency, security and safety.

An escrow is a transaction in which an impartial third party acts in a fiduciary capacity as an agent for the seller, buyer, borrower and lender. In some states or jurisdictions, this function is performed by the title insurance company or agency.

The escrow holders have fiduciary and contractual responsibility for order processing, safeguarding and accounting for funds entrusted to them by escrow customers. Accordingly, this responsibility results in significant exposure to losses from inadvertent or intentional failure to execute their duties properly.

2. Techniques

The authority for review of escrow, settlement, closing and security deposit funds activities may or may not belong to the state insurance department. The examiner should ensure this area falls under their department's jurisdiction prior to review of these standards.

3. Tests and Standards

The escrow, settlement, closing and security deposit funds review includes, but is not limited to, the following standards addressing various aspects of these fiduciary responsibilities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 1

All escrow, settlement, closing or security deposit funds are submitted for collection to or deposited in a separate fiduciary trust account in a qualified financial institution promptly and in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

The funds are the property of the person(s) entitled to them and are segregated for each depository by escrow, settlement, security deposit or closing in the records which allows individual identification.

The funds are applied in accordance with the terms of the individual instructions or agreements by which the funds were accepted.

Ensure the funds are handled as follows:

- Funds held in escrow are disbursed pursuant to the written instruction or agreement specifying how and to whom the funds should be disbursed;
- Funds held in a security deposit account are disbursed in accordance with the written agreement; and
- The written agreement for funds held in a security deposit account complies with requirements of statutes, rules and regulations:
 - The agreement includes what actions the indemnitor needs to take to satisfy his or her obligation under the agreement; and
 - The agreement includes the duties of the title insurance company and title insurance agent with respect to the disposition of the funds held.
 - There is a requirement to maintain evidence of the disposition of the title exception or objection before any balance may be paid over to the depositing party or their designee.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 2
Interest received on funds deposited in connection with any escrow, settlement, security deposit or closing shall be paid in accordance with applicable statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

Administrative costs (i.e., the cost of maintaining the accounts) may be recovered from the interest.

Instructions for the funds or a governing statute may override this standard.

Refer to local statutes, rules and regulations relative to administrative/interest cost recovery. In the event of remittance delays that are contrary either to local law or the agency contract itself, the examiner may wish to explore the agency's financial condition vis-à-vis cash flow problems. If a pattern of delay exists relative to tax statements, and if funds are found to be commingled (i.e., funds in the premium account are being used in addition to an operating account; operating costs are being paid out of a trust account; etc.), for solvency reasons, examiners should report such findings to their appropriate financial examination section.

Not for Distribution

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 3

Disbursements made from an escrow, settlement or closing account are done in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

Expedited Funds Availability Act, 12 U.S.C Section 4001 et seq. as amended, and related regulations of the Federal Reserve System

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

Files should be balanced prior to closing to ensure sufficient deposits have been made to equal calculated disbursements. Disbursements should be made only from collected funds related to the same escrow.

“Collected funds” as used herein means:

- Cash;
- Wire transfers that are unconditionally received and available for disbursement;
- Certified, cashier and teller checks from an institution insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Share Insurance Fund (NCUSIF);
- U.S. Treasury checks; or
- Checks that have cleared the banking system.

Not for Distribution

I. Title Insurance Producer (Agent) Licensing and Relations

Use the standards set forth below.

Not for Distribution

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 1

Written underwriting contracts, which include required provisions, are in place between title insurance agencies and all applicable title companies, and business is not placed without a contract.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreements

Others Reviewed

NAIC Model References

Title Insurance Agent Model Act (#230)

Title Insurers Model Act (#628)

Review Procedures and Criteria

The agreement shall set forth the responsibilities of each party and explain the division of responsibilities if a particular function is a shared responsibility between the two parties.

The agreement should incorporate underwriting guidelines and limitations on title claims settlement authority.

The written agreement should include the following:

- Responsibilities of each party and division of responsibilities clearly specified;
- Provisions applicable to contract termination and notice of cancellation;
- Provisions specifying requirements for reporting and removal of funds.
- Provisions related to the fiduciary capacity and handling of title insurance company funds;
- Provisions related to ownership and access to policy records, escrow files and claim files;
- Provisions applicable to assignment of the contract;
- Guidelines related to the basis of rates charged, types of risks which may be written, maximum limits of liability, territorial limitations, title searches, examinations and underwriting;
- Provisions regarding the reporting of claims, claim settlement authority and risk retention;
- Where prohibited, the contract may not permit title insurance agents to bind reinsurance on behalf of the title insurance company or appoint a title insurance sub-agent; and
- The title insurance agent shall not bind reinsurance or retrocessions on behalf of the title insurance company.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 2 Policies and premiums are reported and remitted on a timely basis.
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Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Listing of title insurance agent accounts current exceeding contract limits
- _____ Title insurance agent and/or agency contracts
- _____ Agency listing of issued and unexpired commitments where the final title insurance policy has not yet been issued
- _____ Agency listing of issued title insurance policies that have not yet been reported to the title insurer

Others Reviewed

- _____
- _____

NAIC Model References

- Title Insurance Agent Model Act (#230)*
- Title Insurers Model Act (#628)*

Review Procedures and Criteria

The focus of this standard relating to title insurance agent accounts current is to aid in the detection of fraud or misuse of funds held by the title insurance agent in a fiduciary capacity.

In many cases, title insurance premium is paid to the agency at the time of a real estate closing. Following the closing, certain conditions—such as mortgage releases or filings—may need to be met prior to issuance of the policy. Payment of premium to the title insurer by the agency often occurs after policy issuance. Examiners should request a listing of all files where agents have issued commitments but the final title insurance policies have not been issued. Preferably, the listing should provide an aging of those files. If not, the examiner should sample the files to determine the aging and reasons why final policies have not been issued. Examiners should determine what procedures are in place at the agency to follow-up on those files to hasten completion, especially for those files in which premium payment has been received by the agency. In instances where a listing is not readily available, the examiner should physically inspect all locations where such files are stored to obtain an inventory, by approximation.

Examiners should request a listing of all files where the agency has issued final title policies, but not yet reported the policies to the title insurer. Determine that reporting is being handled in accordance with the insurer/agency agreement and ascertain an estimated reporting date and reason for any policies outside the scope of that agreement.

For both issued commitments pending issuance of the title policy (where the agency has collected premium) and issued policies not yet reported to the insurer, the examiner should obtain an estimated premium owed. The examiner should determine that the agency has kept those funds available for remittance to the insurer.

Review a listing of title insurance agent accounts current.

Discuss excessive balances with the title insurance company.

Refer to the appropriate division within the insurance department, if necessary.

Not for Distribution

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 3
The title insurance company maintains a record of financial stability for each title insurance agent under contract with the title insurance company.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Errors and omissions, fidelity coverage and surety bonds
- _____ Credit history report

Others Reviewed

- _____
- _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Verify that errors and omissions, fidelity coverage and surety bonds are in place, if required by statutes, rules and regulations.

Not for Distribution

STANDARDS

TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 4

The title insurance company conducts a review of underwriting, claims and escrow practices of the title insurance agent in accordance with statutes, rules and regulations.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurer audit reports of agent reviews

Others Reviewed

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

This review should include a review of the title insurance agent's policy inventory and processing operations.

If the title insurance agent does not maintain separate bank or trust accounts for the premiums for each title insurance company the agent represents, the title insurance company should verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the title insurance agent.

Note: In some jurisdictions, the title insurance company is required to conduct this review on-site.

Not for Distribution

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 5
The title insurance company maintains an inventory of all policy forms or policy numbers allocated to each title insurance agent.

Apply to: All title insurance companies

Priority: Recommended

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy register, stock list, log or similar record

Others Reviewed

- _____
- _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Reconcile policies on hand with the policy register, stock list, log or similar record, if applicable.

Not for Distribution

J. Special Considerations for Title Insurance Companies and Title Insurance Agents

In title insurance, there is risk elimination where potential defects that would produce loss are identified and specifically excluded from coverage or where certain risks may be over-insured, excluded or corrected. The policy is written to indemnify against losses to the title to real property, as stated in the policy on the date of policy issuance and has no expiration. Coverage is provided at any time thereafter, if the title was not as stated in the policy at that precise point in time.

Title insurance companies and title insurance agents may also be regulated or governed by banking authorities, the U.S. Department of Housing and Urban Development (HUD) or other authorities. In some states, title insurance statutes reference the federal Real Estate Settlement Procedures Act (RESPA), in which case the examiner should be familiar with the provisions of RESPA, 12 U.S.C., Section 2607, as amended. The Expedited Funds Availability Act, 12 U.S.C. Section 4001 et seq. as amended and related regulations of the Federal Reserve System should also be referenced.

Many of the requirements in this chapter are in accordance with the *Title Insurers Model Act* (#628) and the *Title Insurance Agents Model Act* (#230). Examiners should be familiar with the applicable statutes in their jurisdiction and apply only those standards and tests suggested in this chapter that are based in statute, rule or regulation in their jurisdiction.

An examination of title insurance agencies should include verification of compliance with issues which are both common with other types of insurance and unique to title insurance. In addition to licensing, appointment, disclosure, policyholder treatment and record retention requirements, the examiner should review issues relating to referrals, controlled or affiliated business relationships, underwriting contracts with companies, bond and errors and omissions coverage requirements, escrow accounts and audits.

An understanding of terms, definitions and typical business practices which are unique to title insurance is also helpful. An example is the term “producer” as used by the title insurance profession. Whereas the term “producer” in most lines of insurance may be used to refer to an insurance agent or broker, the term “producer,” as it relates to title insurance, refers to persons involved in the buying and selling of real estate, mortgage loans, lenders or attorneys. It is significant that many in the title insurance profession do not view the property owner as their customer. They view persons involved in the buying and selling of real estate, mortgage loans, lenders or attorneys as their customer—as these are entities that frequently exercise the ability to select a title insurer or title insurance agent on behalf of the named insured. The examiner should be aware that in some jurisdictions, on a purchase transaction, policies are commonly issued to both an owner and mortgagee, while in other jurisdictions, on a purchase transaction, policies may only be issued to a mortgagee, although the owner always has the option to purchase a policy. When the transaction involves a refinance, the mortgagee commonly purchases a policy but the owner does not, although the owner always has the option to purchase a policy. When the transaction involves a refinance, the mortgagee commonly purchases a policy but the owner does not.

In most jurisdictions, title insurance is a monoline policy, which can only be written by title insurance companies who are prohibited from writing any other line of business. In addition to issuing a title policy, in some jurisdictions, title insurance agencies may perform a variety of functions, including performing title searches, abstracting, performing underwriting functions, establishing and handling escrow funds and performing real estate closings. Approved attorneys, depending on the jurisdiction, will perform many of the same tasks as a title agent, but generally do not issue title policies. Approved attorneys are licensed by their local state bar association and are not licensed by the insurance department.

The agreement by the title insurer to provide the typical title insurance policy is usually referred to as a “commitment” or “preliminary commitment to title insurance.” The commitment generally specifies what defects need to be corrected prior to title policy issuance, together with the conditions, exclusions or exceptions that will appear in the title policy when issued. When issued, a title policy may cover the interests of the real estate lender or the buyer if these interests differ. Title insurance rates vary from state to state and are regulated in a variety of

ways: promulgation, prior approval, file and use, use and file and no direct regulation. Under all of the above, there is usually a discount applied for simultaneously issued policies, refinancing or to a property for which a previous title policy was issued within some specified period of time.

In many instances, the examiner will need to access and review records at the title insurance agent's office during a title insurance company examination.

In some jurisdictions, there are "title plants" that duplicate the public record affecting real property and reorganize those records, typically by legal description. In those jurisdictions in which the title insurance agent builds, owns, controls or maintains a title plant used to search title preliminary to the issuance of a title policy, it is important that the examiners verify that there are appropriate standards for maintenance of the title plant. It is also critical that the insurer provide an adequate level of oversight of such an agent.

The examiners should request the following items upon initiating a title insurance agent examination:

- Issued commitment files with no policy issued;
- A listing of all files or orders in which commitments have been issued, but policies have not yet been issued (whether or not outstanding conditions have been met and reported);
- Issued policies not yet reported to the underwriter; and
- A listing of all issued title policies and endorsements for which reporting to the title insurer is pending or not yet accomplished, as of the date of the request.

Not for Distribution

K. Example Title Letter

DATE

Address

Re: Affiliated Business Arrangements

Dear

The _____ Division of Insurance is conducting an investigation of affiliated business arrangements (“AfBAs”) in the title insurance industry. The Division is sending this letter to all title insurance agencies licensed in the State of _____ to facilitate the investigation. **Please respond to this inquiry within ten (10) business days from the date of this letter.**

According to _____ law, the term “affiliated business arrangements” means:

“Settlement producer” means: _____.

“Affiliate” means: _____.

State insurance commissioners are authorized to enjoin violations of the federal Real Estate Settlement Procedures Act (RESPA).

RESPA defines an affiliated business arrangement (AfBA) as:

(A)n arrangement in which (A) a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally-related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than 1 percent in a provider of settlement services; and (B) either of such persons directly or indirectly refer such business to that provider or affirmatively influences the selection of that provider. 12 U.S.C. §2602(7).

Furthermore, RESPA defines “associate” as follows:

The term “associate” means one who has one or more of the following relationships with a person in a position to refer settlement business: (A) a spouse, parent or child of such person; (B) a corporation or business entity that controls, is controlled by, or is under common control with such person; (C) an employer, officer, director, partner, franchisor or franchisee of such person; or (D) anyone who has an agreement, arrangement or understanding, with such person, the purpose or substantial effect of which is to enable the person in a position to refer settlement business to benefit financially from the referrals of such business. 12 U.S.C. §2602(8).

Using the definitions contained in Division of Insurance regulation _____ and RESPA, please respond to the following questions. Submit your responses to the Division of Insurance within seven (7) business days of the date of this letter. An officer of the company must attest to the accuracy of the responses and sign the responses. Failure to supply complete, signed responses within the seven (7) day time frame subjects your company to monetary or other penalties pursuant to Division of Insurance regulation _____.

Please note that in accordance with § _____ all working papers, claim files, recorded information and documents disclosed to the Division of Insurance will be given confidential treatment until the informal investigation is concluded. If documentation submitted to the Division of Insurance is additionally protected from disclosure under the exceptions to the _____ Open Records Act of § _____, you must mark each document

as confidential. In addition, you must submit an index of the documents that describes the content of each document, the basis for the claim of confidentiality and the supporting rationale for the claim. This index must accompany the documentation.

Finally, please be advised that you may or may not receive further correspondence from the Division of Insurance concerning AfBAs, regardless of how you respond to the following question:

Is the title entity to which this letter is addressed, or any of its affiliates or associates, an affiliated business arrangement as defined by Division of Insurance regulation _____ or RESPA?

Please mark the appropriate response:

YES NO

As an officer of the company who is authorized to sign on behalf of the company, I do hereby attest to the accuracy of the above responses.

Company Name (as licensed)

Company Officer (print full name)

Title

Signature of Company Officer

Date

Please return this entire letter with complete, signed response to:

_____ *Division of Insurance*

or

Scan and email to:

Thank you for your cooperation and prompt response

Very truly yours,

Not for Distribution

L. Example Title Interrogatory

Affiliated Business Arrangements Interrogatories

The following terms, definitions and law shall apply when answering all questions:

State Law Definitions:

“Affiliate” means _____.

“Affiliated Business Arrangements” means _____.

(See _____ Division of Insurance Regulation _____)

“Settlement producer” means _____.

“Title entity” means _____.

“Title insurance business” means _____.

Federal Law Definitions:

In addition to enforcing state laws, state insurance commissioners are authorized to enforce violations of the federal Real Estate Settlement Procedures Act (RESPA). The following RESPA definitions shall also apply when answering these questions:

“Affiliate Relationship” means the relationship among business entities where one entity has effective control over the other by virtue of a partnership or other agreement or is under common control with the other by a third entity or where an entity is a corporation related to another corporation as parent to subsidiary by an identity of stock ownership. 24 CFR §3500.15(c)(2).

“Affiliated Business Arrangement” means (a) an arrangement in which (A) a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally-related mortgage loan, or an associate of such person, has either an affiliate relationship with or direct or beneficial ownership interest of more than 1 percent in a provider of settlement services; and (B) either of such persons directly or indirectly refers such business to that provider or affirmatively influences the operation of that provider. 12 U.S.C. §2602(7).

“Associate” means one who has one or more of the following relationships with a person in a position to refer settlement business: (A) a spouse, parent or child of such person; (B) a corporation or business entity that controls, is controlled by, or is under common control with such person; (C) an employer, officer, director, partner, franchisor or franchisee of such person; or (D) anyone who has an agreement, arrangement or understanding, with such person, the purpose or substantial effect of which is to enable the person in a position to refer settlement business to benefit financially from the referrals of such business. 12 U.S.C. §2602(8).

“Beneficial ownership” means the effective ownership of an interest in a provider of settlement services or the right to use and control the ownership interest involved even though legal ownership or title may be held in another person's name. 24 CFR §3500.15(c)(3).

Please submit detailed written responses to the following questions along with the requested documentation to the Division of Insurance within twenty (20) calendar days of the date of this letter. An officer of the company must attest to the accuracy of the responses and sign the responses. Failure to supply complete, signed responses within the twenty (20) day time frame subjects your company to monetary or other penalties pursuant to _____ Division of Insurance Regulation _____.

Please note that in accordance with § _____ (cite state law), all working papers, claim files, recorded information and documents disclosed to the Division of Insurance will be given confidential treatment until the informal investigation is concluded. If documentation submitted to the Division of Insurance is additionally protected from disclosure under the exceptions to the _____ Open Records Act, you must mark each document as confidential. In addition, you must submit an index of the documents that describes the content of each document, the basis for the claim of confidentiality and the supporting rationale for the claim. This index must accompany the documentation.

For each of the following questions, please be sure to include all relevant dates and provide full and complete copies of all relevant written documents to the Division of Insurance with your responses.

Identify any and all AfBAs that exist or have existed between and among the title entity to which this letter is addressed and any other title entities or settlement producers. Indicate the dates of creation of all such AfBAs and provide full and complete copies of all written documents relating to affiliation with all such AfBAs to the _____ Division of Insurance with your responses.

If no such AfBAs exist or have existed between and among your title entity and any other title entities or settlement producers, please indicate this fact and you do not need to answer the remaining questions. If you are unsure whether AfBAs exist or have existed, please respond to the following question.

Explain in detail how and when the title entity to which this letter is addressed was initially capitalized and state the net worth for each year from January 1, 2000, to the present, explaining how this figure was derived.

Provide a list of the names, addresses and occupations of all persons who contributed initial capital to the title entity to which this letter is addressed. Include the amount of capital obtained from each source and the respective capitalization ratios.

For each identified person, indicate whether this person took out a loan to cover any part of his/her contribution to the initial capital of the title entity to which this letter is addressed. Indicate the dollar amount and source of the loan.

For each identified person, state whether the title entity to which this letter is addressed has or has ever had any loan agreements with the identified person. Indicate the dates of all such loan agreements and provide full and complete copies of all written documents relating to all such loan agreements to the Division of Insurance with your responses.

Provide full and complete copies of any and all financial pro forma statements prepared by or for the title entity to which this letter is addressed. Indicate the date(s) on which each financial pro forma statement was prepared.

For each financial pro forma statement provided, explain in detail the reason(s) the financial pro forma statement was prepared.

For each financial pro forma statement provided, identify all persons who were involved in the preparation of the financial pro forma statement.

Has the title entity to which this letter is addressed ever owned or been owned, in whole or in part, by one or more settlement producers? If so, respond to the following:

Provide a list of the names, addresses and occupations of any and all settlement producers who have, in whole or in part, owned or been owned by the title entity to which this letter is addressed.

For each identified settlement producer, state the commencement date of the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed. Provide full and complete copies of all written documents relating to the commencement of the ownership arrangement(s).

For each identified settlement producer, state the termination date of the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed. Provide full and complete copies of all written documents relating to the termination of the ownership arrangement(s).

For each identified settlement producer whose ownership arrangement(s) with the title entity to which this letter is addressed was terminated or otherwise extinguished, state the reason(s) for the termination of the ownership arrangement(s) on the identified date(s). Provide full and complete copies of all written documents substantiating the reason(s) for the termination of the ownership arrangement(s).

For each identified settlement producer, indicate whether the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed was adjusted or changed in any way. Indicate the date(s) on which the identified ownership arrangement(s) was adjusted or changed and provide full and complete copies of all written documents relating to any adjustments or changes that were made in the ownership arrangement(s).

For each identified settlement producer whose ownership arrangement(s) with the title entity to which this letter is addressed was adjusted or changed, state the reason(s) for the adjustment or change in the ownership arrangement(s) on the identified date(s). Provide complete copies of any and all written documents substantiating the identified reasons for the adjustments or changes in the ownership arrangement(s).

Provide a complete list of all employees who are currently or have ever been employed by the title entity to which this letter is addressed and indicate their dates of employment.

Respond to the following:

Provide a complete list of the names and job titles of all employees of the title entity to which this letter is addressed.

For each identified employee, identify any and all affiliated or associated businesses for which he/she performs services.

For each identified employee, identify any and all unaffiliated businesses for which he/she performs services.

Explain the proportion of time allotted by each such employee to each affiliated and/or unaffiliated business as a percentage of 100 percent.

Provide a complete list of the names and job titles of all employees who are not full-time employees of the title entity to which this letter is addressed.

For each identified part-time employee, identify any and all affiliated or associated businesses for which he/she performs services.

For each identified part-time employee, identify any and all unaffiliated businesses for which he/she performs services.

Explain the proportion of time allotted by each such employee to each affiliated and/or unaffiliated business as a percentage of 100 percent.

Explain in detail the specific job functions performed by each identified employee.

Explain in detail all services provided by the title entity to which this letter is addressed that have not already been identified as being performed by the identified employees of the title entity to which this letter is addressed.

Identify all employment-related licenses held by each identified person; e.g. title insurance producer, real estate agent, attorney, etc.

Provide full and complete copies of all 1096 (Annual Summary and Transmittal of U.S. Information Returns) forms filed with the IRS by or for the title entity to which this letter is addressed.

Provide full and complete copies of all Unemployment Insurance Quarterly Wage and Tax Reports filed with the State of _____ by or for the title entity to which this letter is addressed.

Provide a list of the names and job titles of all persons not listed above who manage or have ever managed the business affairs of the title entity to which this letter is addressed and indicate their dates of employment.

Respond to the following:

Describe when, how and by whom each identified person is compensated.

Describe the job-related duties performed by each identified person.

Identify any and all affiliated or associated businesses for which each identified person performs or has performed services, and describe those services.

Identify any and all unaffiliated businesses for which each identified person performs or has performed services, and describe those services.

Does the title entity to which this letter is addressed perform any of the following core title services: (1) title searches; (2) title examinations; (3) abstracts; (4) title evaluations to determine insurability; (5) prepare and/or issue title commitments and/or title policies; (6) maintain policy records; (7) receive premiums; (8) closing and settlement services; (9) solicit and negotiate for the issuance of your title commitments; (10) maintain escrow accounts? If so, please respond to the following questions for *each* of the above core title services:

Provide a list of the names and job titles of all persons who have performed each core title service for the title entity to which this letter is addressed from January 1, 2000, to the present.

For each identified person, state the number of each core title service performed per year by that person for the title entity to which this letter is addressed from January 1, 2000, to the present. In addition, state this number as a percentage of the total number of each core title service performed per year by the title entity to which this letter is addressed.

For each identified person, state the name of any and all employers of that person.

For each identified employer, state whether that employer is an affiliated or associated business.

For each identified employer, state whether the employer is a settlement producer and describe how they meet this definition as described in _____ Division of Insurance Regulation _____.

For each identified person, describe in detail the specific activity or activities performed to accomplish the identified core title services.

For each identified person, state the name of the business that appears on each person's paycheck and/or paystub.

Has the title entity to which this letter is addressed ever contracted out any part of its work relating to the performance of title services? If so, please respond to the following:

Provide a list of all persons to whom the title entity to which this letter is addressed has contracted out any part of its work relating to the performance of title services.

Identify all licensed producers who conduct or have conducted title insurance business for the title entity to which this letter is addressed. For each identified licensed producer, indicate the dates that the licensed producer conducted business for your title entity.

Identify all underwriters for whom the title entity to which this letter is addressed is or has been authorized to conduct title insurance business. For each identified underwriter, indicate the dates that your title entity was authorized to conduct title insurance business for the underwriter and provide full and complete copies of all underwriting agreements to the Division of Insurance with your responses.

For each identified person, state whether that person is or was an affiliate or associate of the title entity to which this letter is addressed.

For each identified person, state whether that person is or was a settlement producer, and describe how they meet this definition as described in _____ Division of Insurance Regulation _____.

Identify any and all agreements, written or oral, that the title entity to which this letter is addressed has made relating to the contracting out of any part of its work relating to the performance of title services. Indicate the date on which each agreement was made and provide full and complete copies of all such written agreements.

Identify any and all payments that the title entity to which this letter is addressed has made or received for the contracting out of any part of its work relating to the performance of title services. Indicate the date on which each payment was made and provide full and complete copies of all written documents relating to all such payments.

Has the title entity to which this letter is addressed ever rented office space, facilities, items or services *to or from* any other title entities or settlement producers? If so, respond to the following:

Describe in detail all rented spaces, facilities, items or services. Indicate the date(s) for which each identified space, facility, item or service was rented and provide full and complete copies of all written documents relating to all such rental agreements.

State the amount of rent paid for each identified space, facility, item or service and explain how the identified amount was derived.

State the name of the person(s) from whom each identified space, facility, item or service was rented.

Are any of the persons identified affiliates or associates of the title entity to which this letter is addressed? If so, please identify their affiliations or associations.

Are any of the identified persons settlement producers, as defined in regulation _____? If yes, please identify in what capacity they are settlement producers.

Respond to the following questions concerning (1) affiliated settlement producers; (2) affiliated title entities; (3) unaffiliated settlement producers; and (4) unaffiliated title entities:

Since January 1, 2000, has the title entity to which this letter is addressed attempted to obtain business from one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of all affiliated settlement producers and/or title entities that the title entity to which this letter is addressed has attempted to obtain business from since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, describe in detail any and all marketing or advertising used from January 1, 2000, to the present by the title entity to which this letter is addressed in its attempt to obtain business from the affiliated settlement producer.

For each identified affiliated settlement producer and/or title entities, describe in detail any and all marketing or advertising agreements made with the affiliated settlement producer from January 1, 2000, to the present in its attempt to obtain business from the affiliated settlement producer.

Include all relevant dates and copies of all related documents.

Since January 1, 2000, has the title entity to which this letter is addressed received business from one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of the names and addresses of all affiliated settlement producers and/or title entities that the title entity to which this letter is addressed has received business from since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, indicate both the total number of customers and the total dollar amount of business received from the affiliated settlement producer and/or title entities from January 1, 2000, to the present.

Include all relevant dates and copies of all related documents.

Since January 1, 2000, has the title entity to which this letter is addressed sent business to one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of the names and addresses of all affiliated settlement producers and/or title entities to which the title entity to which this letter is addressed has sent business since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, indicate both the total number of customers and the total dollar amount of business sent to the affiliated settlement producer and/or title entities from January 1, 2000, to the present.

Include all relevant dates and copies of all related documents.

Does a settlement producer who refers business to the title entity to which this letter is addressed receive any services or products at a below market or discounted rate from an affiliate of the entity to which this letter is addressed?

Provide a list of the names and addresses of all settlement producers and affiliates of the entity to which this letter is addressed who receive or give services or products at a below market or discounted rate, as well as identification of which services or products are provided.

Identify all relevant documentation, including documentation consulted to prepare your responses. In addition, you may provide any other documentation, including a position statement, which you feel is relevant to this inquiry.

Please attach the following attestation form to the back of your written responses. Electronic answers will NOT be accepted. Please mail or hand-deliver your written responses and supporting documents to:

Division of Insurance

Please direct any inquiries concerning the above questions to:

Attn:

As an officer of the company to which this letter is addressed, who is authorized to sign on behalf of the company, I do hereby attest to the accuracy of the above responses.

Company Name (as licensed)

Company Address

Company Officer (print full name)

Title

Signature of Company Officer

Date

This letter commences an informal investigation of your company's practices. Your responses to these questions must be postmarked no later than twenty (20) calendar days from the date of this letter to avoid imposition of monetary penalties permitted under _____.

Not for Distribution

M. Sample Checklist

TITLE INSURANCE COMPANY CHECKLIST OF EXAMINATION REQUIREMENTS

All documents, lists and reference materials must be prepared for the period under examination and be ready at the commencement of the examination. If there were any substantive changes during the period under examination—i.e. a rate change or substantive underwriting rule change—your documents must so note and specifically describe how this change was implemented. Whenever possible, please supply the requested information in electronic format.

ADDITIONAL REQUESTS FOR INFORMATION MAY BE MADE BY THE EXAMINERS AT ANY TIME DURING THE EXAMINATION PROCESS.

1. Provide a brief narrative history of its business in general and specifically in _____ (state). Include, at a minimum, the state(s) in which the company is licensed to do business, when the company was licensed in _____ (state), premium writings as of the last day of the examination period for the life of business being examined and any other historically significant detail pertinent to _____ (state). Provide an annual statement for the period(s) under examination.
2. Identify all internal audits performed by the company from the beginning date of the examination period to the present and provide a copy of same.
3. Provide a specimen of each policy and endorsement form in use during the examination period; include samples of manuscripted endorsements when applicable. Prepare a copy of all title insurance rate filings applicable to the period under examination and stamped by the _____ (state) Division of Insurance. Provide a schedule of fees and charges for closing and settlement services, which has been stamped by the _____ (state) Division of Insurance.
4. Provide a copy of the company's antifraud plan, if required by statute.
5. If the company possesses its own title plant, provide a detailed explanation of the company's procedures for the maintenance of this title plant.
6. Provide a copy of the underwriting rules manual, guidelines, memoranda and directives and procedures manuals applicable to (state) business written during the period under examination.
7. Provide a copy of the (state) claims manual, guidelines, memoranda, directives and procedures for the processing of claims during the period under examination.
8. Provide a copy of all promotional and advertising materials utilized by the company or its agents during the period of examination.
9. Provide a list of all promotional and advertising activities—including, but not limited to, products, services, seminars, conventions, gifts and prizes—utilized by the company or its agents during the period of examination. Outline any incentive programs available to realtors, lenders, builders, et al., provided by the company or its agents during the period of examination.
10. Provide a list of policies issued during the period under examination. Include at least the policy number, effective date, named insured, named lender/mortgagee, amount of coverage and premium.
11. Provide a list of claims made during the period under examination. Include at least the claim number, named insured, date claim made and status; i.e., open/amount reserved and closed/amount paid.

12. Provide a list of all affiliated entities.
13. Provide a list of all disbursements pertaining to advertising, sales and marketing and promotional activities.

Not for Distribution

Not for Distribution

Chapter 19—Conducting the Life and Annuity Examination

IMPORTANT NOTE:

The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.

This chapter provides a format for conducting life insurance and annuity company examinations. Procedures for conducting property/casualty insurance company examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of life insurance/annuity operations may involve any review of one or a combination of the following business areas:

- A. Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Service
- F. Underwriting and Rating
- G. Claims (Several specialized checklists are available in Sections H–J of this chapter.)
- H. Checklist for Marketing and Sales Standard #1
- I. Checklist for Marketing and Sales Standard #3
- J. Checklist for Marketing and Sales Standard #8

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

IIPRC-Approved Products

When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (IIPRC) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The IIPRC website is www.insurancecompact.org and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the compact (including the uniform standards).

A. Operations/Management

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

Not for Distribution

**STANDARDS
OPERATIONS/MANAGEMENT**

Standard 1
The regulated entity files all certifications with the insurance department, as required by statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Insurance department records of certifications made by the regulated entity

Others Reviewed

- _____
- _____

NAIC Model References

- Life Insurance Illustrations Model Regulation (#582)*
- Advertisements of Life Insurance and Annuities Model Regulation (#570)*

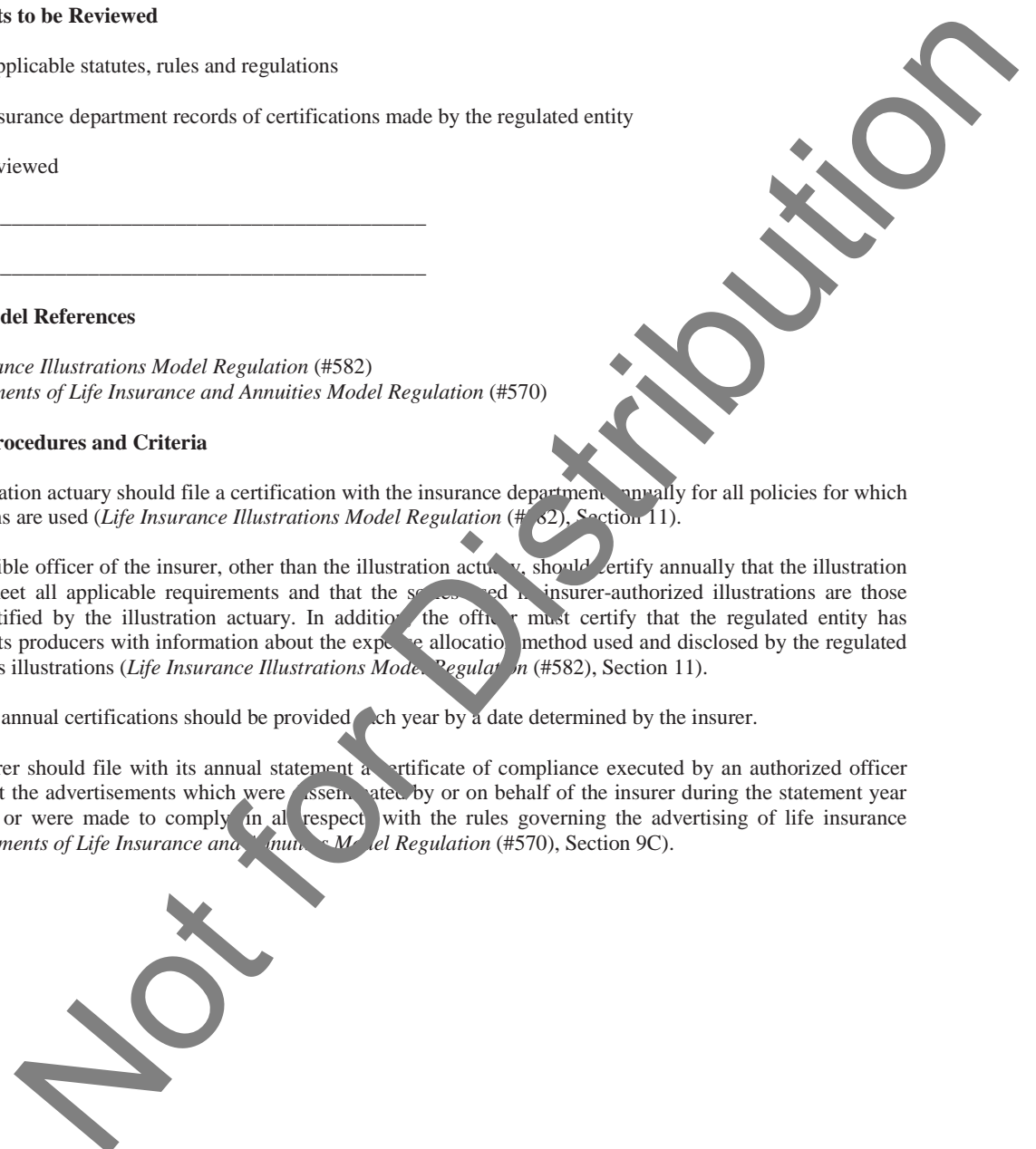
Review Procedures and Criteria

The illustration actuary should file a certification with the insurance department annually for all policies for which illustrations are used (*Life Insurance Illustrations Model Regulation (#582), Section 11*).

A responsible officer of the insurer, other than the illustration actuary, should certify annually that the illustration formats meet all applicable requirements and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary. In addition, the officer must certify that the regulated entity has provided its producers with information about the expense allocation method used and disclosed by the regulated entity in its illustrations (*Life Insurance Illustrations Model Regulation (#582), Section 11*).

Note: The annual certifications should be provided each year by a date determined by the insurer.

Each insurer should file with its annual statement a certificate of compliance executed by an authorized officer stating that the advertisements which were disseminated by or on behalf of the insurer during the statement year complied, or were made to comply in all respects with the rules governing the advertising of life insurance (*Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 9C*).



B. Complaint Handling

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the company about its product(s). It is not typically based on sampling techniques, but it can be. The areas to be considered in this kind of review include all written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every insurance company is required to have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for and authorized by the insurer are the responsibility of the insurer.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a company's Internet advertisements, it is important to also review the safeguards implemented by the company.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

There may be special requirements for applicants age 60 or older. The examiner should refer to statutes, rules and regulations to determine what requirements apply.

In addition to reviewing advertising, examiners should be aware that several NAIC models impose additional duties on regulated entities which go beyond the delivery of accurate information to consumers. If an insurance product is involved and a regulated entity, producer or a registered representative makes a recommendation regarding that insurance product, both insurance suitability laws and insurance replacement laws may apply to the transaction. A person who is advising a consumer about an insurance product, even if it is to replace it with a non-insurance product, must hold an insurance license. An insurance producer who does not hold a license as a registered representative should not give advice or recommendations about securities products.

The *Life Insurance and Annuities Replacement Model Regulation* (#613) was thoroughly updated and expanded in 1998. The new model applies to annuities and life insurance products and requires delivery of certain notices if the proposed purchaser has any existing life insurance or annuity products. Under the new model, insurers are required to have systems in place to monitor compliance with replacement procedures. Under the old model, which is still in place in a number of states, producers generally make a

decision at the point of sale as to whether the transaction involves a replacement. Under either model, market regulators should review insurer systems and should also sample transactions that are not reported as replacements to verify that the insurer's system is effective in properly identifying replacement transactions.

Historically, replacement ratios were quite low. This was due in part to the fact that the definition of a replacement under the "old" *Life Insurance and Annuities Replacement Model Regulation* (#613) only applied to life insurance products and external replacements. Under the prior model, either the producer or the insurer made a decision as to whether the transaction involved a "replacement."

The new model covers internal and external replacement and, if any funds for the new product come from an existing product, the transaction is a replacement and must be reported as such. There are several limited exceptions. Another factor in the increase in replacement activity is the tendency of consumers to move funds between investment and insurance products when the stock market fluctuates. In such transactions, an analysis should be performed to determine whether the insurer has systems in place to supervise its producers. Regulators should review transactions involving the sale or replacement of variable products involving the insurer and its products to verify that a system is in place to confirm that its producers are properly licensed. In the context of the examination, an examiner or analyst is only responsible for reviewing the conduct of insurance producers and conduct which requires an insurance producer license.

The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2006. Previously, this model was known as the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to "senior." This model has been adopted in some states in various forms. Model #275 was revised in 2010 to include new provisions regarding insurer supervision and monitoring of annuity recommendations and continuing education and training requirements for producers. While the previous version of the model imposed a duty on insurers and producers, or the entities they subcontract with, the revised model places the responsibility of supervision and monitoring on the insurer. The language of the revised model provides that an insurer's issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued. The model was also updated to include a revised definition of annuity, a definition of "replacement" and provisions expanding the scope of the model to include replacement of annuity products.

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in the *Unfair Trade Practices Act* (#880) and the *Annuity Disclosure Model Regulation* (#145).

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A continuum approach, such as use of a desk audit, may also be appropriate. Sampling enables examiners to evaluate whether the established processes have been clearly communicated and implemented rather than to function as a means to "second-guess" each individual suitability determination. Company programs for reviewing suitability may vary widely and should not be considered a "once-size-fits-all" approach. Annuity products can be designed or tailored to serve a wide variety of clientele and customer objectives.

Some insurers may outsource the administration of their suitability review, while maintaining ultimate responsibility for the outcomes. It may be instructive for examiners to become familiar with the structure and practices of commonly used services that perform suitability reviews. Examiners may also want to become familiar with vendor-owned services commonly used by insurers to document their suitability reviews.

The NAIC *Stranger-Originated Annuity Transactions Sample Bulletin* was adopted by the NAIC in October 2011. The bulletin was developed to address stranger-originated annuity transactions (STOA). Similar to stranger-originated life insurance transactions (STOLI), STOA transactions provide annuity contracts for the benefit of investors.

In STOAs, insurance producers and/or investors offer an individual, who is usually a “stranger” to the producer and/or investor, a nominal fee for the use of the individual’s identity as the annuitant in an investment-oriented annuity.

Typically, individuals targeted to serve as annuitants are in extremely poor health and are not expected to live beyond the first year of the policy. In order to find individuals who meet the aforementioned criteria, producers and/or investors have been known to take out advertisements in papers as well as solicit individuals residing in nursing homes or hospice facilities.

Once an individual has agreed to the set of conditions posed, the producer will complete the annuity application, ensuring that particular riders, such as a bonus rider or a guaranteed minimum death benefit, are in place to maximize the rate of return for those financing the transaction. Depending on the number of companies the producer represents and the commission policies in effect, the producer may seek to use multiple policies from various companies.

To avoid added scrutiny of the policy or detection of the scheme, producers and/or investors involved in STOAs will often take precautions to ensure that the dollar amount of the annuity falls below specific underwriting guidelines, while other annuities above these dollar amounts are subject to more stringent underwriting. After the annuity is issued, then the investor will significantly increase their investment in the annuity. A trust or an organization may additionally be named as beneficiary of the annuity in order to hide the true identity of those who will benefit from the annuitant’s death.

As the financial implications of STOA transactions could be detrimental to both companies and consumers, the adopted bulletin recommends that insurance companies take certain actions to mitigate their exposure to STOA transactions, which are outlined in the NAIC *Stranger-Originated Annuity Transactions Sample Bulletin*.

It is appropriate for the examiner to remind annuity insurers of this bulletin and to ask if the insurer has considered this bulletin when implementing compliance and/or enterprise risk management procedures.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

**STANDARDS
MARKETING AND SALES**

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials
- _____ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials
- _____ Producers' own advertising and sales materials

Others Reviewed

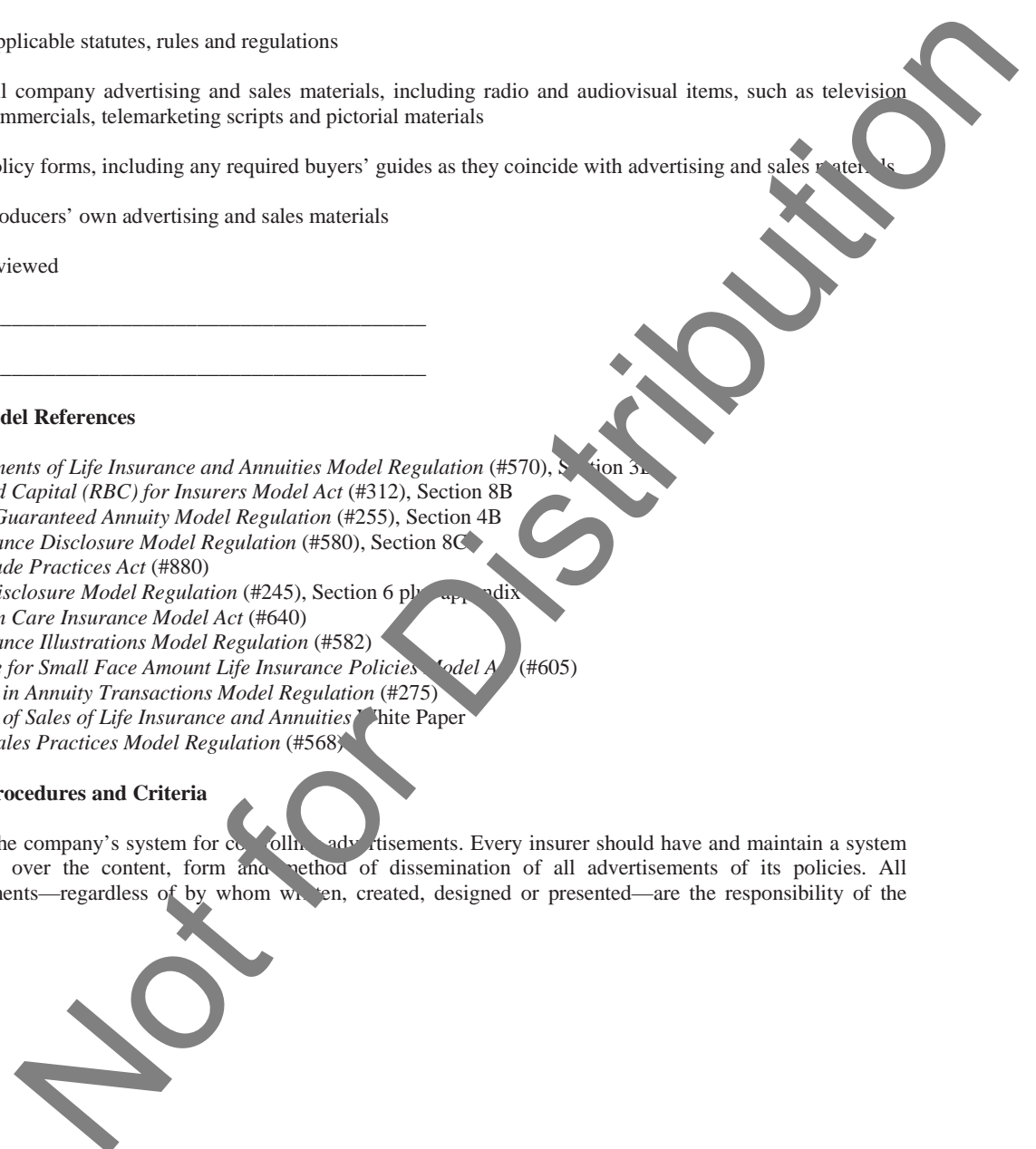
- _____
- _____

NAIC Model References

- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3A*
- Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B*
- Modified Guaranteed Annuity Model Regulation (#255), Section 4B*
- Life Insurance Disclosure Model Regulation (#580), Section 8C*
- Unfair Trade Practices Act (#880)*
- Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*
- Long-Term Care Insurance Model Act (#640)*
- Life Insurance Illustrations Model Regulation (#582)*
- Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)*
- Suitability in Annuity Transactions Model Regulation (#275)*
- Suitability of Sales of Life Insurance and Annuities White Paper*
- Military Sales Practices Model Regulation (#568)*

Review Procedures and Criteria

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements—regardless of by whom written, created, designed or presented—are the responsibility of the insurer.



Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either 4 years or until the filing of the next regular report on examination of the company, whichever is the longer period of time.

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead a prospective buyer to believe that he/she is purchasing an investment or savings plan. Problematic terminology may include such terms as investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required" if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. Enrollment periods may not be described as terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised, because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate the fact, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in an advertisement;

- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance³⁰ shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to a policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed;
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact, and any proprietary relationship or payment for the testimonial must be disclosed; and
- The sales material for any modified guaranteed life insurance must clearly illustrate there can be both upward and downward adjustments to nonforfeiture benefits, due to the application of the market value adjustment formula.

Determine if the company approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as a life insurance agent. Improper terms may include financial planner, investment advisor, financial consultant or financial counseling, if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Determine if the company has procedures in place to monitor the use of senior-specific certifications or professional designations used by producers that solicit for the company.

³⁰ "Modified Guaranteed Life Insurance Policy" means an individual policy of life insurance, the underlying assets of which are held in a separate account and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period or periods when the policyholder can surrender the policy.

Determine if the company allows its life and annuity products to be marketed to the military. If so, review the company procedures to ensure that the procedures are in compliance with all applicable laws and regulations regarding sales to military personnel.

Determine if analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments are complete and accurate.

Determine if the advertisement states or implies in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or an improper practice.

If nonforfeiture values are shown in any advertisement, ensure the values are shown, either for the entire amount of the basic life policy death benefit, or for each \$1,000 of initial death benefit.

Review the use of the words/phrases "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

If an advertisement represents a pure endowment benefit as a "profit" or "return" on the premium paid, rather than as a policy benefit for which a specified premium is paid, this is deemed deceptive and misleading and is prohibited.

Determine that company procedures and materials relative to long-term care products comply with "right to free look" requirements.

Review the company and producer's website with the following questions in mind:

- Does the website disclose who is selling, advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism, including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run a search with the company's name;
- Review the company's home page;
- Identify all lines of business referenced on the company's home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the company's procedures related to producers' advertising on the Internet and ensure the company requires prior approval of the producer pages, if the company name is used.

A summary of special requirements is available for the following:

- Products sold using enrollment periods;
- Direct response products;
- Graded or modified benefit policies;
- Policies with premium changes;
- Policies with non-guaranteed elements;
- Products sold to students;
- Individual deferred annuity products or deposit funds; and
- Combination life insurance and annuity products.

Review advertising carefully for use of the term “guarantee.” Verify that the scope and duration of any guarantee is accurately described. Determine that the regulated entity has accurately portrayed non-guaranteed elements. Verify that complete information is provided regarding the scope and duration of guarantees.

Review advertising carefully for use of the term “bonus.” Review the functioning of any such bonus payments and verify that the information provided is accurate in describing the amount and the conditions for payment, retention or recoupment of the bonus.

Review advertising carefully for explanations of surrender periods and charges. Review the functioning of any such surrender charge and, in particular, how the charge is calculated in death claims. Verify that the information provided regarding the amount of the charge and the conditions for assessment are accurate.

Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options.

Review the methods used by the regulated entity, annually or otherwise, to convey ongoing information about policy/contract values and options available to the consumer to change interest crediting methods or exercise other policy/contract features in future terms.

**STANDARDS
MARKETING AND SALES**

Standard 2

The insurer's rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Loan and surrender files

Others Reviewed

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)

Suitability in Annuity Transactions Model Regulation (#675)

Suitability of Sales of Life Insurance and Annuities White Paper

Military Sales Practices Model Regulation (#155)

Review Procedures and Criteria

Review loan and surrender files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm receipt of sales material or required statement. Copies of sales material other than regulator entity-approved sales material, if permitted, must also be in the file.

Review replacement disclosure forms for completeness and signatures, as required.

If the applicable state's definition of "recommendation" encompasses replacements, review policy/underwriting files to verify that the producer's treatment of and classification of replacements is in compliance with the applicable state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of

reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that producer written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to determine that prior to the execution or replacement of an annuity resulting from a recommendation, an insurance producer has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

**STANDARDS
MARKETING AND SALES**

Standard 3
The insurer's rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Replacement register/Data
- _____ Policy/Underwriting files
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Agency sales/lapse records
- _____ Regulated entity systems manual

Others Reviewed

NAIC Model References

- Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)*
- Suitability in Annuity Transactions Model Regulation (#275)*
- Suitability of Sales of Life Insurance and Annuities White Paper*
- Military Sales Practices Model Regulation (#568)*
- Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin*

Review Procedures and Criteria

Determine if the regulated entity has advised its producers of its replacement policy.

Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.

Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.

Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.

Determine if the regulated entity has issued letters in a timely manner to policyholders, advising of the effects of loans and other disbursements on policy values.

Review policy/underwriting files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the regulated entity provides required credit for suicide and contestability periods on replacements.

If the applicable state's definition of "recommendation" encompasses replacements, review regulated entity procedures to verify that the regulated entity's treatment of and classification of replacements is in compliance with the state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that regulated entity written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and rider and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information.
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to ensure that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurer, where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

Note: All documents necessary to review the appropriateness of a sale may not be in the insurer's possession. It may be necessary to give the insurer additional lead time to obtain the documents from a producer, a third party reviewer or other entity.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

**STANDARDS
MARKETING AND SALES**

Standard 4

An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ Underwriting file

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582)

Universal Life Insurance Model Regulation (#585)

Variable Life Insurance Model Regulation (#270)

Life Insurance Disclosure Model Regulation (#580)

Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)

Review Procedures and Criteria

Note: Some policies may be deemed to be sold without an illustration.

If a jurisdiction continues to require surrender cost indices, ensure they are appropriately disclosed in the Statement of Policy Cost and Benefit.

Ensure that the insurer, its producers or authorized representatives do not:

- Represent the policy as anything other than a life insurance policy;
- Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
- State or imply that the payment or amount of non-guaranteed elements is guaranteed;
- Use an illustration that does not comply with statutes;
- Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
- Provide an applicant with an incomplete illustration;
- Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

- Use the terms “vanish,” “vanishing premium” or a similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is “lapse-supported”; or
- Use an illustration that is not “self-supporting.”

Ensure that the insurer has a documented, reasonable methodology for the manner in which it determines its index-crediting strategy. Verify that the insurer has a system which monitors the interest rates used by its insurance producers in illustrations for compliance with the insurer’s credited interest rates.

Ensure that the insurer has established requirements for producers to provide universal life applicants with a “Statement of Policy Information.” The statement should substantially follow the format set forth in the *Universal Life Insurance Model Regulation* (#585). Insurers that use direct response solicitation of universal life insurance products should provide such a statement at the time of policy delivery.

Ensure illustrations are retained in accordance with statutes, rules and regulations. A copy of the basic illustration and a revised basic illustration (if any) signed, as applicable, or a certification that either no illustration was used or that the policy was applied for other than as illustrated, should be retained until 3 years after the policy is no longer in force.

Determine if the illustration is submitted to the regulated entity as required.

- If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of the illustration must be submitted to the insurer at the time of policy application. A copy must also be provided to the applicant.
- If the policy is issued other than as applied for:
 - A revised basic illustration conforming to the policy as issued should be sent with the policy;
 - The revised illustration should be labeled “Revised Illustration”;
 - The illustration should be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered; and
 - A copy must be provided to the insurer and the policyowner.
- If no illustration is used by an insurance producer or other authorized representative, or if the policy is applied for other than as illustrated:
 - The producer or representative must certify to that effect in writing on a form provided by the insurer;
 - The applicant should acknowledge (on the same form) that no illustration conforming to the policy applied for was provided and also acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than the time of policy delivery; and
 - The form must be submitted to the insurer at the time of application.
- If the basic or revised illustration is sent by mail from the insurer:
 - It should include instructions for the applicant/policyowner to sign the duplicate copy of the numeric summary page and return the signed copy; and
 - An insurer’s obligation will be satisfied if it demonstrates a diligent effort to obtain the signature. Diligent effort includes the mailing of a self-addressed postage-prepaid envelope with instructions for the return of the signed page.

Ensure a signed copy of the basic illustration and revised basic illustration, if any, or a certification that either no illustration was used or that the policy was applied for other than as illustrated is retained until 3 years after the policy is no longer in force. (A copy does not have to be retained if the policy is not issued.)

A summary of illustration requirements is available with special requirements for:

- Basic illustrations;
- Supplemental illustrations;
- Interest-indexed universal life;
- Universal life; and
- Variable life.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 5

The insurer has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

NAIC Model References

Variable Life Insurance Model Regulation (#270), Section 5.1
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Stranger-Originated Annuity Transactions (SOAT) NAIC Sample Bulletin

Review Procedures and Criteria

Determine if multiple sales of the same product have been made to individuals. Identify and review a random sample of policyholders for which multiple policies exist.

Determine if underwriting guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine whether marketing materials encourage multiple issues of policies; e.g., use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the regulated entity has a system to discourage “over-insurance” of policyholders as defined by the regulated entity’s underwriting requirements.

For annuity products, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. The standards should specify that an insurer’s issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their jurisdiction.

Inquire if the company has detected any STOA transactions and if so, the examiner may want to determine if there were any suitability issues surrounding the sale of the STOA. If there were suitability issues, the examiner may want to inquire as to what actions were taken by the company to prevent further suitability issues and if the company took any action against the producer.

Note: Sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. Examiners should be mindful of the fact that both variable annuity sales and variable life sales are typically sold using FINRA requirements.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions NAIC Sample Bulletin* because sales of stranger-originated annuities may result in adverse suitability situations.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 6
Preneed funeral contracts or prearrangement disclosures and advertisements are in compliance with statutes, rules and regulations.

Apply to: All preneed products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Disclosure Model Regulation (#580), Section 7
Advertisements of Life Insurance and Annuities Model Regulation (#510), Section 5Y

Review Procedures and Criteria

Ensure there is evidence that the disclosures have been made in accordance with statutes, rules and regulations.

A summary of special requirements for preneed disclosures is available.

Advertisements for a preneed funeral contract or prearrangement that is funded or is to be funded by a life insurance policy or annuity contract should disclose the following:

- The fact that a life insurance or annuity contract is involved or being used to fund a prearrangement; and
- The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise services, the administrator and any other person.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 7
The regulated entity’s policy forms provide required disclosure material regarding accelerated benefit provisions.

Apply to: All individual and group life insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Claim procedure/underwriting manuals

_____ Claim files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

The terminology “accelerated benefit” shall be included in the description title.

Disclosure is required that receipt of accelerated benefits may be a taxable event, and assistance should be sought from a personal tax advisor.

Disclosure providing description of accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant.

Products marketed under this regulation shall not be described as long-term care insurance or as providing long-term care benefits.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 8
Policy and contract application forms used by depository institutions provide required disclosure material regarding insurance sales.

Apply to: All individual and group life insurers and depository institutions

All covered persons³¹ as defined by the Gramm-Leach-Bliley Act. This includes any person who sells, solicits, advertises or offers an insurance product or annuity to a consumer at an office of the depository institution or on behalf of a depository institution.

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting manuals

_____ Policy and contract application forms

_____ Policy files

Others Reviewed

NAIC Model References

Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to Meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act

Review Procedures and Criteria

One notice provides the written disclosures that must be given to a consumer in connection with an initial purchase of an insurance or annuity product that is unrelated to an extension of credit.

The other notice provides the written disclosures that must be given to a consumer in connection with the solicitation, offer or sale of an insurance or annuity product that is related to an extension of credit.

For notices unrelated to an extension of credit: (1) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (2) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank or any affiliate; and (3) that there is the potential for investment risk, including the possible loss of value. (Note: The last requirement may not be required for all products.)

³¹ Please refer to the bulletin for a detailed explanation of what constitutes a covered person.

For notices related to an extension of credit (which includes solicited, offered or sold): (1) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer also purchasing an insurance product or annuity from the bank or the bank's affiliate; (2) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer not obtaining an insurance product or annuity from an entity not affiliated with the bank. In addition, (3) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (4) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or any affiliate; and (5) that there is the potential for investment risk, including the possible loss of value. Note: The last requirement may not be required for all products.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 9

Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Other relevant files

_____ New business reports

_____ Policy/Underwriting files

Others Reviewed

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

If the insurer has a business rule that calls for completion of a fact-finder or similar disclosure document, review policy files to determine if forms have been completed regarding suitability.

Review policy files. Copies of sales material other than insurer-approved materials, if permitted, must also be in the file or made available to the regulator upon request.

Examine for effectiveness of the insurer's system of verifying that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Examine for effectiveness the insurer's system for review or oversight of annuity transactions that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A customer refused to provide relevant suitability information and the annuity transaction was not recommended; or;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to verify that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another transaction or series of transactions, the insurance producer, or the insurer, where no producer is involved, had reasonable grounds for believing that the product was suitable on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting/other files to verify that an insurance producer has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 10
Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy/Underwriting files
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Complaint log
- _____ Agency sales/lapse records
- _____ Regulated entity’s systems manual
- _____ Regulated entity’s producer training materials

Others Reviewed

- _____
- _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

Determine if the insurer has advised the producer of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer’s product-specific standards, policy and procedures regarding verification of suitability of annuity products.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer procedures for verifying producer supervision and compliance with requirements on suitability.

Examine for effectiveness the insurer's system of monitoring and reviewing that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245)).
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
 - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
 - The consumer would benefit from product enhancements and improvements; and
 - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Monitor and determine that an insurance producer or, where no insurance producer is involved, the responsible insurer representative, has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

Monitor and determine that prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation an insurance producer or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

Examine for effectiveness the insurer's system of recording or monitoring whether an insurance producer or an insurer, proceeded with an annuity transaction that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A consumer refused to provide relevant suitability information and the annuity transaction was not recommended;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Verify that the insurer has established a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with applicable state suitability statutes, rules and regulations, including, but not limited to the following criteria:

- Examine the regulated entity's suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- Review the regulated entity's producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;
- Examine the regulated entity's producer training materials to ensure that the insurer provides adequate product-specific training and training materials which fully explain all material features of its annuity products to its insurance producers;
- Review the regulated entity's suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation, prior to issuance of an annuity, that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer's review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer's review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by applying sampling procedures, or by confirming suitability information after issuance or delivery of the annuity; and
- Verify that the insurer annually provides a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

An insurer may contract for performance of one or more functions (including maintenance of procedures) under the criteria set forth in Section 6F(1) of the *Suitability in Annuity Transactions Model Regulation* (#275). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of Model #275 regardless of whether the insurer contracts for performance of a function and regardless of the insurer’s compliance with subparagraph (b) of Section 6F(2) of Model #275.

An insurer’s supervision system as described above should include supervision of contractual performance by third parties. This includes, but is not limited to, the following criteria:

- Verify that the insurer is monitoring and, as appropriate, conducting audits to assure that contracted function(s) are properly performed; and
- Review insurer procedures to verify that the insurer is annually obtaining a certification from a senior manager who has responsibility for the contracted function(s) that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

Review agency files and related documentation to verify that insurance producers do not dissuade, or attempt to dissuade, a consumer from:

- Truthfully responding to an insurer’s request for confirmation of suitability information;
- Filing a complaint; or
- Cooperating with the investigation of a complaint.

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner’s ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state’s statutes, rules and regulations.

Review the insurer’s system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer’s business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Review insurer records of corrective action taken in mitigation of apparent violations of suitability standards for sales directly by the insurer and by any insurance producers who are acting as agents for the entity.

Determine whether the insurer has elected to maintain records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions, or if the insurer has elected to require its producers to maintain these records. Verify that such a system is in place and is monitored by the insurer.

Note: Review the insurer's denials for suitability reasons. Review underwriting data to determine if an annuity was subsequently issued to the client. If an annuity was subsequently issued, the examiner may want select a sampling to ensure the sale was appropriate.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 11

The insurer has procedures in place to educate and monitor compliance with insurer-specific education and training requirements and with applicable statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity producer education/training files
- _____ Producer continuing education files
- _____ Producer new business/replacement log
- _____ Regulated entity producer training materials
- _____ Regulated entity standards for product training
- _____ Regulated entity policies and procedures
- _____ Complaint logs, complaint files and producer complaint logs/producer investigation files, if applicable

Others Reviewed

- _____
- _____

NAIC Model References

- Suitability in Annuity Transactions Model Regulation (#275)*
- Unfair Trade Practices Act (#880)*
- Producer Licensing Model Act (#218)*

Review Procedure and Criteria

Review regulated entity policies and procedures to ensure that the regulated entity has adequate procedures in place to provide training, including product-specific training that is appropriate to the specific product being sold. Review the regulated entity's procedures to inform producers of the regulated entity's standards for annuity product training and of applicable state statutes, rules or regulations regarding the solicitation, recommendation and sale of the annuity product.

Monitor and determine if the insurer has taken any actions against producers who lack adequate product knowledge and if so, was the action appropriate for the circumstances.

Compare data in producer continuing education files to applicable data in state insurance department producer continuing education records to monitor and determine that any insurance producer who engages in the sale of annuity products has met the one-time 4 hour credit training course in accordance with applicable state statutes, rules and regulations.

Determine that the regulated entity has adequate procedures in place to verify that a producer has completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the producer to sell an annuity product for that insurer.

Review content of producer training materials for compliance with applicable state statutes, rules and regulations regarding solicitation, recommendation and sales of annuity products. Determine if the insurer product-specific training materials are appropriate and accurately reflect the features of the specific annuity.

Review complaint logs, any applicable complaint files and any producer investigation files for allegations of unsuitable, improper or misleading sales.

Automation Tip:

Examiners should request underwriting, policy and claim data using the NAIC standardized data request for a period of three to five years. The expanded time frame allows the examiner to trend sales practices over a number of years.

Examiners should then use a program such as ACL to review underwriting data, product data and claim data for possible unsuitable sales.

Examiners can review and trend this data for:

- Sales from producers who were the subject of complaints and/or investigations that alleged unsuitable sales, misrepresentations, or improper sales activities;
- Sales of producers who had a materially large number of replacements or exchanges;
- Sales of producers who sell a materially large number of annuities that pay the highest commissions and have the longest surrender period or have the highest surrender amounts;
- Sales of producers who have had previous sales denied based on suitability reasons;
- sales of producers who had disciplinary actions – Financial Industry Regulatory Authority (FINRA) and state disciplinary actions;
- Sales from producers who have sold a materially large number of deferred annuities to consumers over age 75;
- Withdrawals from products where the consumer incurred a penalty (a contractual penalty or IRS tax penalty) for taking the withdrawal within two years of purchase of the annuity; and
- Sales from producers who have sold multiple annuities to the same consumer.

Examiners should realize that trending data is not a definitive means to identify unsuitable sales. Further review of the individual transaction will be necessary to determine suitability.

Examiners should cross-reference new business data and data in the replacement logs with the regulated entity's producer education/training files to ensure that prior to a sale of an annuity product the insurance producer has been trained in the regulated entity's standards for the specific annuity product and trained in the applicable state statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

**STANDARDS
MARKETING AND SALES**

Standard 12

The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Agency sales/lapse records
- _____ Systems manuals
- _____ Producer training materials
- _____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

- _____
- _____

NAIC Model References

- Suitability in Annuity Transactions Model Regulation (#275)*
- Unfair Trade Practices Act (#880)*
- Producer Licensing Model Act (#218)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

Review Procedure and Criteria

Contact other regulators that may have conducted a recent review of the insurer's training standards.

Review regulated entity's records to confirm that it verifies producers complete a one-time 4 credit hour general annuity training course prior to soliciting the sale of an annuity product.

Determine if the insurer product-specific training materials are appropriate and accurately reflect the specific annuity being recommended. Review regulated entity's records to determine if, when and how product-specific training occurred prior to a producer recommending an annuity.

Note: Testing is not a requirement of the *Suitability in Annuity Transactions Model Regulation* (#275). Assessing compliance with this standard may require the examiner to access compliance with many facets of Model #275. The insurance producer training requirement of the model regulation requires that producers not solicit the sale of an annuity product unless the producer has adequate product knowledge to recommend the annuity. It is the insurer's responsibility to establish standards for product specific training for its producers. Insurers must also establish reasonable procedures to require its producers to have adequate product knowledge prior to the producer recommending an annuity.

If the examiners believe an unsuitable sale may have occurred, the examiner may need to determine the cause of the unsuitable sale.

Examiners will need to assess the product-specific training materials and determine if the materials were appropriate for the specific product. According to *Suitability in Annuity Transactions Model Regulation* (#275), insurance producers may rely on insurer-provided product-specific training materials and standards to comply with Section 7 of Model #275.

Examiners will also need to assess the procedures the insurer established to require its producers have an adequate product knowledge before the producer recommends the annuity. Specifically the examiner will need to determine if the training for the specific product took place before the recommendation of an annuity, how the producer was trained and if the training was reasonably designed to require the producer to have adequate product knowledge prior to the sale.

Based upon the complexity of the product being offered, there is an expectation that the content of training materials and the way the training occurs may differ.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 13

The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All fixed-index annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy/Underwriting file
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Complaint log
- _____ Agency sales/lapse records
- _____ Systems manuals
- _____ Producer training materials
- _____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

- _____
- _____

NAIC Model References

- Unfair Trade Practices Act (#880)*
- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Annuity Disclosure Model Regulation (#245), Section 6 plus appendix*
- Suitability in Annuity Transactions Model Regulation (#275)*
- Suitability of Sales of Life Insurance and Annuities White Paper*

Review Procedures and Criteria

- Review policy files to determine that required records are retained for required time frames.
- Examine procedures for verifying producer compliance with established policies and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper crediting and computation of surrender charges at death.

Review commission structure and note any differences between indexed and non-indexed annuity products. If it appears that the difference may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 14

The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All index life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Policy/Underwriting file
- _____ Agency correspondence file/Agency bulletins
- _____ Agency procedural manual
- _____ Claim files
- _____ Complaint log
- _____ Agency sales/lapse records
- _____ Regulated entity's systems manual
- _____ Regulated entity's producer training materials
- _____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

NAIC Model References

- Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B*
- Life Insurance Disclosure Model Regulation (#580), Section 8C*
- Unfair Trade Practices Act (#880)*
- Life Insurance Justification Model Regulation (#582)*

Review Procedures and Criteria

Review policy files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with the regulated entity's policy and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper interest crediting and computation of death claims.

Review commission structure and note any differences between indexed and non-indexed life insurance products. If it appears that differences noted may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

Not for Distribution

**STANDARDS
MARKETING AND SALES**

Standard 15

The insurer's underwriting requirements and guidelines pertaining to travel are in compliance with applicable statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Life insurance applications and related disclosure and consent forms
- _____ Related questionnaires for applicants
- _____ Underwriting guidelines and field underwriting guidelines for products
- _____ Review contracts with reinsurers of life insurance and all applicable guidelines from the reinsurer
- _____ Regulated entity's guidelines regarding lawful travel

Others Reviewed

- _____
- _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure the regulated entity does not discriminate against individuals by using an individual's past lawful travel to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure the regulated entity does not discriminate against individuals by using an individual's future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual, unless:

- The risk of loss for individuals who travel to a specified destination at a specific time is reasonably anticipated to be greater than if the individuals did not travel to that destination at the time; and
- The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

Examples of the exceptions outlined above are future lawful travel plans to areas where the Centers for Disease Control and Prevention (CDC) have issued a highest level alert, including a recommendation for non-essential travel or to areas where there is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

Review the life insurers' and reinsurers' underwriting guidelines for guidelines pertaining to past and future travel.

Review applications and any related questionnaires for questions related to past and future travel plans.

Review contracts with applicable reinsurers for content regarding past and future lawful travel plans.

Not for Distribution

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

Not for Distribution

**STANDARDS
POLICYHOLDER SERVICE**

Standard 1
Reinstatement is applied consistently and in accordance with policy provisions.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Notice of reinstatement

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine that notices were sent out in a timely manner.

Verify that reinstatement provisions were applied consistently and in a non-discriminatory manner.

Reinstatements should be applied per policy provisions.

Not for Distribution

**STANDARDS
POLICYHOLDER SERVICE**

Standard 2
Nonforfeiture options are communicated to the policyholder and contractholder and correctly applied in accordance with the policy contract.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ Underwriting file

_____ Policy and contract history file

_____ Regulated entity's procedures manual

Others Reviewed

NAIC Model References

Standard Nonforfeiture Law for Life Insurance (#808)

NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables (#311)

Life Insurance Disclosure Model Regulation (#580)

Variable Life Insurance Model Regulation (#200)

Model Policy Loan Interest Rate Bill (#590)

Standard Nonforfeiture Law for Individual Deferred Annuities (#805)

Annuity Nonforfeiture Model Regulation (#306)

Review Procedures and Criteria

Determine if the correct policy option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to the nonforfeiture values, refer to statutes, rules and regulations regarding the calculation of nonforfeiture values for details on calculating the values.

Review the regulated entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Cash Surrender Values

- Review the issue date of the policy to determine whether the policy is mature enough to provide surrender values (usually by the end of the second or third year);
- Calculate the service time to process the surrender by subtracting the date the request was received from the date the surrender check was mailed (should be within 60 days);
- Review the calculation of the net cash value to determine the appropriate surrender value (include any outstanding policy loans, policy loan interest and policy dividends);
- Compare calculated surrender value with illustration surrender value. Confirm that any variance can be explained and is in accordance with policy provisions (i.e., interest rates, surrender charges, policy fees);
- Confirm with the regulated entity that there is an audit procedure in place to verify the calculation of surrender values (they are usually calculated systematically);
- Review cash surrender check for accuracy, including mail date; and
- Review returned mail procedures.

Extended Term Insurance (ETI)

- Determine if the ETI was automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Confirm the regulated entity's calculated policy value by taking the face value of the policy, adjusted for any indebtedness, such as policy loans or paid-up additions;
- Check to make sure the regulated entity issued the correct amount of term insurance; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Reduced Paid-Up (RPU)

- Determine how the RPU option came about, whether automatic at lapse or policyowner requested;
- Review the policy's contract language for content;
- Review the calculation of net cash value (including years the policy was in force) to verify the amount used as the net single premium to purchase the paid-up life insurance. Verify that the paid-up insurance is of the same type of policy as the original policy; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Additional Paid-Up

- Review the policy for content and time schedule for allowed increases in coverage;
- Review the policyowner's request to elect the additional paid-up option benefit; and
- Check that evidence of insurability was required before the rider was added to the in force policy.

Automatic Premium Loan (APL)

- Review the policy's contract language for content;
- Review the application to see if the insured selected another option. If not, verify that the grace period expired prior to the initiation of the APL;
- Check the net cash value calculation to make sure that the proper amount was used to deduct the overdue premium; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Note: The examiner should be alert to occurrences of producers automatically selecting the APL option on the insurance application.

Ensure the regulated entity notifies policyowners of material changes to any non-guaranteed factors in accordance with statutes, rules and regulations.

For variable life products with flexible premiums, ensure that a report is sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following processing day. The report should include the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of the amount.

Ensure that at the time of processing policy loans, the insurer notifies policyholders of the initial rate of interest, maximum interest rates and the frequency at which rates may be adjusted. Such notice is to be provided within a reasonable time after processing premium loans.

Ensure the insurer sends advance notice to policyholders with loans, advising of any increases in loan rates.

For annuity contracts that provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall any cash value benefit be less than the minimum nonforfeiture amount. The death benefit shall be at least equal to the cash surrender benefit.

For annuity contracts that do not provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall the present value of a paid-up annuity be less than the minimum nonforfeiture amount.

Not for Distribution

**STANDARDS
POLICYHOLDER SERVICE**

Standard 3

The regulated entity provides each policyowner with an annual report of policy values in accordance with statutes, rules and regulations and, upon request, an in force illustration or contract policy summary.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

Life Insurance Illustrations Model Regulation (#582), Section 10
Life Insurance Disclosure Model Regulation (#580), Section 5C(1)
Variable Annuity Model Regulation (#250), Section 8
Variable Life Insurance Model Regulation (#270), Section 9
Modified Guaranteed Annuity Model Regulation (#255) Section 11
Universal Life Insurance Model Regulation (#585), Section 9

Review Procedures and Criteria

Note: Traditional life (not universal or variable life) products that are unillustrated or that were issued prior to a jurisdiction's adoption of the equivalent of the *Life Insurance Illustrations Model Regulation* (#582) may not be required to provide annual reports.

If required, ensure annual reports are being provided annually.

For universal life, ensure the report includes:

- The beginning and end date of the current report period;
- The policy value at the end of the previous report period and at the end of the current report period;
- The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g. interest, mortality, expense and riders);
- The current death benefit at the end of the current report period on each life covered by the policy;
- The net cash surrender value of the policy as of the end of the current report period; and
- The amount of outstanding loans, if any, as of the end of the current report period.

For fixed premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect should be included in the report.

For flexible premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period, unless further premium payments are made, a notice to this effect should be included in the report.

For traditional life policies, where applicable, ensure the report includes:

- Current death benefit;
- Annual contract premium;
- Current cash surrender value;
- Current dividend;
- Application of current dividend; and
- Amount of outstanding loan.

Ensure that if there are policies that do not build nonforfeiture values, an annual report is provided for those years when a change has been made to non-guaranteed policy elements by the insurer.

Determine if the annual report includes an in force illustration. If it does not, it should contain the following notice displayed prominently: "**IMPORTANT POLICYOWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's telephone number), writing to (insurer's name) at (insurer's address) or contacting your producer. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining a current illustration.

If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report should contain a notice of that fact and the nature of the change prominently displayed.

For variable annuity products, ensure there is a statement or statements reporting the investments held in a separate account. The statement report period should be not more than 4 months prior to the date of mailing. The statement should also include the number of accumulation units and the dollar value of an individual unit or the value of the contractholder's account.

For variable life products, ensure the annual report includes the following:

- The cash surrender value;
- Death benefit;
- Any partial withdrawal or policy loan;
- Any interest charges; and
- Any optional payments.
- The following disclosures:
 - In accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease;
 - Prominent identification of any value which may be recomputed prior to the next annual report;
 - A statement if the policy guarantees the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in the report;
 - For flexible premium policies, a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made to the cash value;

- The projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report, assuming that planned periodic premiums, if any, are paid as scheduled;
- Guaranteed costs of insurance are deducted;
- The net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero;
- If the projected value is less than zero, a warning message should be included that the policy may be in danger of terminating without value in the next 12 months, unless additional premium is paid;
- A summary of the financial statement of the separate account based on the last annual statement filed with the insurance department;
- The net investment return of the separate account for the last year, and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than 5 years, when available;
- A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the insurance department;
- Any charges levied against the separate account during the previous year; and
- A statement of any change since the last report in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or to the investment advisor of the separate account.

Annual reports for modified guaranteed life insurance policies shall state that the cash value may increase or decrease and shall prominently identify any value that may be recomputed prior to the next statement.

Determine if, upon the request of the policyowner, the insurer furnishes an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. No signature or other acknowledgment of receipt of this illustration is required.

Also, determine, if a policyowner requests one, the insurer provides policy data for the policy. Unless otherwise requested, the data should be provided for 20 consecutive years beginning with the previous policy anniversary and include cash dividends according to the current dividend scale, the amount of outstanding policy loans and the current policy loan interest rate. Values shown should be based on the dividend option in effect at the time of the request. A reasonable fee may be charged for the preparation of the statement.

**STANDARDS
POLICYHOLDER SERVICE**

Standard 4

Upon receipt of a request from a policyholder for accelerated benefit payment, the regulated entity must disclose to the policyholder the effect of the request on the policy's cash value, accumulation account, death benefit, premium, policy loans and liens. The regulated entity must also advise that the request may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Apply to: All individual and group life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Policy files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620), Sections 4, 6, and 8

Review Procedures and Criteria

Review the above documents to determine that proper disclosure has been made.

Verify that prior to payment of accelerated benefits the insurer has obtained from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for accelerated benefit payout.

The regulated entity may offer waiver of premium in absence of such provision in an existing policy. At the time accelerated benefits are claimed, the insurer must explain any continuing premium requirements to maintain the policy in force.

Unfair discrimination is prohibited.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 1
Pertinent information on applications that form a part of the policy and contract is complete and accurate.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (IIPRC) uniform standards for products approved by the IIPRC)

_____ All applications

Others Reviewed

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the regulated entity has a verification process in place to determine the accuracy of application information.

Verify if applicable nonforfeiture options and dividend options are indicated on the application.

Determine how automatic premium loan options are disclosed on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Not for Distribution

**STANDARDS
UNDERWRITING AND RATING**

Standard 2

The regulated entity complies with the specific requirements for Acquired Immune Deficiency Syndrome (AIDS)-related concerns in accordance with statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Life insurance applications and related disclosure and consent forms
- _____ Health questionnaires for applicants
- _____ Medical underwriting guidelines
- _____ Regulated entity's guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

- _____ _____
- _____ _____

NAIC Model References**Review Procedures and Criteria**

Ensure the regulated entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies should establish reasonable procedures related to the administration of an AIDS-related test.

- Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional;
- Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test and should be a part of the underwriting file; and
- Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the regulated entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

- Questions may ask if the applicant has been diagnosed with AIDS or AIDS-Related Complex (ARC), if they are designed to establish the existence of the condition, but are not used as a proxy to establish sexual orientation of the applicant.

Ensure the regulated entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation to be a factor in the determination of insurability.

A sample of underwriting files for denied applications should be reviewed to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the regulated entity's guidelines (e.g., based on the amount of insurance).

Neither the marital status, living arrangements, occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

Not for Distribution

G. Claims

Use the standards for this business area that are listed in Chapter 16—General Examination Standards and the standards set forth below.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 1

The regulated entity provides the required disclosure material to policyholders at the time an accelerated benefit payment is requested.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim procedure manuals

_____ Claim files

_____ Claim complaint records

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review the regulated entity's procedure manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Disclosure of possible tax consequences and advice that the claimant seek assistance from a tax advisor;
- A written statement to the policy owner and to the irrevocable beneficiary explaining any effect the payment will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens;
- A statement warning that receipt of accelerated benefits may adversely affect claimant eligibility for government benefits entitlements;
- Administrative expense charges, if any, applicable to the payment of accelerated benefits;
- Any continuing premium requirement to keep the policy in force;
- Lump sum settlement options are required; and
- Any accidental death benefits remain intact.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from policyowners not receiving required disclosure material.

Accelerated benefits are available on the effective date of the policy or rider for accidents and no more than 30 days following the effective date for illness.

No restrictions are permitted on use of accelerated benefit proceeds.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 2

The regulated entity does not discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Regulated entity's claim procedures manual and claim bulletins
- _____ Claims training manual
- _____ Claim files

Others Reviewed

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review procedure manuals, training manuals, and the regulated entity's internal claim bulletins to determine if regulated entity standards exist for consistent evaluation of criteria for approval of accelerated benefits payments.

Review claim files to verify that the regulated entity does not apply further conditions on the payment of accelerated benefits beyond those conditions specified in the policy or benefit rider.

Not for Distribution

**STANDARDS
CLAIMS**

Standard 3

The regulated entity provides the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options.

Apply to: All life insurance companies

Priority: Essential

Documents to be Reviewed

- _____ Applicable statutes, rules and regulations
- _____ Claim procedure manuals/claim training manuals/claim bulletins
- _____ Claim files
- _____ Claim complaint records
- _____ Disclosures provided to beneficiaries

Others Reviewed

- _____
- _____

NAIC Model References

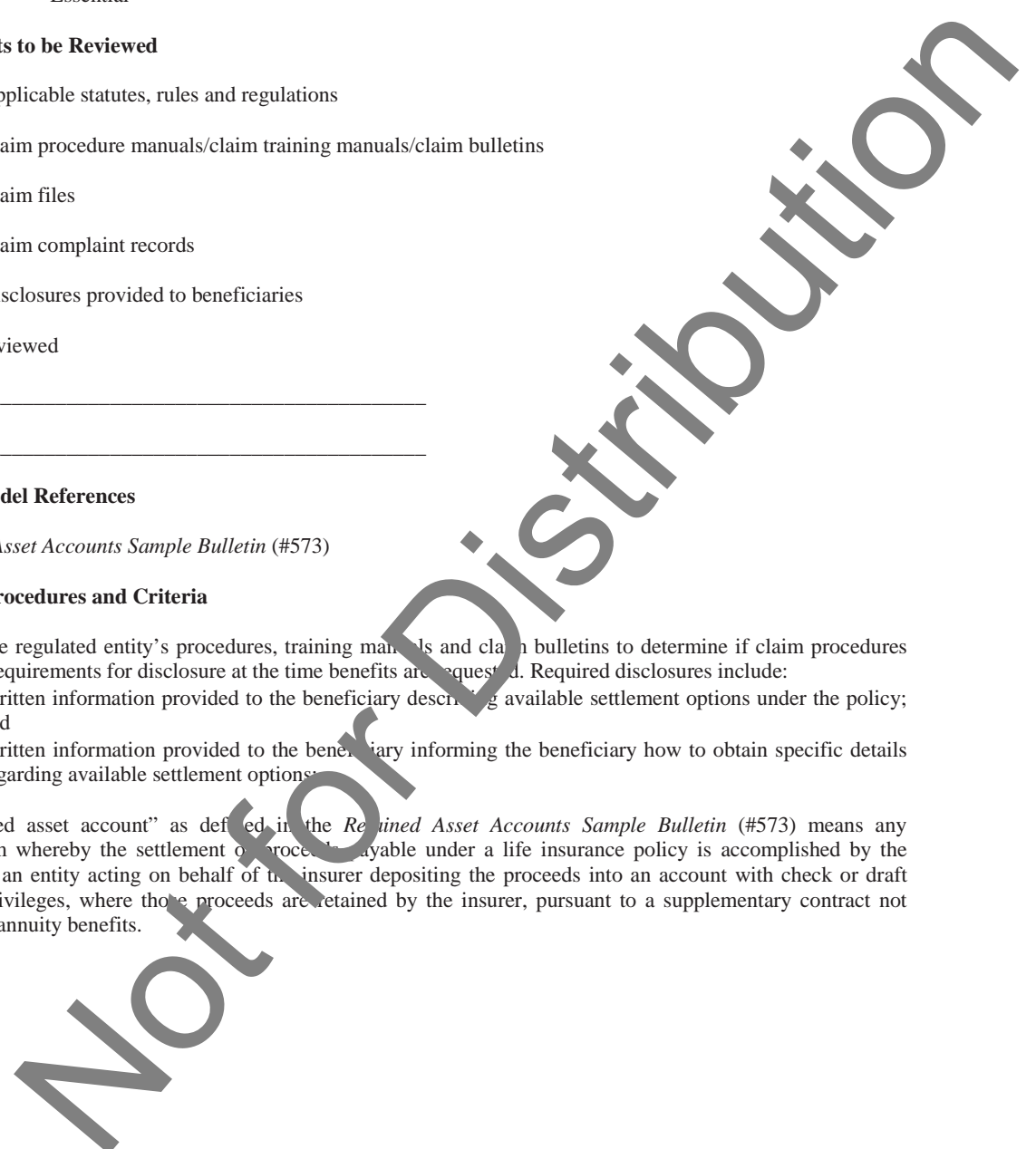
Retained Asset Accounts Sample Bulletin (#573)

Review Procedures and Criteria

Review the regulated entity’s procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Written information provided to the beneficiary describing available settlement options under the policy; and
- Written information provided to the beneficiary informing the beneficiary how to obtain specific details regarding available settlement options.

A “retained asset account” as defined in the *Retained Asset Accounts Sample Bulletin (#573)* means any mechanism whereby the settlement proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.



If the regulated entity settles benefits through a retained asset account, examiners should review and verify in accordance with the applicable state's record retention requirements that the regulated entity has established and implemented procedures to ensure that the regulated entity has:

- a) Provided the following written disclosures to the beneficiary before the account is selected, if optional, or established, if not:
 - Payment of the full benefit amount is accomplished by delivery of the “draft book”/“check book”;
 - One draft or check may be written to access the entire amount, including interest, of the retained asset account at any time;
 - Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the regulated entity's minimum balance requirements;
 - A statement identifying the account as either a checking or draft account and an explanation of how the account works;
 - Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services;
 - A description of fees charged, if applicable;
 - The frequency of statements showing the current account balance, the interest credited, drafts/checks written and any other account activity;
 - The minimum interest rate to be credited to the account and how the actual interest rate will be determined;
 - The interest earned on the account may be taxable;
 - Retained asset account funds held by regulated entities are not guaranteed by the Federal Deposit Insurance Corporation (FDIC) but are guaranteed by the state guaranty associations (where permitted by state law). The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about the coverage limitations for his or her account;
 - A description of the regulated entity's policy regarding retained asset accounts that may become inactive; and
- b) Provided the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and obligations of the regulated entity under the contract.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from beneficiaries not receiving required disclosure material.

H. Supplemental Checklist for Marketing and Sales Standard #1

Yes	No	Requirement
For companies that use enrollment periods:		
		Advertisements should specify the date by which the applicant must mail the application, which should be not less than 10 days and not more than 40 days from the date the enrollment period is advertised for the first time.
For direct response policies:		
		The advertisement should not state or imply there is a cost savings because there is no insurance producer or commission, unless true.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older when the policy is guaranteed-issue.
For graded or modified benefit policies:		
		The advertisement must prominently display any limitation of benefits.
		If the premium is level and coverage decreases or increases with age or duration, that fact must be prominently disclosed.
		If the death benefit varies with the length of time the policy has been in force, the advertisement should accurately describe and clearly call attention to the amount of minimum death benefit under the policy.
		The advertisement should not use the terms “inexpensive,” “low cost” or other similar language when the policies are being marketed to persons who are 50 years of age or older, when the policy is guaranteed-issue.
For policies with premium changes:		
		The advertisement for a policy with non-level premiums should prominently describe the premium changes.
		An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.
For policies with non-guaranteed policy elements:		
		An advertisement should not utilize or describe non-guaranteed policy elements in a manner that is misleading or has the capacity or tendency to mislead.
		An advertisement should not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed. If non-guaranteed policy elements are illustrated, they must be based on the insurer’s current scale, and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		An advertisement that includes any illustrations or statements containing or based upon non-guaranteed elements should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
		If an advertisement refers to any non-guaranteed policy element, it should indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way—such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer’s current or anticipated experience—the advertisement may indicate any such limitation on the insurer’s right.
		An advertisement should not refer to dividends as “tax free” or use words of similar import, unless the tax treatment of dividends is fully explained, and the nature of the dividend as a return of premium is indicated clearly.
For policies sold to students:		
		The envelope in which insurance solicitation material is contained may be addressed to the parent(s) of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution, nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student, unless such is a correct and truthful statement.
		All advertisements including, but not limited to, informational flyers used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer; if such is the case, and these entities must be clearly identified as such.
		The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.
For individual deferred annuity products or deposit funds:		
		Any illustration or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The higher interest rates should not be greater than those currently being credited by the company, unless the higher rates have been publicly declared by the company with an effective date on new issues not more than 3 months subsequent to the date of declaration.

Not for Distribution

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it should also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.
		If a contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning such contract should prominently state that cash surrender benefits are not provided.
For combination life insurance and annuity products:		
		An advertisement of a life insurance product and an annuity as a single policy or life insurance policy with an annuity rider should include a disclosure before the application is taken (if the policy contains an unconditional refund provision of at least 10 days, the disclosure statement can be delivered with the policy, or upon the applicant's request, whichever occurs sooner). The disclosure defines the gross annual life and premium annuity percentages and guaranteed cash value of the annuity and should include the first 5 policy years, the tenth and twentieth policy years, at least one age from 60 to 70 and the scheduled commencement of annuity payments.

Not for Distribution

I. Supplemental Checklist for Marketing and Sales Standard #3

For all illustrations: Determine if the illustration contains the following:

Yes	No	Requirement
		The illustration should be clearly labeled “life insurance illustration.”
		Name of insurer.
		Name and business address of producer or insurer’s authorized representative, if any.
		Name, age and gender of proposed insured except where a composite illustration is permitted.
		Underwriting or rating classification upon which the illustration is based.
		Generic name of the policy, the company product name, if different, and the policy form number.
		Initial death benefit.
		Dividend option election or application of non-guaranteed elements, if applicable.

(Life Insurance Illustrations Model Regulation (#582), Section 6A)

Note: “Generic name” means a short title descriptive of the policy being illustrated, such as “whole life,” “term life” or “flexible premium adjustable life.”

Not for Distribution

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont'd)**Determine if the *basic* illustration contains or complies with the following:**

Yes	No	Requirement
		Date illustration prepared.
		Page numbers for entire illustration and explanatory notes.
		Assumed dates of payment receipt and benefit payout within a policy year.
		The issue age plus the number of years the policy is assumed to have been in force, if the age is shown as a component of tabular detail.
		Assumed payments on which the illustrated benefits and values are based are identified as premium outlay or contract premium. For policies that do not require a specific contract premium, the illustrated payments should be identified as premium outlay.
		Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium should be shown and clearly labeled guaranteed.
		Non-guaranteed elements should not be based on a scale more favorable to the policyowner than the insurer's illustrated scale at any duration. These elements should be clearly labeled non-guaranteed.
		Guaranteed elements, if any, should be shown before corresponding non-guaranteed elements, and should be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements.
		Account or accumulation value of a policy, if shown, should be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.
		Value available upon surrender should be identified by the name this value is given in the policy being illustrated and should be the amount available to the policyowner in a lump sum after deduction of surrender charges, policy loans and policy interest, as applicable.
		Illustration may show policy benefits and values in graphic or chart form in addition to tabular form.
		Non-guaranteed elements should be accompanied by a statement indicating that, "The benefits and values are non-guaranteed; the assumptions on which they are based are subject to change by the insurer, and actual results may be more or less favorable."

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont'd)

		If the illustration shows that the premium payor may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on the actual results, the premium payor may need to continue or resume premium outlays. Similar disclosure should be made for premium outlay of lesser amounts or shorter duration than the contract premium. If a contract premium is due, the premium outlay should not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid.
		If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium, policy charges, or for any other purpose, the illustration may reflect those plans and the effect on future policy benefits and values.
		A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
		A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration should show the premium outlay that must be paid to guarantee coverage for the term of the policy, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code.
		A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration, and the effect they may have on the benefits and values of the policy.
		Identification and a brief definition of column headings and key terms used in the illustration.
		The following statement, "This illustration assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur. Actual results may be more or less favorable than those shown."
		Following the narrative summary, a basic illustration should include a numerical summary of the death benefits and values and the premium outlay and contract premium as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values should be based on the contract premium. This summary should be shown for at least policy years 5, 10, 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary should show policy years 5, 10, 20 and 30.

Not for Distribution

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont'd)

		<p>The columns of the numeric summary should include:</p> <p>Bases 1: Policy guarantees</p> <p>Bases 2: Insurer's illustrated scale</p> <p>Bases 3: Insurer's illustrated scale used, but with the non-guaranteed elements reduced as follows:</p> <ul style="list-style-type: none"> • Dividends at 50 percent of the dividends contained in the illustrated scale used; • Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and • All non-guaranteed charges, including, but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
		<p>If coverage would cease before policy maturity or age 100, the year in which coverage ceases should be identified for each of the three bases.</p>
		<p>The following statement signed and dated by the applicant or policy owner: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."</p>
		<p>The following statement signed and dated by the insurance producer or other authorized representative of the insurer: "I certify that this illustration has been presented to the applicant, and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."</p>

Not for Distribution

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont’d)

		<p>A basic illustration must include the following for at least each policy year from one to 10 and for every fifth policy year thereafter, ending at age 100, policy maturity or final expiration, and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change:</p> <ul style="list-style-type: none"> • Premium outlay and mode the applicant plans to pay and the contract premium as applicable; • The corresponding guaranteed death benefit, as provided in the policy; • Corresponding guaranteed value available upon surrender, as provided in the policy; • Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer’s current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any; and • If no guaranteed benefit value is available at any duration for which a non-guaranteed benefit or value is shown, a zero should be displayed in the guaranteed column.
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“Basic illustration” means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont’d)

A supplemental illustration may be provided as long as:

Yes	No	Requirement
		It is appended to, accompanied by, or preceded by a basic illustration.
		The non-guaranteed elements shown are not more favorable to the policyowner than the corresponding elements in the basic illustration.
		It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed.
		The premium outlay/contract premium must be equal to the premium outlay/contract premium shown in the basic illustration.
		A notice is included referring to the basic illustration for guaranteed elements and other important information.

“Supplemental illustration” means an illustration furnished in addition to a basic illustration that meets the applicable requirements of [Life Insurance Illustrations Model Regulation (#582)], and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

Not for Distribution

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont'd)

Determine if the *universal life* illustration has the following:

Yes	No	Requirement
		<p>Any statement of policy cost factors or benefits shall contain:</p> <ul style="list-style-type: none"> • The corresponding guaranteed policy cost factors or benefits, clearly identified; • A statement explaining the non-guaranteed nature of any current interest rates, charges or other fees applied to the policy, including the insurer's rights to alter any of these factors; • Any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited; • Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value; • Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined; • If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index resulting in the interest rate credited under the policy; • Any illustrated benefits based upon non-guaranteed interest, mortality or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed; and • If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy's maturity date, such fact shall be disclosed, including notice that coverage can terminate under such circumstances.

(*Universal Life Insurance Model Regulation (#585), Section 8A*)

Not for Distribution

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont'd)**Ensure variable life illustrations contain or comply with the following:**

Yes	No	Requirement
		The hypothetical interest rates used to illustrate accumulated policy values must be an annual effective gross rate after brokerage expenses and prior to any deduction for taxes, expenses and contract charges.
		If illustrations of accumulated policy values are shown, then for the highest interest rate used, one illustration must be based solely upon guarantees contained in the policy contract being illustrated.
		Except for illustrations contained in the prospectus, the pattern of premium payments used in an illustration should be the initial pattern requested by the proposed policyholder at inception or upon change in face amount requested by the policyholder.
		If the illustrated policy contract provides for a variety of investment options, the illustration may either use an asset charge, which is reasonably representative, or use the asset charge of a particular option. The illustration should clearly identify the asset charge and either label it “hypothetical” or identify the fund.
		The illustration must disclose the transaction charges that will be levied against the contract because of transactions requested in accordance with rights and privileges specified in the policy contract. Any charge for the exercise of a right or privilege upon which the illustration is based must be reflected in the illustrated values. The nature of any other such charges must be disclosed in a clear statement accompanying such illustrations.
		A clear statement must be made following the table of illustrated accumulated policy values that use of hypothetical investment results does not in any way represent actual results or suggest that such results will be achieved and must indicate that the policy values which actually arise will differ from those shown whenever the actual investment results differ from the hypothetical results illustrated. Assumptions upon which illustrations are based must be clearly disclosed.
		Any sales illustration to a prospective policyholder must reflect the policy being presented accurately. Misleading statements or captions or other misrepresentations are prohibited.
		The requested sales illustration must be printed clearly and legibly on hard paper copy. An illustration displayed on a computer screen may be used in addition to, but not as a substitute for, hard paper copy.

I. Supplemental Checklist for Marketing and Sales Standard #3 (cont'd)

	<p>In connection with variable life insurance contracts offering both fixed and variable funding options:</p> <ul style="list-style-type: none"> • An illustration of the variable funding option must comply with these guidelines; • If an illustration of the fixed funding option is shown, accumulated policy values must be shown on the basis of guaranteed rates. One or more additional rates may also be shown, but such rates may not exceed current rates; and • A summary illustration may be given in which results from comparable illustrated and hypothetical interest rates are combined. Such summary must cross-reference to the accompanying separate illustrations of the fixed and variable funding options.
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(Life Insurance Illustrations Model Regulation (#582))

Not for Distribution

J. Supplemental Checklist for Marketing and Sales Standard #8

Yes	No	Requirement
Ensure the disclosures include:		
		The fact that a life insurance policy is involved or being used to fund a prearrangement.
		The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.
		The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement.
		<p>The impact on the prearrangement of the following:</p> <ul style="list-style-type: none"> • Any changes in the life insurance policy including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds; • Any penalties to be incurred by the policyholder as a result of failure to make premium payments; • Any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy; • A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need; • All relevant information concerning what occurs and whether any entitlements or obligations arise, if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement; • Any penalties or restrictions, including, but not limited to, geographic restriction or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and <p>The fact that a sales commission or other form of compensation is being paid and, if so, the identity of such individuals or entities to whom it is paid.</p>

Not for Distribution