National Association of Insurance Commissioners & The Center for Insurance Policy and Research

NAIC/FIO Meeting on Market Conduct

(Documents shared with FIO to facilitate discussion are attached)
Wednesday, December 7, 2011
Time: 9am-1pm

NAIC Attendees:
Susan Voss (IA) NAIC President
Jim Donelon (LA) NAIC Vice President
Sharon Clark (KY)
Roger Sevigny (NH)
Mike Chaney (MS)
Tim Mullen (NAIC Staff)
Eric Nordman (NAIC Staff)
Ethan Sonnichsen (NAIC Staff)
Mark Sagat (NAIC Staff)

Proposed Discussion Items:

Overview of Key Areas

- Market analysis and market conduct exams
  - Processes set forth in the market conduct handbook for identifying companies for exams;
  - NAIC reporting systems for exams;
  - Continuum options for market conduct including letter and calls to companies, data calls, and eventually exams;
  - MAWG for purposes of collaboration and coordination; and
  - MCAS as a tool for identifying companies for market conduct analysis
- Anti-Fraud
- Consumer Service Activities
- Catastrophe Response
- Overview of Producer Licensing Regime
- UCAA
- Overview of IIPRC (“Interstate Compact”)

Recent Issues

- Ongoing initiative to examine and enhance market conduct processes
- Surplus Lines Implementation
- Transparency Working Group
- Retained Asset Accounts
- Life insurer use of SSA death master file

Attachments

National Association of Insurance Commissioners & The Center for Insurance Policy and Research

December 5, 2011

The Evolution of Market Regulation

State insurance regulators through the National Association of Insurance Commissioners (NAIC) continually look at ways to improve the regulation of insurers. In doing so, insurance regulators make changes in response to changing market conditions, technological advances and changes in the philosophical view of how to best protect the interest of insurance policyholders and claimants. It is important to remember the focus of market regulation is to protect consumers in ways that strike a balance between the profit seeking interests of insurers and the interests of policyholders who generally want the broadest possible insurance protection at the cheapest price.

Insurance regulation can generally be described in two simple statements. Insurance regulators want insurers to have sufficient assets to make good on the promises they are selling and they want insurers to treat their policyholders and claimants right. The first part of the statement describes what is known as solvency regulation and the second part is known as market regulation.

To fully understand how market regulation has evolved over time, one must first be able to place it in a historical context. Following a brief overview of the history of market conduct regulation, the paper will highlights some of the recent, more significant regulatory developments within the insurance regulatory community, including significant changes to product regulation, producer licensing, consumer assistance, market conduct examination, market analysis and the Market Conduct Annual Statement.

A Brief History of Market Regulation

Benjamin Franklin helped found the insurance industry in the United States in 1752 with the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire. The current state insurance regulatory framework has its roots in the 19th century with New Hampshire appointing the first insurance commissioner in 1851. In 1869, the Supreme Court held, in the case Paul v. Virginia, that "issuing a policy of insurance is not a transaction of commerce." As a result, states were left with responsible over the taxation and regulation of insurance. The need to discuss issues of common concern led to the formation of the National Insurance Convention in 1871, which later became known as the National Association of Insurance Commissioners (NAIC). Insurance regulators' responsibilities grew in scope and complexity as the industry evolved. Another Supreme Court case (United States v. Southeastern Underwriters) led to the overturning of the Paul v. Virginia decision. In the Southeastern Underwriters case the Supreme Court held that insurance was indeed commerce. This caused turmoil as there was a regulatory void that led Congress to enact the McCarran-Ferguson Act in 1945. The McCarran-Ferguson Act clarified that states should continue to regulate and tax the business of

insurance and affirmed that the continued regulation of the insurance industry by the states was in the public's best interest.

It is the McCarran-Ferguson Act that serves as the legal foundation for today's market regulatory framework, which the states have built a robust and constantly evolving insurance code upon. The McCarran-Ferguson Act does not prevent the federal government from regulating the insurance industry. Instead it provides only that states have broad authority to regulate the insurance industry unless the federal government enacts legislation specifically intended to regulate insurance. The McCarran-Ferguson Act also provides that the Sherman Anti-Trust of 1890, the Clayton Act of 1914 and the Federal Trade Commission Act of 1914 apply to the business of insurance to the extent that the business of insurance is not regulated by state law. This provision is generally referred to as a limited anti-trust exemption.

Soon after the McCarran-Ferguson Act was enacted, states moved quickly to establish regulatory frameworks that met the requirement that they regulate the business of insurance to avoid insurers being subject to oversight by the Federal Trade Commission. One of the principle legislative developments was imposing a prior approval rate regulatory framework for property and liability rates. There were two All Industry Model Bills—one of fire insurance and a second for casualty and surety—adopted by the NAIC in 1946. By the late 1940s almost every state had enacted a prior approval framework to combat the evil of the day—the rate bureaus or cartels that forced member insurers to charge the same price for insurance coverage to prevent insolvencies.

As insurers and some regulators became more comfortable with the concept of competitive rating instead of relying on prices set by a rating bureau, gradually state legislatures relaxed the regulatory frameworks allow greater flexibility for insurers. Rating laws were changed in a variety of ways. Some legislatures adopted a file and use mechanism. Others decide on a use and file or informational filing framework. Today there are a wide variety of rate regulatory frameworks in the states reflecting the level of oversight each legislature believes is appropriate for the citizens within their jurisdiction.

Another effort at developing state legislation in response to McCarran-Ferguson was the development of Unfair Trade Practices Act adopted by the NAIC in 1947. The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the McCarran-Ferguson Act by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

The concept of a market conduct examination was born in the late 1970s when the Illinois Legislature could not agree on what type of rate regulatory environment it wished to enact to replace its current law which contained a sunset provision. Following the legislative session, the Illinois Department of Insurance was left with several staff members knowledgeable about rate regulation, but with no rating

law to enforce. It was decided to send them out to conduct on-site examinations of how insurers were treating policyholders and claimants and to look at the prices they were charging. The Illinois Department of Insurance found the market conduct examination to be an effective alternative method to regulate the insurer market practices in place of prior approval rate regulation. Gradually the Department convinced other states to give it a try. Today all states have some form of market oversight as part of their comprehensive framework of regulation. (See Appendix B for list of Key NAIC Market Regulation Model Acts)

Market regulation attempts to ensure consumers are charged fair and reasonable insurance prices have access to beneficial and compliant insurance products and insurers operate in ways that are legal and fair to consumers. In broad terms, market regulation is considered to cover the following broad spectrum of consumer protection activities: (1) company licensing: (2) product regulation; (3) producer licensing; (4) individual consumer assistance; (5) antifraud activities; (6) market analysis; (7) regulatory interventions, including market conduct examinations: and (8) enforcement. With improved cooperation among states and uniform market conduct examinations where uniformity is needed, regulators hope to ensure continued quality consumer protection at the state level. Traditional market conduct examinations occur on a routine basis, but also can be triggered by complaints against an insurer. These exams review producer licensing issues, complaints, types of products sold by insurers and producers, producer sales practices, compliance with filed rating plans, claims handling and other market-related aspects of an insurer's operation. When violations are found, the insurance department makes recommendations to improve the insurer's operations and to bring the company into compliance with state law. In addition, an insurer or insurance producer may be subject to civil penalties or license suspension or revocation.

State regulation of insurance was also impacted by the Financial Services Modernization Act of 1999, also known as the Gramm-Leach-Bliley Act (GLBA). Congress affirmed that states should regulate the business of insurance by declaring that the McCarran-Ferguson Act remained in effect. However, Congress also called for state reform to allow insurance companies to compete more effectively in the newly integrated financial service marketplace and to respond with innovation and flexibility to evermore demanding consumer needs. It established the concept of functional regulation where each functional regulator is responsible for regulation of its functional area. The GLBA also called on the states to implement a system of uniformity or reciprocity in the area of producer licensing.

In the wake of the 2008 financial crisis, the Wall Street Reform and Consumer Protection Act of 2010, better known as the Dodd-Frank Act once again had an impact on state insurance regulation. In the area of market regulation, consumer protection functions were, to a large degree, consolidated in a newly created Consumer Financial Protection Bureau (CFPB). There was some interest in granting the CFPB an explicit role in the areas of credit, title, and mortgage insurance – insurance products most closely linked with the mortgage market – but ultimately Congress deferred market conduct regulation of insurance to the states.

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 an insurer's own operations and the market environment in which it operates may vary considerably from state to state. If an insurer's compliance is inadequate in a particular place or a particular line of business, it does not matter how strong the insurer's performance is in its other operations. Although the impact of an insurer's market conduct is felt locally, an insurer that has demonstrated an outstanding, or outrageous, record of customer service in one market will likely, but not always, have a comparable record in other markets where it does business. 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 insurer does business. Through the NAIC, the states have developed processes to identify such patterns and collaborate in addressing market conduct issues.

Company Licensing

Company licensing addresses the licensing of the risk bearing entities and is the first step in the regulatory process. During this process, the state insurance department reviews the financial resources of the applicant to ensure there is a minimum level of capital and reserves for an ongoing insurance company. In addition, attention will be given to the Officers and Directors of the applicant to ensure the listed individuals have the minimum level of competencies and trustworthiness. Finally, the insurer will be licensed for a specific line or lines of authority.

The NAIC has streamlined the company licensing process through the Uniform Certificate of Authority Application (UCAA) process, which is designed to allow insurers to file copies of the same application for admission in numerous states. Each state that accepts the UCAA is designated as a uniform state. While each uniform state still performs its own independent review of each application, the need to file different applications, in different formats, has been eliminated for all states that accept the uniform application.

The UCAA includes three applications. The Primary Application is for use by newly formed companies seeking a Certificate of Authority in their domicile state and by companies wishing to re-domesticate to a uniform state. The Expansion Application is for use by companies in good standing in their state of domicile that wish to expand their business into a uniform state. The Corporate Amendments Application is for use by an existing insurer for requesting amendments to its certificate of authority.

Product Regulation

State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations.

For personal property-casualty lines, about half of the states require insurers to file rates and to receive prior approval before rate or policy form filings go into effect. With the exception of workers' compensation and medical malpractice, commercial property-casualty lines in many states are subject to a competitive rating approach. Under such a system, regulators typically retain authority to disapprove rates if they find that competition is not working.

Rates for life insurance and annuity products generally are not subject to regulatory approval, although regulators may seek to ensure that policy benefits are commensurate with the premiums charged. Historically, many states subjected health insurance rates to prior approval—with some states using a "file and use" system or no provisions for review. The recently adopted Affordable Care Act has changed the landscape for health insurance. All states now must review health insurance rates before they go into effect. Health insurance rates are also subject to review by the Department of Health and Human Services if the rate change is deemed to be "unreasonable." Improvements are also included addressing the way in which consumers shop for health insurance. Health insurance exchanges are being developed and there is much focus of transparency of consumer information.

Traditionally product filings were paper-based and using the U.S. Postal system caused inherent delays in product approval. Addressing this inefficiency, state insurance regulators, in the early 1990s, developed SERFF (System for Electronic Rate and Form Filings). The intent was to provide a cost-effective method for handling insurance policy rate and form filings between regulators and insurance companies. The SERFF system is designed to enable companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. It has added incredible operational efficiencies that enhanced speed to market for rate and policy form filings. In 2010, over 565,000 filings were processed through SERFF.

Insurance regulators have also been innovative in addressing speed to market concerns of insurers desiring the ability to make a single filing that applies in multiple jurisdictions. The Interstate Insurance product Regulation Compact (Compact) is an important modernization initiative that benefits state insurance regulators, consumers and the insurance industry. The Compact enhances the efficiency and effectiveness of the way insurance products are filed, reviewed and approved allowing consumers to have faster access to competitive insurance products in an ever-changing marketplace. The Compact promotes uniformity through application of national product standards embedded with strong consumer protections.

The Compact established a multi-state public entity, the Interstate Insurance Product Regulation Commission (IIPRC) which serves as an instrumentality of the Member States. The IIPRC serves as a central point of electronic filing for certain insurance products, including life insurance, annuities, disability income and long-term care insurance to develop uniform product standards, affording a high level of protection to purchasers of asset protection insurance products. The IIPRC uses the SERFF filing network for its communications between the 41 participating jurisdictions, representing approximately two-thirds of the applicable premium volume nationwide, and the insurers using the system for flings.

Producer Licensing

Insurance agents and brokers, also known as producers, must be licensed to sell insurance and must comply with various state laws and regulations governing their activities. Currently, more than two million individuals are licensed to provide insurance services in the United States. State insurance departments oversee producer activities in order to protect insurance consumer interests in insurance transactions.

The states administer continuing education programs to ensure that agents meet high professional standards. Producers who fail to comply with regulatory requirements are subject to fines and license suspension or revocation. In 2010, roughly 5,000 insurance producers had their licenses suspended or revoked. Fines exceeded $25 million and over $50 million was returned to rightful owners.

When insurance producers operate in multiple jurisdictions, states must coordinate their efforts to track producers and prevent violations. Special databases are maintained by the NAIC to assist the states in this effort. The National Insurance Producer Registry (NIPR)—a non-profit affiliate of the NAIC—was established to develop and operate a national repository for producer licensing information.

Section 321 of GLBA required a majority of states, not later than three years after its effective date, to enact: (1) uniform laws and regulations governing the licensure of individuals and entities authorized to sell and solicit the purchase of insurance within the state; or (2) reciprocity laws and regulations governing the licensure of non-resident individuals and entities authorized to sell and solicit insurance within those states. The insurance regulators elected to pursue the reciprocity option with uniformity remaining the long-term goal for non-resident (and resident) producer licensing.

In order to be considered reciprocal for non-resident producer licensing, a state must satisfy the following four conditions:

(1) Permit a producer with a resident license for selling and soliciting insurance in its home state to receive a license to sell or solicit the purchase of insurance as a non-resident to the same extent that the producer is permitted to sell or solicit insurance in its home state, if the home state also

licenses reciprocally, without satisfying any additional requirements other than submitting (A) a request for licensure; (B) the application for licensure submitted to the home state; (C) proof of licensure and good standing in home state; and (D) payment of any requisite fee;

(2) Acceptance of a producer's satisfaction of its home state's continuing education requirements as satisfying that state's continuing education requirements, provided that the home state recognizes continuing education satisfaction on a reciprocal basis;

(3) No requirements are imposed upon any producer to be licensed or otherwise qualified to do business as a non-resident that have the effect of limiting or conditioning that producer's activities because of its residence or place of operations (excepting countersignature requirements); and

(4) Each state meeting (1), (2), and (3) grants reciprocity to residents of all other states that satisfy (1), (2), and (3).

In order to provide states with a model for meeting these reciprocity requirements, the NAIC adopted the Producer Licensing Model Act (PLMA) in 2000. The PLMA serves as the primary vehicle for states not only to achieve reciprocity, but also to take major steps toward reaching uniformity. With respect to reciprocity, the PLMA provides for streamlined administrative licensing requirements, reciprocal recognition of continuing education, and reciprocity for surplus lines and limited lines producers, and creates uniform standards for key areas of producer licensing. The model provides for the following:

- Creates uniform definitions for "negotiate," "sell," and "solicit."
- Creates a uniform application process for both resident and non-resident applications by referencing the use of the NAIC Uniform Application for both.
- Establishes uniform definitions for the six major lines of insurance: (1) Life, (2) Accident and Health, (3) Property, (4) Casualty, (5) Variable Life and Variable Annuity, and (6) Personal Lines.
- Establishes uniform exemptions from completing pre-licensing education and examinations for licensed producers who apply for a non-resident license.
- Establishes uniform standards for license denials, non-renewals and revocations.
- Establishes uniform standards regarding what entities may or may not receive as commission related to the sale of an insurance policy.
- Establishes uniform standards for agent appointments. (The adoption of these provisions is optional for states.)
- Establishes uniform procedures as to how regulators, companies, and agents should report and administratively resolve "not for cause" and "for cause" terminations.
- Encourages the use of the NAIC's State Producer Licensing Database (SPLD) and the electronic processing of applications.

In December 2002, subsequent to the adoption of the PLMA, the NAIC adopted the Uniform Resident Licensing Standards. These standards focus on the following broad areas: (1) licensing qualifications, (2) pre-licensing education, (3) licensing testing, (4) integrity/background check standards, (5) license

application process, (6) appointment process, (7) continuing education requirements, and (8) limited lines. The NAIC encouraged and monitored state adoption of the Uniform Resident Licensing standards and pursued the adoption of key Uniform Resident Licensing standards and procedures that were not addressed in the PLMA. This effort was carried out with industry input and was designed to help achieve the NAIC's long-term goal of licensing uniformity among the states.

While these business process reforms helped streamline producer licensing across states, the NAIC and its members recognized tremendous benefits would be recognized through automating the producer licensing process, which began well over a decade ago. One of the first steps was the creation of the State Producer Licensing Database (SPLD) to track general demographic and regulatory actions taken against all producers in the United States. Today, every state and the District of Columbia report producer licensing information to this database. This has dramatically eliminated the ability of rogue producers to cross state lines without detection. According to the NAIC *2010 Insurance Department Resources Report*, states took the following actions against producers:

- 3,064 License Suspensions;
- 1,929 License Revocations;
- 417 Cease and Desist Orders; and
- 1,288 License Denials.

In addition, states levied fines of $25,952,837 against producers and recovered $53,466,409 in restitution for consumers.

The following statistics provide a further snapshot on how states are using electronic tools provided through the NAIC and its affiliate, the National Insurance Producer Registry (NIPR), to enhance and simplify the licensing process for producers:

- 50 jurisdictions electronically process non-resident licenses;
- 46 jurisdictions electronically process non-resident renewals;
- 38 jurisdictions electronically process resident licenses;
- 35 jurisdictions electronically process resident license renewals;
- 41 jurisdictions electronically process appointments and terminations;
- 13 jurisdictions electronically process appointment renewals;
- 51 jurisdictions utilize National Producer Numbers;
- 50 jurisdictions have eliminated paper certifications; and
- 51 jurisdictions electronically accept Address Change Requests.

State producer licensing has changed dramatically over the past decade. The majority of states have changed from using varying applications to using the NAIC Uniform Applications for both individuals and business entities. States have made huge progress moving from a paper-based, forms-intensive environment to an efficient electronic processing environment. States have streamlined the non-resident

licensing process and have eliminated old barriers to this process, such as bond requirements, state-specific applications and retaliatory licensing fees. Through licensing reciprocity, a non-resident applicant may obtain a license by providing proof of good standing in his/her home state, submitting or transmitting the Uniform Application and submitting the required fees. Additionally, producers no longer need to expend the time and money to obtain and submit proof of good standing in hard copy, as this is accomplished electronically through states' access to the NAIC SPLD.

The NAIC membership originally determined that the states met the non-resident producer licensing reciprocity requirements of GLBA in 2002. In total, 47 jurisdictions have been certified as reciprocal under the 2002 reciprocity standard. As part of a renewed push toward increased reciprocity and uniformity in licensing processes, NAIC membership established reciprocity criteria that represent a more detailed analysis of certain aspects of the original 2002 reciprocity standard as well as a review of issues not included specifically in the 2002 report. This enhanced "NAIC Reciprocity Standard" and recent review has re-confirmed the states' commitment to licensing reciprocity with 40 jurisdictions being certified as having met the heighted NAIC reciprocity standard.

Consumer Assistance

The single most significant challenge for state insurance regulators is to be vigilant in the protection of consumers, especially in light of the changes taking place in the financial services marketplace. State insurance regulators have established toll-free hotlines, Internet Web sites and special consumer services units to receive and handle complaints against insurers and insurance producers. The state insurance regulators also have launched an interactive tool to allow consumers to research company complaint and financial data using the NAIC Web site. Called the Consumer Information Source, this web-based tool allows consumers to file a complaint, report suspected fraud and access key financial and market regulatory information about insurers

During 2010, state insurance departments handled over 2.1 million consumer inquiries and over 300,000 formal consumer complaints. As needed, state insurance departments worked together with claimants, policyholders and insurers to resolve disputes. In addition, many states sponsor consumer education seminars and provide consumer brochures on a variety of insurance topics. Many states publish rate comparison guides to help consumers get the best value when they purchase insurance.

The NAIC coordinates consumer outreach through the Consumer Information Source and Insure U. The NAIC Consumer Information Source (CIS) provides information about insurance companies consumers can use before purchasing insurance. Through the CIS consumers can access information about insurance companies, including closed insurance complaints, licensing information and key financial data.

Insure U offers unbiased and trusted consumer resources from the NAIC. The program's robust website provides consumers with helpful tips and information about insurance—and because individual coverage needs vary, materials are provided for various life situations. The site also features quizzes and public service announcements to help consumers *Get Smart About Insurance*.

The NAIC has appointed a Transparency and Readability of Consumer Information Working Group to study and evaluate actions that will improve the capacity of consumers to comparison shop on the basis of differences in coverage provided by different insurance carriers offering personal lines products. The Working Group will examine current industry practices and state laws and regulations relevant to this topic, then develop findings and/or recommended action items. Among the items the working group will study are approaches to: systematize and improve pre-sale disclosures of coverage; increase consumer accessibility to different insurers' policy forms on a pre-sale basis; and facilitate consumers' capacity to understand the content of insurance policies and assess differences in insurers' policy forms.

Antifraud

Fighting fraud is another important aspect of state insurance regulation. Insurance fraud may fall into different categories from individuals committing fraud against consumers to individuals committing fraud against insurance companies. To deal with specific issues involving criminal activity, many state insurance departments have antifraud and criminal investigators, while others rely on their state Attorney General office or state police. These individuals carry out the following functions: investigate suspected fraudulent acts, prosecute fraudulent acts, and engage in fraud prevention efforts.

Market Analysis

A state market analysis program is a system of collection and analysis of data and other information. In summary, market analysis enables regulators to prioritize and coordinate the various market regulation functions of the insurance department and establish an integrated system of proportional responses to market problems. As the General Accounting Office explains 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 starts with baseline analysis methods which are used to narrow the field of companies which should undergo analysis. Once the field of companies is narrowed, a Level One market analysis is performed for each of the companies. A majority of the information used for Level One market analysis is obtained through the NAIC market information systems. Level One analysis is a formulaic approach, consisting of specific questions which the analyst must complete. Each Level One analysis is eventually approved by the state's market analysis chief (MAC) before being made available for viewing by other member state market analysts in the Market Analysis Review System pursuant to an information sharing agreement. Level One analysis reports conclude with a brief explanation of what next steps are contemplated by the state. Examples of next steps are, "no further analysis required", "a Level Two analysis is scheduled", or "we will proceed with the continuum of regulatory responses."

Level Two Analysis is intended to permit a more in-depth review of specific company matters and may include such endeavors as a closer look at complaint files, review of information from other Department of Insurance divisions, information available in SERFF, information available on the internet and other sources. If the analysis indicates that a regulatory response is appropriate, it is intended that the Level Two analysis will assist in determining the appropriate type of response and the scope of the response (issues to be targeted). Like Level One reviews, the completed and approved Level Two reviews are available for review in the Market Analysis Review System.

A key component of market analysis is the Market Conduct Annual Statement (MCAS). Insurance regulators, through the NAIC, began the Market Conduct Annual Statement (MCAS) in 2002 with the goal of collecting uniform market conduct related data. The MCAS provides market regulators with information not otherwise available for their market analysis initiatives. It promotes uniform analysis by applying consistent measurements and comparisons between insurers. MCAS has always been a collaboration of regulators, industry and consumers who recognize the benefits of monitoring, benchmarking, analyzing, and regulating the market conduct of insurance companies. Through this teamwork, MCAS has grown from eight states collecting only Life and Annuity information to nearly all states collecting property and casualty data, as well as life and annuity information. In 2011, state participation in the collection of MCAS data increased from 29 jurisdictions to 45 jurisdictions through the development of a new automated system which has lead to the centralized storage greatly enhanced the reporting efficiency for companies and state use of the data. This MCAS centralization project has presented state insurance regulators an ideal opportunity for market analysis to become more scientifically based and uniform.

There is a continuing demand by regulators for market analysis data that goes beyond the complaints and regulatory action databases the NAIC hosts today. The availability of nationwide, standardized data is a basic necessity in order to monitor company practices on behalf of consumers. Consider the success of the NAIC Financial Annual Statement model where centralization, standardization, full participation, and automation are its cornerstones. This initiative is the first step toward creating a similar resource for market analysis.

Regulatory Interventions

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. Goals similar to the following are kept in mind when determining the most appropriate response:

- Remediation of harm to impacted consumers and preventing future harm to consumers are primary goals;
- The manner of the response should address the problem or issue as widely as possible, with minimal impact to regulated entities that have not otherwise contributed to the problem;
- Regulatory responses should be commensurate to the identified problem;
- Regulatory responses should be selected to best leverage the resources at the regulator's disposal; and
- When possible, regulatory responses should be cost-effective for both the regulatory agency and the regulated entity.

Regulators also determine the nature of the regulatory concerns by reviewing questions similar to the following.

- How immediate is the concern? What is the nature of the harm to consumers? What is the likelihood that consumer harm will occur if the issue is not addressed soon? What is the potential impact of the concern?
- How extensive is the issue? Does the concern involve one regulated entity or multiple regulated entities?
- What are the jurisdictional boundaries of the concern?
- How is the concern impacted by company self-audit or best practices organizations?
- What type of information is needed to evaluate the concern and to recommend corrective action? What is the expected volume of information necessary?
- Can audit software assist in analyzing the concern?

- Might the regulatory response result in an enforcement action?
- What is the regulated entity's history for being proactive with market conduct compliance?
- What types of market conduct responses have been effective with the specific entity in the past?
- What if an analyst or examiner discovers information or activities that raise suspicions of fraudulent activity?

The continuum of regulatory responses is designed to accommodate a flexible method of addressing concerns. States are encouraged to use a method that is least intrusive, yet effective in addressing the regulatory matters at hand. Examples of continuum responses include such things as telephoning or meeting with company officials, issuing an interrogatory, conducting a policy and procedure review or issuing a data call, performing a desk audit or scheduling an on-site examination.

Finally, 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.

- Resources—Standards regarding a state's regulatory authority, staff and training, and standards relating to the state's utilization of contract examiners;
- Market Analysis—Standards regarding market analysis, data collection and the role and responsibilities of a state insurance department Market Analysis Chief (MAC);
- 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 Conduct Examinations

The most discussed and formally developed type of regulatory intervention is the market conduct examination. They are an effective tool when it is desirable to conduct an in depth transactional review or when interaction with multiple divisions within an insurer are necessary. 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. A market conduct examination may cover one or all of the following areas:

- Company Operations and Management: Designed to provide an overview view of the legal entity type and how it operates.
- Marketing and Sales: Designed to evaluate representations made by an insurance company or producer about its product(s) or services.

- Underwriting and Rating: Designed to provide an overview of how an insurance company treats applicants and policyholders and whether that treatment is in compliance with applicable statues, rules, and regulations.
- Policyholder Service: Designed to test compliance with statutes regarding notice/billing, delays/no response, and premium refund and coverage questions.
- Claim Handling: Designed to provide an overview of how an insurance company treats claimants and whether treatment is in compliance with applicable statutes, rules, and regulations.
- Complaints: Designed to review the insurance company's procedures for processing consumer complaints.
- Producer Licensing: Designed to test an insurance company's compliance with state producer licensing laws.

The NAIC Market Regulation Handbook includes chapters that relate generally to all examinations and chapters that relate to specific product types. The chapters include examination standards that are backed by NAIC Model Laws and Regulations. The specific review standards are followed by applicability and review criteria. A comprehensive examination would typically include all applicable review standards within an examination. A targeted or limited examination would focus on specific standards that relate to issues identified during the market analysis process. The handbook recommends use of an examination audit plan, including time and cost estimates, with periodic evaluation and update. It recommends that this document be shared with the company.

Interstate Coordination

Each jurisdiction should exert every effort to ensure that market conduct examinations are conducted in the most efficient and meaningful manner. The NAIC realizes that if the system of state 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. (See Appendix A) 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 Examination Tracking System (ETS). ETS provides jurisdictions with automated calling of insurance regulatory examinations and also allows the tracking of current and historical exams on companies. ETS also provides reports for pre-exam analysis and follow-up reports for historical and trend analysis.

The NAIC Market Actions Working Group (MAWG) 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 MAWG will be able to function and the more effective their market oversight will become. The MAWG consists of 16 individuals and provides policy oversight and direction of 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. MAWG focuses its efforts on those nationally significant insurers that exhibit characteristics indicating current or potential market regulatory issues that impact multiple jurisdictions.

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.

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 collaborative efforts. This includes participating, or assigning a designee to participate, in certain MAWG 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 MAWG. The CAD and MAC are responsible for communicating with other state insurance departments via the NAIC Market Regulation and Market Analysis electronic forums (bulletin boards). The CAD is the person identified with authority to receive information regarding collaborative actions from MAWG.

Enforcement

If there are identified problems with a company, state insurance departments have enforcement authority to implement corrective action and assure future compliance with state insurance laws.

Appendix A
NAIC Market Information Systems

The **Complaints Database System (CDS)** contains information about closed consumer complaints filed against insurance entities and producers. The information contained in this database may be submitted by states at varying times and should be used only as an indicator. There are four closed consumer complaint reports: Closed Complaint Counts by Code; Closed Complaint Counts by State; Closed Complaint Trend Report; and Closed Complaint Index.

The **Examination Tracking System (ETS)** allows market regulation and financial examiners to communicate examination schedules and results. ETS includes functions for calling financial, market and combined examinations, reporting dates and easy access to information about the people involved in the examination of a specific entity or group of entities. ETS can also be used to view or update examination information for a specific entity or group of entities.

The **Market Analysis Prioritization Tool (MAPT)** provides an overall score, a national score and a state score for companies writing a specified line of business based on both market and financial data. The report allows market analysts to compare similar companies on a national and state basis. The eleven available lines of business for this report are: Credit, Group Accident & Health, Group Annuity, Group Life, Homeowner, Individual Accident & Health, Individual Annuity, Individual Life, Long Term Care, Medicare Supplement and Private Passenger.

The **Market Analysis Review System (MARS)** provides regulators with sets of questions to guide them in the completion of a thorough analysis of a company's market and financial data. There are two types of MARS analyses. A MARS "Level One" analysis is a preliminary analysis that only uses data contained within the NAIC financial and market information databases. A MARS "Level Two" analysis is a more detailed analysis of company which requires the analyst to draw upon a broader range of information in six core areas of concern and a number of additional areas of concern. All approved Level One and Level Two analyses are tracked within MARS and can be reviewed by other states.

The **Market Conduct Annual Statement (MCAS)** is an annual statement of market conduct activity that qualifying companies must submit to each state that participates in MCAS. The statement is submitted by companies to the NAIC, which collects this information on behalf of the states. MCAS information is collected on a state and line of business level. The lines of business included in MCAS are Private Passenger Auto, Homeowners, Life and Annuity.

The **Market Initiative Tracking System (MITS)** provides regulators with a method of tracking and sharing information concerning the actions they take in investigating the business practices of a particular company, group of companies or a general issue. The MITS system is designed to capture market initiatives that may impact other jurisdictions. These initiatives may include, but are not limited to, any of the options from the continuum of regulatory responses. This database is distinguished from

the ETS system in that an initiative may include research, investigations or analysis. These initiatives may include single state, multistate, collaborative or even MAWG initiatives. If an initiative starts as a single state effort, it may then be linked to other single state efforts or even other initiatives. In addition, if an initiative is associated with an examination, the MITS system will allow for the two systems to be linked.

The **Regulatory Information Retrieval System (RIRS)** contains records of regulatory actions taken by participating state insurance departments against insurance producers, companies and other entities engaged in the business of insurance. All of these actions have a final resolution. RIRS can be for companies or individuals engaged in the business of insurance. All final adjudicated actions taken by the state insurance department should be submitted to RIRS. All actions should be reported regardless of the voluntary forfeiture, fine or penalty amount. The state submitted information includes, but is not limited to, the following: administrative complaints, cease and desist orders, settlement agreements and consent orders, receiverships, license suspensions or revocations, corrective action plans, restitutions, closing letters and letter agreements. Excluded from the submission of data should be exam report adoption orders without regulatory actions.

The **Special Activities Database (SAD)** contains information related to market activities and legal actions involving entities engaged in the business of insurance. Unlike regulatory actions that are submitted only from the states, SAD submissions are completed by states and NAIC staff. This database contains suspicious activities, legal cases, indictments and issues of regulatory concern researched and obtained from the states or other legitimate resources.

Appendix B
Key NAIC Market Regulation Model Acts

The key NAIC model acts addressing consumer protection are listed in chronological order based upon year of initial adoption by the NAIC.

Unfair Trade Practices Model Act (1948)

The purpose of this Act is to regulate trade practices in the business of insurance by defining all such practices that constitute unfair methods of competition or unfair or deceptive acts or practices and prohibiting such practices. In broad terms, the Act prohibits misrepresentation and false advertising, defamation, coercion, and unfair discrimination by insurance companies. The Act also requires insurance to maintain complaints, claims, rating, underwriting and marketing records in a manner that is retrievable for examination by state insurance regulators.

Model Law on Examinations (1956)

This Act establishes an effective, efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance by authorizing the state insurance commissioner to conduct examinations whenever it is deemed necessary.

Unfair Claims Settlement Practices Model Act (1972)

The purpose of this Act is to set forth standards for the investigation and disposition of claims. This Act requires insurance companies to promptly investigate claims and settle claims in good faith by effectuating prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.

Third Party Administrator Model Act (1977)

This Act establishes the status of a third-party administrator, providing definitions and guidance as to the authority and obligations of a third-party administrator.

Long Term Care Model Act (1987)

The purpose of this Act is to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Producer Licensing Model Act (1988)

This Act governs the qualifications and procedures for the licensing of insurance producers and provides specific guidance regarding the causes for which a state insurance department may place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or levy a civil penalty.

Improper Termination Practices Model Act (1995)

The purpose of this Act is to protect policyholders from improper terminations of insurance coverage and to set forth standards for the regulation and disposition of terminations of policies or certificates of insurance.

Life Illustrations Model Regulation (1995)

The purpose of this regulation is to provide rules for life insurance policy illustrations that will protect consumers and foster consumer education. The regulation provides illustration formats, prescribes standards to be followed when illustrations are used, and specifies the disclosures that are required in connection with illustrations. The goals of this regulation are to ensure that illustrations do not mislead purchasers of life insurance and to make illustrations more understandable.

Health Carrier External Review Model Act (1999)

The purpose of this Act is to provide standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination regarding health care coverage.

Privacy of Consumer Financial and Health Information Regulation (2000)

The purpose of this regulation is to govern the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the state insurance department. This regulation requires insurance companies to provide notice to individuals about its privacy policies and practices; describes the conditions under which insurance companies may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and provides methods for individuals to prevent an insurance company from disclosing that information.

Suitability in Annuity Transactions Model Regulation (2003)

The purpose of this regulation is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed.

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Core Competencies

General Topic/Area	*Standards/Comments*
1. Resources Core Competencies	
Regulatory Authority	The Department of Insurance should have authority to analyze, examine, or investigate entities that transact the business of insurance whenever it is deemed necessary. Such authority should include complete access to the regulated entity's books and records and, if necessary, the records of any affiliated regulated entity, insurance producer, or other entity contracted with to perform any additional services. Such authority should extend not only to inspect books and records but also to examine officers, employees and insurance producers of the regulated entity under oath when deemed necessary with respect to transactions directly or indirectly related to the regulated entity under examination or review. Measures should include: • Statutory authority to perform the continuum of regulatory responses; • Ability to access records; • Ability to keep records confidential; and • An unfair trade practices act and unfair claims settlement act substantially similar to the NAIC model.
Staff & Training	The Department of Insurance should have staff sufficient to perform the continuum of regulatory options including market analysis, market conduct examinations and market conduct investigations. On an ongoing basis, appropriate market analysis should be performed to identify regulated entities of concern. Appropriate prioritization of further investigation and continuum options should be pursued effectively and timely to protect the interests of consumers. Departments of Insurance should ensure that staff is sufficiently qualified to conduct examinations, other continuum options or analysis as needed. The Department of Insurance shall appoint a Market Analysis Chief (MAC) and Collaborative Action Designee (CAD) and ensure their participation at NAIC national meetings.

1. Resources Core Competencies	
Contract Examiner	There are three general types of contract examiners. Individual contractors are individual examiners that contract directly with insurance departments. Individual contractors frequently contract exclusively with one insurance department. Regulatory contractors are firms that contract exclusively with insurance departments. These firms may work for one or more insurance departments in the same or varying capacities. For instance, a firm may do examination work for Insurance Department A, analysis work for Insurance Department B, or baseline analysis and examination work for Insurance Department C. These firms choose not to accept engagements with regulated entities. Corporate contractors are firms that contract with insurance departments and accept engagements with regulated entities. Although specific staff may be dedicated to work for regulators, they work under the same corporate management as staff performing engagements with regulated entities. In addition, staff may change their roles within the firm at any time. The following competency standards apply to all three types of contract examiners. When using contractors for market conduct examinations, the Department of Insurance should ensure that the contractors have the education and professional experience comparable to qualified department staff and that processes and procedures are in place to oversee and monitor the work performance and related activities of the contractors.

2. Market Analysis Core Competencies	
Data Collection	Ability to gather and evaluate data as demonstrated by: 1) utilization of the Market Analysis Review System; 2) collection of data as required by the Commissioner, Director or Superintendent; and 3) for participating Departments of Insurance, collection of data for the Market Conduct Annual Statement; 4) use of the standardized data calls when there is a need for the collection of relevant data prior to the initiation of an investigation of market regulatory action.
Analysis	Departments of Insurance shall gather information from data currently available to the Department of Insurance, as well as surveys and required reporting requirements, information collected by the NAIC and a variety of other sources in both the public and private sectors, and information from within and outside the insurance industry. The information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review regulated entities or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.
Market Analysis Chief	The Market Analysis Chief (MAC) is the principal liaison with the NAIC Market Analysis Division, the Market Analysis Procedures (MAP) (D) Working Group and the Market Information Systems (D) Task Force. The MAC is responsible for all market analysis-related communications with other work units within the Department of Insurance. The MAC and CAD may be two individuals or the same person. The Department of Insurance should have the appropriate staff member assigned as the MAC to ensure an effective market analysis program.

3. Continuum Core Competencies

The Continuum of Regulatory Responses is a means of moving from market analysis to regulatory response. The continuum is a spectrum of regulatory tools to address actions necessary as a result of analysis of specific regulatory concerns regarding the conduct of a regulated entity. Specific examples of the continuum and recommended goals to consider when determining the nature of the regulatory response are discussed in the Continuum of Regulatory Responses chapter of the *Market Regulation Handbook*. Each Department of Insurance should evaluate and document market problems using the continuum of market regulatory responses.

Market Conduct Examinations	A Department of Insurance should have standards in place to determine when a market conduct exam is called. Departments of Insurance should adhere to the standards in the *Market Regulation Handbook*.
Investigations	Investigations should be conducted in accordance with investigation standards. When appropriate, investigations should be posted in any appropriate NAIC database and upon completion, if regulatory action is taken, in RIRS.
Consumer Complaints	The Department of Insurance shall have standards in place to receive and handle complaints and inquiries in accordance with the guidelines developed by the Market Analysis Procedures (D) Working Group. The Department of Insurance records complaints in a database and submits closed complaint data to the NAIC CDS on a regular basis. The Department of Insurance shall have standards for investigating complaints, responding to the complainant, and referring law violations for administrative action and reporting complaint patterns and trends to the Market Analysis Chief.

4. Interstate Collaboration Core Competencies	
Interstate Collaboration	Interstate collaboration may be accomplished by the following: • Participation with the Market Actions Working Group (MAWG) to include, but not be limited to, participation in calls and surveys; • Timely entry and participation in the NAIC databases; • Notifying the Collaborative Action Designee or Market Analysis Chief of the domestic Department of Insurance when considering one of the continuum of regulatory responses; • Verifying the Department of Insurance can ensure the confidentiality of materials and data as necessary; or • Following the collaborative actions guidelines for recommendations to MAWG.
Collaborative Action Designee	The Collaborative Action Designee (CAD) is the one contact identified by the Director/Commissioner of each state/district/territory to have the responsibility for all communications related to interstate collaboration. The Department of Insurance should have an appropriate staff member assigned as the CAD to assure support and participation in multistate collaborative actions.

Competency: Resources
SubSection: Regulatory Authority

The Department of Insurance should have authority to analyze, examine or investigate entities that transact the business of insurance whenever it is deemed necessary. Such authority should include complete access to the regulated entity's books and records and, if necessary, the records of any affiliated regulated entity, insurance producer, or other entity contracted with to perform any additional services. Such authority should extend not only to inspect books and records but also to examine officers, employees, and insurance producers of the regulated entity under oath when deemed necessary with respect to transactions directly or indirectly related to the regulated entity under examination or review.

The following standards apply to this competency:

Standard One. **The Department of Insurance has the necessary authority to implement the continuum of regulatory options.**
The Department of Insurance should have authority to examine regulated entities whenever it is deemed necessary. Such authority should include complete access to the regulated entity's books and records and, if necessary, the records of an affiliated regulated entity, agent and managing general agent. Such authority should extend not only to inspect books and records but also to examine officers, employees and agents of the regulated entity under oath when deemed necessary with respect to transactions directly or indirectly related to the regulated entity under examination. The NAIC Model Law on Examinations or substantially similar provisions shall be part of state law.

Standard Two. **The Department of Insurance has the necessary authority to take corrective action when necessary.**
The Department of Insurance should have the authority to take corrective action or issue cease and desist orders for practices that are determined to be in violation of state law.

Standard Three. **The Department of Insurance has the ability to keep records confidential, when appropriate.**
The Department of Insurance should allow for the sharing of otherwise confidential information, administrative or judicial orders, or other action with other Department of Insurance regulatory officials provided that those officials are required, under their state law, to maintain its confidentiality. The Department of Insurance should have a documented policy to cooperate and share information with other regulators directly and also indirectly through committees established by the NAIC which may be reviewing and coordinating regulatory oversight and activities. A Master Confidentiality and Information Sharing Agreement shall be executed and available for review in I-SITE.

Standard Four. **The Department of Insurance has statutory provisions to protect insurance consumers.**
The Department of Insurance should have a regulatory framework designed for the protection of insurance consumers. An unfair trade practices act or unfair claims settlement act substantially similar to the NAIC model shall be part of state law.

Competency: Resources
SubSection: Staff and Training

The Department of Insurance should have staff sufficient to perform the continuum of regulatory options including market analysis, market conduct examinations and market conduct investigations. On an ongoing basis, appropriate market analysis should be performed to identify companies of concern. Appropriate prioritization of further investigation and continuum options should be pursued effectively and timely to protect the interests of consumers. Departments of Insurance should ensure that staff is sufficiently qualified to conduct examinations, other continuum options or analysis as needed. The Department of Insurance should ensure it has appointed a Market Analysis Chief (MAC) and Collaborative Action Designee (CAD).

The following standards apply to this competency:

Standard One. **The Department of Insurance has a policy that encourages the professional development of market regulation staff through job-related college courses, professional programs, and/or other training programs.**

Standard Two. **The Department of Insurance has minimum educational and experience requirements for all professional employees and contractual staff positions in the market regulation and market analysis area that are commensurate with the duties and responsibilities of the position.**
The Department of Insurance should have examiners with appropriate experience to perform necessary tasks. Although not required, credentials such as Certified Insurance Examiner (CIE), Accredited Insurance Examiner (AIE), IRES MCM, NAIC APIR, NAIC PIR, NAIC SPIR, Chartered Property Casualty Underwriter (CPCU), Fellow of the Life Management Institute (FLMI), AAI, AAM, AAPA, ACP, ACS, AFSB, AIAA, AIAF, AIC, AIC, AIM, AIRC, AIS, AIT, ALCM, AMIM, APA, API, ARA, ARC, ARe, ARM, AU, ARM-P, ARP, ASLI, AU, CCP, CFE, CIC, CISR, ChFC, CLU, CRM, FFSI, INS, LIA, PCS, REBC, RHU, and SM or similar designations may demonstrate expertise in insurance.

Standard Three. **The Department of Insurance should have the ability to attract and retain qualified market regulation personnel.**

Standard Four. **If a Department of Insurance elects to utilize contracts with individuals or firms to conduct market regulatory activities, the Department of Insurance should ensure the individuals meet the minimum educational and experience requirements as outlined above and that the activity is conducted in accordance with the Department of Insurance's established policies and procedures and applicable state law.**

Competency: Resources
SubSection: Contract Examiner

There are three general types of contract examiners. Individual contractors are individual examiners that contract directly with insurance departments. Individual contractors frequently contract exclusively with one insurance department. Regulatory contractors are firms that contract exclusively with insurance departments. These firms may work for one or more insurance departments in the same or varying capacities. For instance, a firm may do examination work for Insurance Department A, analysis work for Insurance Department B, or baseline analysis and examination work for Insurance Department C. These firms choose not to accept engagements with regulated entities. Corporate contractors are firms that contract with insurance departments and accept engagements with regulated entities. Although specific staff may be dedicated to work for regulators, they work under the same corporate management as staff performing engagements with regulated entities. In addition, staff may change their roles within the firm at any time. The following competency standards apply to all three types of contract examiners.

When using contractors for market conduct examinations, the Department of Insurance should ensure that the contractors have the education and professional experience comparable to qualified department staff and that processes and procedures are in place to oversee and monitor the work performance and related activities of the contractors.

The following standards apply to this competency:

Standard One. **The Department of Insurance shall have established procedures to select contractors in accordance with applicable state laws and policies.**

The Department of Insurance shall utilize the approved state method of selection of contractors, such as Requests for Proposal (RFP) and when possible, maintain or select from a national pool of contractors to ensure selection of examiners with market regulation expertise and knowledge of the relevant lines of insurance.

The Department of Insurance shall utilize documented standards to determine whether a conflict of interest exists, either directly or indirectly, that would preclude the contractor's involvement with the proposed market analysis, regulatory investigation or market conduct activity.

The Department of Insurance shall utilize a written contract or Memorandum of Understanding (MOU) when using the services of a contract examiner. The contract or MOU shall include specific information regarding scope of work, fees, timelines, deliverables and deadlines, confidentiality and security.

Standard Two. **The Department of Insurance shall have established minimum educational and experience requirements for all contractual positions within the market regulation areas that are commensurate with the duties and responsibilities of the positions.**

The Department of Insurance shall have contract analysts and examiners with appropriate experience perform necessary tasks. Although not required, credentials such as Certified Insurance Examiner (CIE), Accredited Insurance Examiner (AIE), IRES MCM, NAIC APIR, NAIC PIR, NAIC SPIR, Chartered Property Casualty Underwriter (CPCU), Fellow of the Life Management Institute (FLMI), AAI, AAM, AAPA, ACP, ACS, AFSB, AIAA, AIAF, AIC, AIM, AIRC, AIS, AIT, ALCM, AMIM, APA, API, ARA, ARC, ARe, ARM, AU, ARM-P, ARP, ASLI, AU, CCP, CFE, CIC, CISR, ChFC, CLU, CRM, FFSI, HCAFA, HCSA, HIA, HIPAAA, HIPAAP, INS, LIA, LTCP, MHP, MMA, PCS, REBC, RHU, and SM or similar designations may demonstrate expertise in insurance. Contract staff shall demonstrate experience and expertise in the specific roles for which they are contracted as well as in the particular lines of insurance for which review or examination is undertaken.

The Department of Insurance shall ascertain if the contractors have expertise in state-specific laws and regulations and, if such expertise is lacking, develop procedures to ensure that contract examiners obtain such knowledge.

Standard Three. **The Department of Insurance shall conduct pre-examination conferences with the contract examiners and develop written documentation of goals and expectations.**

The nature and scope of services, time frames, budget and hourly rates, hours of work, confidentiality provisions, contractor responsibilities and reporting mechanisms shall be documented prior to commencement of the examination.

Standard Four. **The Department of Insurance shall establish procedures to ensure that the contract examiners comply with the standards of the Market Regulation Handbook, including uniformity guidelines, as well as the Market Analysis, Continuum and Market Conduct Examinations Core Competencies, as appropriate.**

Standard Five. **The Department of Insurance shall assign Department staff the responsibility to oversee the performance of the contract examiners.**

Department of Insurance authorized staff shall monitor or oversee the pre-examination and exit conferences and appropriate department staff shall meet regularly with the contract examiners to ensure that the examination is being conducted in accordance with pre-exam agreements. Department staff shall

review the contractors' preliminary findings and draft report before it is submitted to the insurer.

The Department of Insurance shall also require that the activities performed by contract examiners on behalf of the Department are conducted in accordance with Department of Insurance established policies and procedures and applicable state law.

Department of Insurance staff shall review contractor billings for cost and reasonability and respond to any questions from insurers regarding contractor performance or billing.

Standard Six. **The Department of Insurance shall establish procedures to ensure confidentiality of work papers and other data, electronic security and requirements for returning market conduct examination work papers to the Department of Insurance.**

To further enhance security, Departments of Insurance should provide or require the contractors to utilize dedicated computers, e-mail and URL addresses with approved virus software and approved encryption. When possible, E-mail and needed URL may be routed through the DOIs and password protected.

Contracts or other written agreements between a Department of Insurance and contract examiners shall contain language that the contract examiner shall safeguard confidential information. This includes protection of proprietary information received from the regulated entity under examination, information received from other state Departments of Insurance and data residing in NAIC databases.

Assuming that the contract between the insurance department and the contractor contains appropriate language regarding confidentiality of information, the NAIC will allow the contractor access to information residing at the NAIC as directed by the insurance department. The Department shall have authorized staff verify that the contract examiner has signed a confidentiality agreement that includes access to I-SITE; determine whether and to what extent the contractor may access NAIC databases such as I-SITE and shall be responsible for notifying the NAIC of any changes regarding the contract examiners and discontinuing such access upon completion of the examination.

The Department of Insurance shall establish policies and procedures in writing with the contract examiners regarding the confidentiality of work papers and other related data as well as the point at which all data and work papers are returned to the Department of Insurance upon completion of the examination. Laptop computers should be sanitized after each examination and at the beginning of each examination, only loaded with software for that specific examination.

Competency: Market Analysis
SubSection: Data Collection

Ability to gather and evaluate data as demonstrated by: 1) utilization of the Market Analysis Review System; 2) collection of data as required by the Commissioner, Director or Superintendent; and, 3) for participating Departments of Insurance, collection of data for the Market Conduct Annual Statement; 4) use of the standardized data calls when there is a need for the collection of relevant data prior to the initiation of an investigation of market regulatory action.

The following standards apply to this competency:

Standard One. **The Department of Insurance fully participates in CDS, ETS, and RIRS.**

"Full" participation means that CDS, ETS, and RIRS data in the Department of Insurance is submitted electronically to the appropriate NAIC databases in a frequent, current, accurate, and complete manner.

Each Department of Insurance will be asked to certify annually that it has made timely and complete submissions of all relevant information to the CDS, ETS and RIRS databases for the preceding calendar year.

Standard Two. **The Department of Insurance should reference and utilize information available through the various databases and resources in I-SITE.**

Standard Three. **The Department of Insurance should actively utilize the Market Analysis Review System.**

Standard Four. **The Department of Insurance should make reasonable attempts to avoid duplicative and overlapping data collection whenever possible. The Department of Insurance should use the uniform data calls for data collection purposes. If the Department of Insurance deviates from standardized data calls, it will notify the regulated entity of the deviation and may allow for additional time for the regulated entity to provide the information.**

Standard Five. **The Department of Insurance collecting data, including data collected through the Market Conduct Annual Statement, should ensure the data is shared and considered in the market analysis process.**

Competency: Market Analysis
SubSection: Analysis

Departments of Insurance shall gather information from data currently available to the Department of Insurance, as well as surveys and required reporting requirements, information collected by the NAIC and a variety of other sources in both the public and private sectors, and information from within and outside the insurance industry. The information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review regulated entities or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

The following standards apply to this competency:

Standard One. **The Department of Insurance has completed Level 1 Analysis and meets any recommended standards established by the Market Analysis Procedures Working Group (MAP) on an on-going basis.**

Standard Two. **The Department of Insurance has appointed a Market Analysis Chief and promptly notifies the NAIC if the Market Analysis Chief changes.**
Each Department of Insurance needs a clearly identified person with whom all other Department of Insurance staff should share indicators of potential market regulation problems and who will also coordinate information sharing with other Departments of Insurance through the NAIC's MAP Working Group and oversee the Department of Insurance's market analysis.

Standard Three. **The Department of Insurance has established a systematic procedure for interdivisional communication.**
It is essential for information to be shared and discussed between the Market Analysis Chief and other Department of Insurance staff. This should be done on a systematic basis, including at a minimum a quarterly questionnaire requesting other work areas within the Department of Insurance to share unusual activity that may be of interest to the Market Analysis Chief such as patterns of adverse financial data, consumer complaints, policy termination activity, insurance producer misconduct, or use of noncompliant forms or rates.

Standard Four. **The Department of Insurance has identified core information that all staff should share with the Market Analysis Chief.**
In particular, all Department of Insurance staff should share any of these indicators with the Market Analysis Chief in accordance with established procedures.

- Participation with the Market Actions Working Group (MAWG) to include, but not be limited to, participation in calls and surveys;

- Significant changes in the ratio of consumer complaints against the regulated entity or significant numbers of complaints in a relatively short period of time;
- Dramatic growth (> +33%) or decline (< -10%) in one or more lines of business;
- Significant changes in the regulated entity'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 a group of regulated entities;
- Recent changes in ownership or senior management;
- A high degree of reliance on third parties, such as MGAs or TPAs, to perform regulated entity functions; or
- Significant problems with electronic data processing systems such that the integrity of data underlying claims, underwriting and financial systems is questionable.

Standard Five. **The Department of Insurance has developed and instructed complaint analysts in key indicators in complaint data.**

Complaint analysts in the Department of Insurance should share the following types of information with the Market Analysis Chief at the time the Department of Insurance receives this information:

- Specific complaints so critical that one complaint merits reporting (e.g., antitrust);
- Spikes in complaints against the same regulated entity 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 in Standard Four.

Standard Six. **The Department of Insurance identifies potential problems from complaints.**

As a minimum, complaint ratios should be calculated annually at a regular time and the Market Analysis Chief should use information generated on regulated entities with ratios outside of the norms, along with other information about those companies available in the Department of Insurance, to determine whether any further review is necessary.

Standard Seven. **Annual statement State Pages and other financial indicators are routinely shared with the Market Analysis Chief in accordance with established procedures.**

Every regulated entity—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 regulated

entity's business in the state. In most Departments of Insurance, a significant amount of staff resources at that time are devoted to review and analysis of the financial statements. While such financial analysis should be primary, at some point after the Blanks are available, the Market Analysis Chief should be aware 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).

Standard Eight. **There is an established baseline market analysis program on a coordinated schedule.**

All Departments of Insurance should analyze the various data elements and indicators within the same general timeframe, so that if one or more of the Departments of Insurance have issues with a particular regulated entity, then they can discuss it first within the framework of the Market Actions Working Group (MAWG). Results should be compiled and reviewed on no less than a quarterly schedule.

Standard Nine. **The Department of Insurance coordinates results with the NAIC Market Actions Working Group.**

In addition to reporting plans for examinations and investigations, all noteworthy market analysis results should be recorded in NAIC systems. Concerns with nationally significant companies should be specifically noted when reporting to MAWG and issues that appear to focus on a small number of other states should be brought to the attention of those states' Departments of Insurance.

Standard Ten. **The Department of Insurance's procedures require that all material adverse indications be promptly presented to the commissioner or an appropriate designee for determination and implementation of appropriate regulatory action.**

Upon the reporting of any material adverse findings from the market analysis staff, the Department of Insurance should take timely action in response to such findings or adequately demonstrate the determination that no action was required. Action should include but not be limited to the NAIC's Continuum of Regulatory Options. Departments of Insurance should be mindful that findings that suggest potential solvency concerns should be promptly reported to the appropriate financial regulation staff.

Standard Eleven. **The Department of Insurance provides for appropriate supervisory review and comment.**

Standard Twelve. **The Department of Insurance has documented procedures.** The Department of Insurance should have documented market analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each regulated entity.

Competency: Market Analysis
SubSection: Market Analysis Chief

Departments of Insurance shall gather information from data currently available to the Department of Insurance, as well as surveys and required reporting requirements, information collected by the NAIC and a variety of other sources in both the public and private sectors, and information from within and outside the insurance industry. The information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review regulated entities or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

The following standards apply to this competency:

Standard One. **The Department of Insurance has appointed a Market Analysis Chief and promptly notifies the NAIC if the Market Analysis Chief changes.** The MAC or the MAC's designee shall have the authority to represent the Department of Insurance in matters related to discussions regarding market analysis**.**

Standard Two. **The MAC or his or her designee is actively involved with the NAIC market analysis areas and working groups.**
The MAC will work with the NAIC to accomplish the goal that 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. The MAC or, when unavailable, a designee assigned by the MAC, shall participate in all Market Analysis Procedures Working Group (MAP) meetings or conference calls.

If the MAC does not attend the NAIC national meetings, the MAC or designee shall participate in each MAP conference call.

Standard Three. **The Department of Insurance has procedures for the MAC to communicate with appropriate Department of Insurance staff.**
The MAC shall work with the appropriate staff in areas including consumer services, enforcement, legal, forms and filing, financial, market analysis and market conduct to ensure that there are documented

procedures to notify the MAC of unusual activity that may be of interest for market analysis.

The MAC shall establish means of regular communication with the unit heads of these areas. Such communication shall include, at a minimum, a quarterly questionnaire in accordance with the Market Analysis Core Competencies.

Standard Four. **The MAC participates in communication with other Departments of Insurance regarding market analysis.**
The MAC, in coordination with the Department of Insurance's CAD, shall be responsible for posting and responding to communications via the NAIC Market Regulation and Market Analysis Electronic Bulletin Boards. Information related to the role of the Market Analysis Chief (MAC) shall be handled by the MAC or their designee.

Standard Five. **The MAC shall be responsible for implementation of the NAIC's recommended tasks for an effective market analysis program.**
The MAC will coordinate with Department of Insurance staff to ensure that at least the NAIC's minimum recommended tasks for an effective market analysis program as outlined in the *Market Regulation Handbook* are accomplished.

Standard Six. **The Department of Insurance shall provide the MAC with the necessary authority to communicate with responsible staff to ensure that CDS, ETS and RIRS data is submitted electronically in a frequent, current, accurate and complete manner.**

Standard Seven. **The MAC shall ensure that market analysis staff utilize appropriate information such as the Market Analysis Company Prioritization Tool for baseline analysis of lines of business and that Level 1 Analysis is recorded in the Market Analysis Review System (MARS).**
The MAC shall also assure that Level 1 recommendations are acted upon and where appropriate, the MITS system is updated with the action taken.

Competency: The Continuum

The Continuum of Regulatory Responses is a means of moving from market analysis to regulatory response. The continuum is a spectrum of regulatory tools to address actions necessary as a result of analysis of specific regulatory concerns regarding the conduct of a regulated entity. Specific examples of the continuum and recommended goals to consider when determining the nature of the regulatory response are discussed in the Continuum of Regulatory Responses chapter of the *Market Regulation Handbook*. Each Department of Insurance should evaluate and document market problems using the continuum of market regulatory responses.

The following standards apply to this competency:

Standard One. **The Department of Insurance designates, authorizes and maintains staff responsible for reviewing market analysis findings and determining the necessary regulatory response.**

Standard Two. **The Department of Insurance considers factors including but not limited to consumer harm; scope and nature of the concern; jurisdictional boundaries of the issue; cost effectiveness for regulator and regulated entity; the regulated entity's history regarding cooperation and regulatory compliance; whether another state has addressed a similar concern with the entity and whether enforcement action is contemplated when considering the nature of regulatory response.**

Standard Three. **The Department of Insurance has procedures for staff responsible for continuum actions to communicate with the Market Analysis Chief (MAC) to obtain analysis information and recommendations for continuum actions when warranted.**

Standard Four. **The Department of Insurance has procedures for staff responsible for continuum actions to communicate and coordinate with the Collaborative Action Designee (CAD) in instances of multistate concern.**

Standard Five. **Where appropriate, the Department of Insurance inputs and updates continuum actions into the applicable NAIC regulatory databases.**

Competency: The Continuum
SubSection: Market Conduct Examinations

A Department of Insurance should have standards in place to determine when a market conduct exam is called. Departments of Insurance should adhere to the standards in the *Market Regulation Handbook*.

The following standards apply to this competency:

Standard One. **Each Department of Insurance shall prioritize examinations.**
Each Department of Insurance shall establish criteria for calling a market conduct examination. Each Department of Insurance 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.

The trigger or reason for the examination shall be maintained in the examination documents, preferably the work papers, and where appropriate shared with the regulated entity.

Standard Two. **The Department of Insurance shall utilize the exam tracking system Examination Tracking System (ETS).**
As soon as scheduled, each Department of Insurance shall enter the examination into the ETS, which is administered by the NAIC.

Each Department of Insurance shall adopt a system for ensuring proper implementation and maintenance of the ETS system. The NAIC will develop aids such as a data entry checklist that will assist in maintaining the ETS program.

Standard Three. **Exams shall be entered into the ETS 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, or to accommodate the schedule of the regulated entity.

Standard Four. **Each Department of Insurance shall, wherever possible and permissible by law, comply with the guidance provided in the *Market Regulation Handbook* when scheduling, planning, calling and performing an examination.**

Standard Five. **Each Department of Insurance 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.

- At the end of the planning process, the Department of Insurance 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.
- Each Department of Insurance shall prepare an examination work plan prior to the examination. The work plan or planning memorandum shall include:
    a. The scope of the examination;
    b. The justification for the examination;
    c. A time and cost estimate; and
    d. An identification of factors that will be included in the billing.

Standard Six. **Each Department of Insurance shall develop a system to announce the examination to the selected regulated entity.**

The announcement of the examination should be sent to the regulated entity as soon as possible but in no case any later than 60 days before the estimated commencement of the on-site examination. Exceptions to this rule are made for examinations that are called to respond to more immediate concerns, or to accommodate the schedule of the regulated entity. The announcement notice should contain:

- The name and address of the regulated entity(ies) 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 regulated entity, if any;
- A request for the regulated entity to name its examination coordinator; and
- Additional information may be requested at a later date.
- If the examination is to be led by a contract firm, the regulated entity shall be notified.

Standard Seven. **Each Department of Insurance shall develop a preliminary examination packet or handbook that should be sent to the examination coordinator as soon as possible but in no case any later than 30 days before the estimated commencement of the on-site examination.**

The preliminary information shall contain the following information:

- General instructions;
- The scope of the examination;
- The materials requested to perform the examination;
- Data calls;
- Requirements for accommodations and supplies including modem requirements;

- Time and cost estimates;
- Travel information;
- Specific instructions regarding sampling, communications with the regulated entity and other pertinent information;
- Location of on-site examination;
- Security arrangements; and
- Billing procedures.

Standard Eight. **The Department of Insurance shall adopt the standardized data calls contained in the referenced documents section of the *Market Regulation Handbook*.**

If a Department of Insurance deviates from the standardized data call, it will notify the regulated entity of the deviation and may want to allow additional time for the regulated entity to provide the information.

Standard Nine. **The Department of Insurance shall provide an opportunity for a pre-examination conference with the regulated entity coordinator and key personnel to clarify expectations prior to the commencement of the examination.**

Standard Ten. **The Department of Insurance shall develop a system for exchanging information with the regulated entity that advises them of the errors and other problems developed during the examination. The state should be mindful of timeframes contained in the Market Conduct Record Retention and Production Model Regulation.**

The system could consist of "crit" sheets, summaries, or both. Any form of communication concerning errors should include the following information:

- Record numbers or other identifying factors;
- The examiners' statement of the problem or error and, if relevant, the applicable law and/or standard; and
- A request for signature and comment from the regulated entity.

Standard Eleven. **Each Department of Insurance shall develop a procedure for document handling, including the removal of original documents, where that is necessary, to a location other than the Department of Insurance.**

To address the issue of confidentiality, original work paper documents shall remain at the Department of Insurance, especially if the examiner is a contracted employee of the state Department of Insurance.

Standard Twelve. **The Department of Insurance shall use documented sampling guidelines or develop their own scientifically-based sampling programs.**

- All sampling methods should be random;

- If using a method other than the NAIC sampling guidelines, the method shall indicate the confidence levels, tolerable error rates and include extrapolation;
- All sampling methods shall avoid pre-selection; however, stratified sampling is allowed; and
- The nature of the sampling method chosen should be disclosed to the regulated entity that is the subject of the examination.

Standard Thirteen. The Department of Insurance shall offer to conduct an exit conference at the end of an examination.

The exit conference should offer the following:

- The examination status and proposed findings;
- The report process; and
- An explanation of any post-examination billing.

Standard Fourteen. The Department of Insurance shall utilize the standard report format found in the *Market Regulation Handbook*.

Each report shall at a minimum include the following:

- Title page;
- Table of contents;
- Salutation;
- Foreword;
- Scope;
- Executive summary;
- Results of previous examinations;
- Pertinent facts of the current examination;
- Summarization; and
- Appendices.

Standard Fifteen. The Department of Insurance shall utilize a standardized timeline as required by the state's statute or the NAIC Model Law on Examinations.

- The draft report is delivered to the regulated entity within 60 days of completion of the examination;
- The regulated entity must respond with comments to the Department of Insurance within 30 days;
- The Department of Insurance has 30 days to informally resolve issues and prepare a final report (unless there is a mutual agreement to extend the deadline); and
- The regulated entity has 30 days to accept the final report or request a hearing.

Standard Sixteen. The Department of Insurance shall include the regulated entity's response in the final examination report where allowed by law.

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 regulated entity 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.

Standard Seventeen. The Department of Insurance shall publish final reports as public documents where allowed by law.

- Departments of Insurance should publish the final examination report on the Department of Insurance's Web site; and
- Department of Insurance shall develop a process for releasing final examination results to the public. A press release may be used.

Standard Eighteen. The Department of Insurance should be able to demonstrate an enforcement strategy, and specifically the role of market conduct activities in that effort.

An effective enforcement strategy includes having a system in place to differentiate between willful actions and inadvertent ones and consider appropriate administrative resolutions whether it is financial or non-financial. Departments of Insurance should also want to consider a methodology for determining the amounts of fines, based on a host of criteria including the size of the regulated entity, the market share, whether the problems have been corrected, and any host of mitigating or aggravating circumstances.

Standard Nineteen. Each Department of Insurance shall establish a process to follow-up on examination and/or investigative findings.

Competency: The Continuum
SubSection: Investigations

Investigations should be conducted in accordance with the Market Regulation Investigation Guidelines chapter in the *Market Regulation Handbook*. If applicable, investigations should be posted in the appropriate NAIC database. If regulatory action is taken upon completion of the investigation, the regulatory action should be posted in RIRS. Note: These competency standards may also be applicable in agent misconduct cases.

The following standards apply to this competency:

Standard One. The Department of Insurance has the necessary authority to conduct an investigation into entities.

If the Department of Insurance has reason to believe an entity has violated or is violating any provision of the insurance code or upon complaint by any resident of its state, the Department of Insurance should have the necessary statutory authority to investigate. Such authority should include

complete access to the accounts, records, documents and transactions of anyone engaging in the business of insurance.

Investigations may be conducted by the Department of Insurance's examiners or investigators. The examiners or investigators should not remove, destroy or deface any account, record, document or property of the entity under investigation. The examiner or investigator may remove such documentation upon written consent of the entity, upon administrative subpoena or other statutory authority granted the Department of Insurance, or pursuant to a court order.

Standard Two. **The Department of Insurance has the ability to keep records confidential, when appropriate.**

The Department of Insurance should have the statutory authority to keep an investigation and its results confidential if no regulatory action is taken. The Department of Insurance should allow for the sharing of otherwise confidential information, administrative or judicial orders, or other action with other Department of Insurance regulatory officials or with law enforcement officials of any state or agency of the federal government. The Department of Insurance should have a documented policy to cooperate and share information with other regulators, with state law enforcement officials or agency of the federal government, and/or with NAIC, which may be reviewing and coordinating regulatory oversight and activities.

Standard Three. **The Department of Insurance may develop a pre-investigation planning process.**

Each Department of Insurance may prepare an investigation work plan prior to the investigation. The work plan or planning memorandum shall include:

a. The justification for the investigation;
b. The scope of the investigation;
c. A time and cost estimate; and
d. Costs, which may be billed to other sources.

Where applicable, information should be gathered from internal sources, including:

a. Annual reports;
b. Policy and form filings;
c. Examination reports (financial, market); and
d. Producer licensing files and applications.

Information should also be obtained from various NAIC databases including:

a. RIRS (Regulatory Information Retrieval System);
b. SAD (Special Activities Database);

c. CDS (Complaints Database System);
d. ETS (Examination Tracking System);
e. SPLD (State Producer Licensing Database); and
f. MITS (Market Initiative Tracking System).

Standard Four. **As soon as possible, each Department of Insurance shall enter the investigation into the appropriate NAIC database(s).**

Initially, if the entity is one with a valid NAIC company code and the subject of a civil or administrative investigation, the matter should be entered into the MITS database. Should the investigation lead to an examination of a regulated entity, the regulated entity subject to this examination should be entered into the ETS database.

Additionally, if at any time the entity subject to the investigation is suspected of criminal activity or is the subject of final adjudicated actions taken by regulatory or law enforcement agencies other than a Department of Insurance, such information should be entered into the SAD database.

Standard Five. **The Department of Insurance may require a written report of investigation at the conclusion of each investigation.**

The report of investigation should adequately summarize the underlying documentation contained in the investigative file. The investigative file documentation should include but may not be limited to:

a. Written notes of calls/interviews;
b. Written statement;
c. Summary and organization of relevant documents;
d. Preservation of original evidence (when feasible); and
e. Written findings and recommendations.

Standard Six. **Upon conclusion of an investigation, the Department of Insurance should determine the appropriate investigative response or action, if appropriate.**

At the conclusion of an investigation, the Department of Insurance may choose, but is not limited to, one of the following investigative actions:

a. Contact the entity for response—If applicable, the examiner or investigator may request a written response from the entity as to his or her findings. Note: Sometimes, the entity does not know it is the subject of an investigation;
b. Closing letter—The Department of Insurance may notify the entity that no violation was found. Note: Sometimes, the entity does not know it is the subject of an investigation;
c. Warning letter—If a violation was found, but mitigating circumstances indicate an isolated incident or technical violation, the Department of Insurance should notify the entity of its findings to place the entity on notice that further violations may lead to the appropriate administrative, civil and/or criminal actions; and

d. Choose an option from the continuum of regulatory responses.

Standard Seven. **If the investigation and/or the option chosen from the continuum of regulatory responses determines that further action is necessary to correct the deficiency and/or statutory violation, the Department of Insurance may choose from, but is not limited to, the following enforcement options.**

a. Administrative complaint—An administrative complaint may be filed against the entity or individual who is the subject of the investigation. The examiner or investigator should review the results of the investigation with legal counsel for further advice;
b. Cease and desist order—If the conduct uncovered is causing or is about to cause substantial harm, the Department of Insurance may issue a cease and desist order;
c. Settlement agreement and/or consent order—The Department of Insurance should have the authority to enter into settlement agreements and/or consent orders at any time during the investigation phase. In this settlement agreement and/or consent order, corrective action may be agreed upon by the parties;
d. Administrative fines or penalties and/or suspension or revocation of license(s); and/or
e. Post-investigation audits, corrective action plans, and/or self-audits by the entity.

Standard Eight. **At the conclusion of any regulatory action, each Department of Insurance shall enter the appropriate information into the RIRS system.**

Each Department of Insurance shall enter the appropriate information into the RIRS database as well as update any previous information provided to the MITS, ETS, or other NAIC databases.

Competency: The Continuum
SubSection: Consumer Complaints

The Department of Insurance shall have standards in place to receive and handle complaints and inquiries in accordance with the guidelines developed by the Market Analysis Procedures (D) Working Group. The Department of Insurance records complaints in a database and submits closed complaint data to the NAIC CDS on a regular basis. The Department of Insurance shall have standards for investigating complaints, responding to the complainant, and referring law violations for administrative action and reporting complaint patterns and trends to the Market Analysis Chief.

The following standards apply to this competency:

Standard One. **Each Department of Insurance shall have a unit or staff responsible for receiving consumer complaints and inquiries.**

The Department of Insurance shall have a separate unit or individuals whose duties are to receive consumer complaints and inquiries.

The unit or individuals have sufficient training and expertise to identify the elements of a complaint.

The unit or individuals have sufficient training and expertise to handle the complaints or to assign them to the appropriate Department of Insurance employee to handle.

Standard Two. **Each Department of Insurance shall establish criteria defining complaints and inquiries, the method of receipt and the content required in order to accept the complaint.**

The Department of Insurance will use, at a minimum, the definition of a complaint developed by the Market Analysis Procedures (D) Working Group.

The Department of Insurance shall have a process to accept complaint referrals from the NAIC Consumer Information Source (CIS).

The Department of Insurance shall, at a minimum, accept written complaints and have procedures for obtaining additional information from the consumer.

Standard Three. **The Department of Insurance shall have a process for acknowledging receipt of complaints, investigating the allegations and reporting the results of the investigation to the consumer.**

The Department of Insurance shall establish criteria for determining if the Department of Insurance has jurisdiction over a complaint and communicating that information to the consumer.

Complaints requiring investigation are referred to the appropriate staff in the Department of Insurance for processing.

The Department of Insurance has procedures in place to make the regulated entity aware that a complaint has been filed and to provide an opportunity to respond to the allegations in the complaint.

The Department of Insurance reviews the response of the regulated entity and provides the consumer with a written response when the complaint file is closed.

Standard Four. **The Department of Insurance shall have a process for identifying complaints involving violations and referring these complaints for administrative action.**

The Department of Insurance has procedures to identify complaints that require administrative action.

Standard Five. **Each Department of Insurance shall have a system for recording and tracking complaints in a database using a coding system to facilitate analysis and trending.**

The Department of Insurance shall record complaints on receipt using uniform definitions and standard coding protocols.

The Department of Insurance's complaint tracking system contains sufficient data to compile and measure complaints by type, reason and company or licensed entity.

The database allows the Department of Insurance to track key elements of the complaint process including date received, date resolved and the current status of the complaint.

The Department of Insurance submits all, accurate, closed complaints to the NAIC CDS in accordance with URTT criteria.

The Department of Insurance has a procedure in place to monitor the accuracy of complaint data.

Standard Six. **Complaint analysts provide periodic reports to the Market Analysis Chief regarding complaint ratios, trends and significant individual complaints.**

The Department of Insurance has procedures in place and provides regular reports on complaint patterns, trends, unusual activity and significant individual complaints.

The Department of Insurance calculates complaint ratios and provides information on outliers to the Market Analysis Chief.

Competency: Interstate Collaboration

Interstate collaboration may be accomplished by the following:

- Participation with MAWG to include, but not be limited to, participation in calls and surveys;
- Timely entry and participation in the NAIC databases;
- Notifying the Collaborative Action Designee or Market Analysis Chief of the domestic Department of Insurance when you realize you are considering one of the continuum of regulatory responses;

- Verifying the Department of Insurance can ensure the confidentiality of materials and data as necessary; or
- Following the collaborative actions guidelines for recommendations to MAWG.

The following standards apply to this competency:

Standard One. **The Market Analysis Chief or their designee is actively involved with MAP and participates in MAP meetings.**

Standard Two. **The Market Analysis Chief or their designee must participate on the quarterly MAP/MAC conference calls**.

Standard Three. **The Collaborative Action Designee or their designee is actively involved with MAWG.**

Standard Four. **The Department of Insurance participates fully in the NAIC databases and its submissions are timely, accurate and complete.**

Standard Five. **The referring Department of Insurance has taken recommended action on all companies it has referred to MAWG.**
If a Department of Insurance refers a regulated entity to the MAWG agenda that results in a collaborative action, a lead Department of Insurance(s) will be identified and the lead Department of Insurance(s) will identify additional participating Departments of Insurance as identified in the *Collaborative Actions Guide*. The referring Department of Insurance should continue to participate and support the MAWG initiative.

Standard Six. **The Department of Insurance follows the procedures in the Collaborative Actions chapter of the *Market Regulation Handbook*.**

Standard Seven. **Referrals to MAWG are made when appropriate and when material issues may impact other jurisdictions. Referrals should be made by the Collaborative Action Designee, Deputy Insurance Commissioner, Insurance Commissioner or other individual designated by the Commissioner.**

Standard Eight. **Department of Insurance referrals and accompanying materials to MAWG are provided in the format developed and approved by MAWG or the NAIC (D) Committee, as appropriate.**

Standard Nine. **In instances where MAWG refers an issue to the Department of Insurance, and the Department of Insurance accepts responsibility for following through with the recommendation, the Department of Insurance reviews the issue in a timely manner and responds timely and appropriately to MAWG.**

Standard Ten. **In lieu of any such examination or investigation, the Department of Insurance may accept the report of a similar examination or investigation made by the insurance supervisory official of another state.**

Standard Eleven. **The Department of Insurance participates in collaborative activities or communicates with other affected Departments of Insurance when there are common areas of concern between Departments of Insurance, but the issue is not appropriate for referral to MAWG.**

Standard Twelve. **The Department of Insurance notifies MAWG when a material issue has been detected and the regulated entity has offered to take corrective action in all impacted jurisdictions.**

Standard Thirteen. **When appropriate, the Department of Insurance participates in collaborative actions and settlements.**

Standard Fourteen. **Upon the reporting of any material adverse findings from the market analysis staff, the Department of Insurance should take timely action in response to such findings or adequately demonstrate the determination that no action was required.**

Standard Fifteen. **The Department of Insurance should make reasonable efforts to respond to inquiries from MAWG, NAIC (D) Committee and other working groups formed by the NAIC to aid in the market analysis process.**

Competency: Interstate Collaboration
SubSection: Collaborative Action Designee

The Collaborative Action Designee (CAD) is the one contact identified by the Director/Commissioner of each state/district/territory to have the responsibility for all communications related to interstate collaboration. The Department of Insurance should have an appropriate staff member assigned as the CAD to assure support and participation in multistate collaborative actions.

The following standards apply to this competency:

Standard One. **The Department of Insurance has appointed a Collaborative Action Designee and promptly notifies the NAIC if the Collaborative Action Designee changes.**
The CAD or the CAD's designee shall have the authority to represent the Department in discussions regarding collaborative actions among states.

Standard Two. **The CAD or his or her designee is actively involved with MAWG.**
The CAD or when unavailable, a designee assigned by the CAD, shall participate in all Market Actions Working (D) Group (MAWG) meetings

or conference calls that are opened to non-working group member regulators. If the state does not have a designee attending national meetings, the CAD or designee shall participate in each quarterly MAWG/CAD conference call.

Standard Three. **The Department of Insurance has procedures for the CAD to communicate with appropriate Department of Insurance staff regarding potential collaborative action issues and ongoing collaborative actions.**

The CAD shall advise the appropriate staff in areas including, but not limited to consumer services, enforcement, market analysis and market conduct of the role of the CAD and procedures to notify the CAD of compliance issues that may affect multiple jurisdictions.

The CAD shall establish a method of at least quarterly communication with the unit heads of these areas to follow-up on ongoing and potential collaborative actions.

Standard Four. **The CAD participates in communication with other Departments of Insurance regarding interstate collaborative actions.**

The CAD, in coordination with the Department of Insurance's Market Analysis Chief, shall be responsible for posting and responding to communications via the NAIC Market Regulation and Market Analysis Electronic Bulletin Boards. Information related to the role of the Market Analysis Chief (MAC) shall be handled by the MAC, and those related to potential or active collaborative actions shall be the responsibility of the CAD.

The CAD shall coordinate responses and information obtained via the Bulletin Boards with the appropriate Department of Insurance staff.

The CAD shall maintain communication with appropriate staff of the domestic regulator on issues and status related to potential collaborative actions.

Standard Five. **When authorized by the Department of Insurance Commissioner or Director, the CAD prepares referrals to MAWG for potential collaborative actions affecting multiple jurisdictions.**

The CAD shall follow the procedures of the Collaborative Actions Guide in the *Market Regulation Handbook* or the MAWG Procedures/Participation Guidelines, as appropriate, to determine if the matter should be referred to MAWG.

The CAD shall use the appropriate MAWG referral form and identify the issue(s), specific companies affiliated with the issue(s) and all requested information contained on the form.

Standard Six. **The CAD shall follow up on MAWG referrals and if requested, report to MAWG.**

If the MAWG referral results in the Department of Insurance becoming a lead state in the collaborative action, the CAD shall coordinate the Department's handling of the matter and report as requested to MAWG and other CADs.

Standard Seven. **In regard to privileged and confidential information they may receive from other participating states and the NAIC, the CAD and the Department of Insurance shall maintain said privileged and confidential information at least as confidential as required by the NAIC's Master Information Sharing and Confidentiality Agreement.**

Standard Eight. **If MAWG refers a matter to the Department of Insurance, the CAD shall relay the referral to the appropriate Department staff in a timely manner and respond appropriately and timely to MAWG regarding the referral.**

Standard Nine. **The Department of Insurance has appropriate procedures in place for the CAD to communicate and where authorized by the Commissioner, provide recommendations on collaborative action settlements to the Commissioner or his/her designee.**

Transmittal of collaborative action settlement documents and the Department's participation shall be made within the time frames established in the communication from the lead state(s) or the NAIC.

Collaborative Actions Guide

It is the intent of this document to offer guidelines and techniques that may assist states in collaborating regulatory responses when an issue or concern impacting multiple jurisdictions is detected and the issue necessitates an appropriate regulatory response.

A. Goal

By collaborating efforts, states that identify issues or concerns with regulated entities can perform more effective, efficient and expedient regulatory responses. By implementing market analysis techniques and sharing pertinent information with the NAIC's Market Actions (D) Working Group (MAWG), states can identify those regulated entities where there is a shared concern regarding the regulated entities' market practices. The goal of this document is to establish procedures and guidelines to facilitate the communication and coordination of regulatory responses between and among the states. Moreover, this document is designed to identify alternatives to performing a market conduct examination and assist the states in effectively addressing problems of selected insurers, or other regulated entities, whose business crosses jurisdictional boundaries. It is anticipated that coordinated, collaborative regulation will benefit both regulated entities and the states. Examples of some of the benefits of collaboration include the following:

- By collaborating efforts instead of pursuing individual state actions, states should more efficiently address specific regulatory issues that cross jurisdictional boundaries;
- Fewer individual state market conduct examinations will result in less expensive market regulation oversight and would ideally reduce the amount of regulatory intervention needed to resolve a regulatory concern;
- States will benefit from sharing techniques, skills, resources, and experience;
- Collaboration could offer greater regulatory leverage to resolve multi-state market regulatory issues or concerns;
- Corrective action may be enforced on a multistate or national basis rather than a state-by-state basis; and
- Collaboration should provide for consistency between state regulatory responses.

B. Definitions

1. Regulated Entity: Any person engaging in or proposing or attempting to engage in any transaction or 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.

2. Final Report: A final document prepared by the lead state in accordance with the *Market Regulation Handbook* and issued jointly by the participating states upon completion of the action. Any recommendations for continued review or state-specific addenda should also be included in this document, if appropriate.

3. Regulatory Review Trigger: An event or identified concern that initiates a regulatory response.

4. Interested State: A state insurance department that expresses a concern or problem with said regulated entity. The concern may be expressed to the regulated entity's domestic state or MAWG.

5. Lead State: The state insurance department selected by the participating states to coordinate the collaborative regulatory response.

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

7. Participating State:
    a. Active: a state that provides resources to assist the lead state;
    b. Passive: a state that defers review of the identified area(s) of concern to the lead state to review.

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

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

C. Assumptions

The guidelines offered in this document are based on several assumptions defined and agreed upon by the members of the National Association of Insurance Commissioners (NAIC).

1. Collaborative actions should 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.

2. Collaborative actions can be conducted for both nationally significant and non-nationally significant regulated entities.

3. Not all states must participate for a collaborative action to be successful.

4. The collaborative action, depending on the severity of the problem and the level of the action taken, can be handled by one designated state who reports to the other states or by a group of states where one state is designated as the lead state, but the others participate in the process.

5. States retain the ability to choose to participate in a collaborative action (the state does not have to be actively involved in the review, but may designate another state to review the information on their behalf). However, if the state does designate another state to review information on their behalf, it is the participating state's responsibility to outline their interpretation of the participating state's laws they would like included in the review.

6. 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.

7. The collaborative review should follow the guidelines and standards outlined in the *Market Regulation Handbook*. Participating states should agree on the appropriate standards to be applied during the review.

8. The states must work individually to determine if state-specific recommendations and actions are needed at the end of the collaborative action process.

9. 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 or re-examination.

10. Regulator resources responsible for completing the work to review data and information must be made available for follow-up proceedings, if 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.

11. If an examination is the collaborative action selected, participating states will determine, and agree to use, computer software programs that will be used in conjunction with the examination.

12. If something besides an examination is selected as the collaborative action, the lead state is obligated to provide a final report to participating states and MAWG.

13. MAWG can request a state to lead a proposed regulatory response if:
    a. the regulated entity is domiciled in the lead state;
    b. the lead state is one of the top five premium volume states;
    c. the lead state is representing a zone during the review; or
    d. the lead state has expressed an interest in leading the effort.

D. MAWG Procedures for the Coordination of Collaborative Efforts

MAWG analyzes regulated entities that exhibit characteristics that might indicate current or potential future market regulatory issues that impact multiple jurisdictions.

MAWG will send a formal letter of correspondence to the state of domicile for each specific regulated entity for which a significant concern that impacts multiple jurisdictions is identified. For issues of less significance, a phone call will be made by NAIC staff requesting that the domestic state report to MAWG on the issue. MAWG will determine the method of communication used in each instance. A response time of 30 calendar days is given to the state of domicile to address the issues of concern outlined in the letter. At a minimum, the domestic state's response should disclose the following:

- That the state is aware of the nature and extent of the problem enumerated;
- That the state concurs with the working group's identified issues of concern or provides specific information to rebut or redefine the issues of concern;
- That the state is monitoring the situation;
- That the state or the regulated entity has a corrective plan of action for all states impacted by the issue;
- That the state is monitoring the corrective plan of action; and
- That the state has effectively communicated concerns and any regulatory actions to other states that might be at risk.

If MAWG concludes that the response has open issues remaining, a request may be made to the state of domicile to make a written and oral presentation to MAWG at one of its meetings during NAIC national meetings. A formal collaborative regulatory action may be initiated subsequent to this presentation. All such collaborative actions should adhere to the following guidelines:

- The lead state (a regulated entity's domestic regulator or a lead state designated by the participating states), in collaboration with additional participating states, will assume the lead for the collaborative regulatory effort;
- The lead state will identify additional states to participate in the regulatory effort and provide a presentation to MAWG outlining the general scope of the regulatory effort prior to the initiation of the effort;
- Selection criteria for the other participating states should include the following: (1) a domestic state for a regulated entity within a group being examined/investigated and (2) a state in which the regulated entity has a significant premium volume;
- The lead state, in collaboration with the participating states of the regulatory effort, will request all states to participate in the regulatory effort;
- Participating states shall agree to accept the findings of the collaborative regulatory effort and forego examining/investigating the identified regulated entity unless the state has specific reason that requires a separate regulatory effort to be initiated;
- All participating states will have access to confidential and privileged information as long as they have signed the NAIC's Information Sharing and Confidentiality Agreement;

- The lead state, in collaboration with the participating states, will provide periodic written and oral updates about the regulatory effort under a timeframe mutually agreed upon by the lead state and MAWG;
- The lead state, in collaboration with the participating states, will provide a written and oral presentation to MAWG summarizing the examination/investigating findings and proposed settlement prior to the formal issuance of any regulatory report to the regulated entity;
- After 20 calendar days for advisory comment by MAWG, the lead state, who will retain final authority over the examination/investigation findings and settlement in collaboration with the participating states, will consider these comments and present the final examination/investigation report and proposed settlement to the regulated entity; and
- The lead state, in collaboration with the participating states, will communicate additional changes to the examination/investigation report and proposed settlement to MAWG.

E. Determining the Appropriateness of a Collaborative Action

States should gather information from data currently available to the states including any state surveys and required data reports, information collected by the NAIC, 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 for further review practices that deviate from the norm or that may pose a potential risk to the insurance consumer. States should refer to the *Market Regulation Handbook* as one resource to use to perform the analysis of the market activities.

States should report all significant findings to MAWG. Through MAWG, states will be able to identify other states that may have similar issues or concerns with the market practices of a regulated entity.

MAWG should take those steps reasonably necessary to eliminate duplicative inquiries and to coordinate regulatory responses and findings with other states. Should states determine that further inquiry into a particular insurer or practice is necessary, the states may consider collaborating their actions and choosing from one of a number of possible regulatory responses available through the continuum of regulatory responses.

F. Types of Collaborative Actions

There are several different types of collaborative actions. The one constant with all collaborative efforts is the effort is designed to produce information or results that would impact multiple states. The type of effort will vary based on the number of issues being addressed, the number of entities involved in the review and the product lines being reviewed.

States Involved	Issues	Regulated Entities	Outcome
Multiple States	Similar Issue	One Entity	Resolution for multiple states
Multiple States	Multiple Issues	One or More Entities	Resolution for multiple states
Multiple States	Single Issue – Immediate Action Required	Multiple Entities	Resolution for multiple states
Single State	State-specific issue or multiple state-specific issues	One Entity	Resolution for single state only
Single State	Similar or multiple issues	One entity	Resolution for all states with common issues/concerns

In each instance, you may want to consider breaking out each row of this table into a separate section for life, property and casualty and health.

In outline form, it might look something like the following:

I. Multiple States/Similar Issue/One Entity
    a. Life
    b. Property and casualty
    c. Health
II. Multiple States/Multiple Issues/One or More Entities
    a. Life
    b. Property and casualty
    c. Health
III. Multiple States/Single Issue—Immediate Action Required/Multiple Entities
    a. Life
    b. Property and casualty
    c. Health

The last category would be designed to capture the type of situation described as a "fire drill" that requires immediate action on the part of regulators due to known harm to consumers.

G. Criteria for Collaboration

The following questions are designed to assist states with the determination of whether an issue is appropriate for collaboration. Regulators are encouraged to review these questions whenever there is an issue of concern raised that involves a regulated entity that does business in many states.

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, you should determine how many other states have similar statutes. The NAIC Market Regulation Department or Research Library can assist you by providing a compendium or model law adoption chart to assist with this determination. If there is not a reference available from the NAIC Research Library or NAIC Market Regulation Department, your concern is not likely going to impact other states.

2. Is this a high profile issue that has raised your commissioner's concern and has the potential to impact multiple jurisdictions?
   ☐ Yes ☐ No

3. Does the regulated entity have written premiums reported in 2 or more states for the previous calendar year?
   ☐ Yes ☐ No

4. Are there other states in the Examination Tracking System (ETS) that have an examination entry for the regulated entity?
   ☐ Yes ☐ No

   If yes, you should contact all states where there is a new, open or called examination status 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 state contacted to consider collaboration, even if the examination is a financial examination or appears to be unrelated to the topic of concern.

5. Are there any entries in the market information systems including Regulatory Information Retrieval System (RIRS), Special Activities Database (SAD), Complaints Database (CDS) and the market regulator electronic forums?

6. Is this regulated entity already on the MAWG agenda? (available on StateNet)
   ☐ Yes ☐ No

7. Was the regulated entity selected by any other states for Level One market analysis and at least one recommendation was to do further analysis or refer the regulated entity to MAWG?
   ☐ 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, you should consider collaboration.

To determine if you need to refer the regulated entity to MAWG, complete the following questions. If the answer to any of the following questions is yes, you should refer the issue to MAWG.

Criteria for Collaboration – When to Involve MAWG

8. Is the regulated entity nationally significant?
   ☐ Yes ☐ No

   If you selected no, indicate the number of states where the regulated entity is licensed.

   Note: It is not necessary that a regulated entity be nationally significant for MAWG referrals. If a regulated entity is nationally significant, it is likely there are other states interested in the regulated entity's activities or engaged in contact with the regulated entity for other or related issues.

9. Has the regulated entity previously been included on the MAWG agenda for this issue or any other issues?
   ☐ Yes ☐ No

   If the response is yes, you should review the closing report or final report created from the previous MAWG review. If this is a related or similar issue that should have been resolved based on a prior collaborative effort, you should refer this to MAWG.

10. Does the issue involve a significant amount of consumer harm?
    ☐ Yes ☐ No

H. Lead State Responsibilities

The lead state is determined through agreement with the domicile state and other interested states. The lead state may be the domestic state, one of the top five premium volume states or another state that has an interest in coordinating a regulatory response. The lead state is responsible for overseeing the regulatory response selected and acts as the primary resource for communications between the regulated entities and the participating states. Additional duties of the lead state include:

1. Communication with MAWG and participating states. Successful collaborative efforts have a history of consistent and thorough communication with all participating states. In some instances, an advisory group of states has been identified to help with key decision points throughout the effort. The lead state is responsible for ensuring that participating states are engaged in decisions when appropriate. In addition, the lead state is responsible for providing communication to all participating states throughout the process.

2. Correspondence with the regulated entity. To avoid duplicative inquiries, the lead state is primarily responsible for correspondence with the regulated entity. There may be instances when it is appropriate to defer discussions directly between a particular state or states and the entity and the lead state may designate when that is the appropriate course.

3. Oversight of the regulatory effort. The lead state is responsible for supervising regulator resources active with the review. If there are new areas of concern that develop after the lead state has initiated the regulatory review, the lead state has the option to include the new area for review in conjunction with the ongoing regulatory effort.

4. Supervision of regulator resources utilized during the regulatory response. The lead state is responsible to oversee the use of regulator resources assigned to assist with the regulatory review. If there are performance or personnel issues that arise during the assigned regulator's period of assignment to the regulatory review, the lead state is responsible for notifying and working to resolve the issues with the assigned regulator's state or the state that hired the assigned regulator for the review.

I. Participating State Responsibilities

Participating states are obligated to track the progress of the regulatory response. Participating states are encouraged to assign responsibility to one or two individuals to act as key contacts for the effort to help ensure there is knowledgeable representation from the participating state. If the individuals assigned to track the effort are not available for a scheduled call or meeting, they are to delegate the responsibility for participation to another person that will update the key contacts.

It is also the participating state's responsibility to advise the lead state if there are specific statutes or requirements they would like to be considered during the regulatory review. In addition, the participating state is responsible for educating the lead state or assigned regulators on the specifics of their state requirements and how they should be tested for compliance.

Participating states agree they will not engage an alternate regulatory review with the entity undergoing the collaborative effort, unless they fully discuss the additional area of concern with the lead state and mutually agree it should be handled via a separate regulatory response. Participating states also agree they will respond to inquiries, requests for information or other requests for guidance from the lead state in a timely manner so they do not impede or delay the progress of the regulatory review.

J. Continuum of Regulatory Responses

States should choose a regulatory response action that is reasonable, appropriate and proportional to the type of market practices identified during market analysis. A determination about the appropriate regulatory response should consider mitigating factors such as the least intrusive response that demands the least amount of regulatory resources, the regulated entity's history of cooperation with regulators and the potential amount of consumer harm. Regulatory responses may include:

1. Correspondence with the Regulated Entity

   A domestic state, top premium volume state or other selected lead may be designated to correspond with the entity about the area of concern. This option provides for prompt communication about the concern. In addition, by corresponding directly with the insured, the states can request specific information or request that specific action be taken to quickly resolve the issue. Correspondence with the regulated entity may not be a sufficient regulatory response action if the specific market practice has not been identified, or if the regulated entity has previously been resistant and uncooperative with regulatory communications.

2. Interviews

Interviews of personnel familiar with the practices of a regulated entity may also be appropriate. There are some general interviewing techniques outlined in the investigations documentation included in a separate document. Interviews may typically be utilized in those instances where the states have determined that the insurer is operating 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. 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.

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 questionable practices, interviews may be conducted to give states a better understanding of the activities.

3. Information Gathering

Information gathering is a frequently utilized option. It is designed to enhance or build upon existing market analysis information. This option might be useful to glean further information regarding a practice that appears, from available data, to be prohibited. Note that information gathering alone may not be sufficient to resolve the areas of concern.

Possible sources for gathering information may include, but not be limited to:

a. Producers;
b. Internet Web sites;
c. Testing;
d. Trade publications;
e. Trade associations;
f. Media;
g. Other states;
h. NAIC;
i. Other regulatory agencies;
j. Policyholders and claimants;
k. Data calls;
l. Market conduct annual statement information;
m. Regulatory filings and other public documents;
n. Court records; and
o. Subject-matter experts.

Should the states 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.

4. Policy and Procedure Review

This type of review is most suitable for reviewing functions of the regulated entity that are either automated or routine in nature. It is also useful for situations involving complex processes that have specific time limitations, notifications or procedures.

5. Interrogatories

Interrogatories are a good option when attempting to determine compliance with a particular rule or law, especially if the review involves multiple insurers. Interrogatories might include a survey, certification or questionnaire.

6. Review of Insurance Self-Evaluation, Compliance Programs and Best Practices Programs

   The review of an entity's self-audit reports, reports from a regulated entity's compliance programs or reports produced by best practices organizations such as NCQA, URAC, and IMSA 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 cope of the issue, problem or concern that the states wish 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.

7. Desk Examinations

   A desk examination is a targeted examination that is conducted at a location other than the regulated entity's premises. Desk examination is typically performed at the insurance department's offices. The regulated entity provides requested documents by hard copy, microfiche, disc or other electronic media for review. This procedure is most suitable when there is a need to review documents that are either not original or that are specimen copies.

8. On-Site Market Conduct Examinations

   There are two major types of on-site market conduct examinations that can be performed collaboratively by the states:

   a. Targeted examinations are focused examinations based on the results of market analysis indicating the need to review either a specific line of business or specific business practices, including but not limited to underwriting and rating, marketing and sales, complaint handling, operations/management, advertising materials, licensing, policyholder services, nonforfeitures, claim handling, or policy forms and filings.

   b. Comprehensive examinations are full scope examinations that involve review of all or most of the regulated entity's lines of business and all or most of the exam categories listed under targeted examinations. Comprehensive examinations should be utilized only in the event that market analysis findings indicate that such a comprehensive review of the regulated entity is necessary.

K. Coordination of Collaborative Enforcement Actions

Should a collaborative effort produce 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. The settlement document should contain a brief overview stating the reason for the regulatory review, a list of the participating states, the alleged violations found during the review process and the resulting terms of settlement.

The primary negotiator of the settlement document should be the lead state, with advisory assistance from the other participating states. If there are a large number of participating states, advisory assistance should be requested from the domestic state, the top five premium volume states and at least one state from each zone.

The settlement document should contain a signature page to be signed by an authorized representative of the regulated entity and the regulator from the lead state. The settlement document will then be disseminated to all states affected by the findings of the review for their consenting signatures in counterpart. The settlement document should also include an "addendum" page whereby a state whose laws vary from the specified regulatory action may alter terms of that state's settlement.

At times, a collaborative enforcement action may be contemplated parallel to 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 settlements should be the responsibility of the state of domicile of the entity being examined or regulators from the identified lead state(s), with advisory assistance from the other participating states.

In the event a collaborative effort is challenged or participating states cannot reach a settlement, a resolution strategy should be developed. Participating states should outline their strategy and recommendations to ensure violations are appropriately addressed in the appropriate jurisdictions. Examiners from active states must be made available for follow-up proceedings, if required. Expenses associated with the appearance of an examiner of a proceeding arising out of the examination may be borne by the states conducting the action.

1. Types of Collaborative Regulatory Enforcement Actions

   The types of regulatory actions include, but are not limited to:
   - Cessation of the alleged unlawful practice in all states affected who also sign the settlement document;
   - Corrective action;
   - Restitution, with or without interest;
   - Monetary penalties;
   - Voluntary settlement agreements
   - Suspension or revocation of license or certificate of authority; or
   - Any other action allowed by statute that is determined to be acceptable to the participating states.

2. Collaborative Regulatory Penalties

States considering regulatory penalties as a result of collaborative efforts may wish to consider various factors before making a final determination as to the type and severity of the penalty. These factors may include, but are not limited to, the following:

- The seriousness or egregiousness of the violation;
- Whether the violation is found to be a general business practice;
- Whether the violation is identified as an unfair trade practice;
- Whether the violation is determined to be unfair discrimination;
- Whether the violations were committed in "good faith" or were intentional;
- Whether the regulated entity has a history of past violations (consider similar and non-similar violations);
- How the regulated entity has responded when past violations have been detected and whether they have willingly taken corrective action for those violations;
- Whether the regulated entity cooperated with the regulators involved in the collaborative review;
- The financial condition of the regulated entity and the subsequent impact of any monetary penalties;
- The extent of consumer harm incurred as a result of the violation; and
- Other pertinent mitigating factors

PLAN OF OPERATION
NAIC CONSUMER PARTICIPATION PROGRAM
March 28, 2010

Section 1. Mission

The mission of the NAIC Consumer Participation Program is to assist the NAIC in its efforts to support state insurance regulation by providing consumer views on insurance regulatory issues. A qualified consumer organization is a national, state, or local organization that serves to protect the interests of consumers as they relate to the regulation of insurance. Their participation is based on their desire to collect and/or impart information of mutual concern and interest to insurance regulators and that represents a consumer perspective. One measure of whether an organization represents a consumer perspective is its source of funding.

Section 2. Board

A. The NAIC Consumer Participation Board of Trustees shall consist of 12 members. The six NAIC members shall each serve one-year terms. The other six Board members shall be consumer representatives. The consumer members shall serve staggered two-year terms.

B. The current President of the NAIC or his/her designee shall chair the Board.

C. Immediately following the annual Officer Committee Assignment Meeting, the newly elected NAIC officers shall appoint the NAIC members to the Board, which may include the four NAIC officers. In December, the six NAIC members serving on the current Board shall appoint six consumer representatives to serve on next year's Board. The consumer representatives selected to serve on the Board shall have served for at least one year as a funded consumer representative. In the event there are not six consumer representatives with at least one year of experience with the program, the Board may fund a consumer who has applied for participation in the Funded Consumer Representative Program and appoint that person to the Board.

D. The term of service for Board members shall begin on January 1st and conclude December 31st.

E. A consumer representative may be removed by a majority vote of the Board (four of the six regulators and four of the six consumer representatives) whenever in its judgment the best interests of the Board would be served thereby.

F. No later than December 15th, the full Board shall select the remaining consumer representatives to receive NAIC funding for participation in NAIC meetings and conference calls.

Section 3. Consumer Applications

A. Each August, NAIC staff shall distribute applications to a diverse group of consumer organizations. Additionally, NAIC staff may circulate applications through other means, including posting the application on the NAIC Web site. Application packages shall include the following information: 1) a statement that the NAIC encourages those representing the public interest and consumer advocacy groups to apply; 2) a statement that the NAIC encourages applications from women, minorities and the physically challenged; 3) a statement describing the NAIC and its services to the state insurance departments; 4) a schedule of the NAIC meetings for the following

year and their locations; 5) a list of the NAIC committees and their memberships; and 6) an explanation that the role of the consumer representatives at NAIC meetings is to serve as a liaison to consumer and community-based organizations and to offer the consumer perspective as it relates to the charges of the NAIC committees.

B. Women, minorities and those physically challenged shall be encouraged to apply.

C. Consumers shall submit applications to the NAIC by the end of October. Late applications may not be considered.

Section 4. Consumer Qualifications

A. Consumers qualified to receive NAIC funding shall:

1. Demonstrate consumer-oriented skills;
2. Demonstrate an expertise in NAIC committee issues;
3. Represent a non-profit organization with a membership of at least 30 members;
4. Submit a copy of their organization's by-laws reflecting the organization's purposes to represent consumer interests and promote consumer protection;
5. Describe the applicant's need for funding with sufficient detail on source of funding and the need for NAIC financial support;
6. Submit an application to the NAIC;
7. Sign the NAIC Conflict of Interest Statement; and
8. Participate in NAIC meetings and conference calls.

B. Successful applicants shall be notified as soon as the Board reaches consensus on the number of positions available for the next year and selects the consumers to receive funding.

Section 5. Reimbursement of Expenses

NAIC funded consumers shall submit expense reports itemizing the costs of attending NAIC meetings according the NAIC Funded Consumer Representative Guidelines for Reimbursement of Expenses.

Section 6. Consumer Representative Term

Consumer representatives shall serve staggered two-year terms. The term for which a designated consumer representative is eligible to receive funding to participate in NAIC meetings and conference calls shall start on January 1st and continue through December 31st.

Section 7. Annual Report

At the last National Meeting each year, the NAIC President, or his/her designee, shall report to the Executive Committee a summary of the Board's activities for the year and the consumer participation in NAIC meetings and conference calls as a result of the NAIC Consumer Participation Program.

Section 8. NAIC/Consumer Liaison Committee

The NAIC Consumer Participation Board of Trustees shall select the consumer participants on the NAIC/Consumer Liaison Committee. Consumer organizations (as defined in Section 1) that choose not to request funding in the Consumer Participation Program may ask to participate in the NAIC/Consumer Liaison Committee. The request should be made in a letter or an e-mail stating the name of their organization, its mission, the ways in which the organization is involved in insurance issues, the amount and sources of the organization's income, the name of the individual who would represent the organization at NAIC, and provide the reasons the organization would like to participate in the NAIC/Consumer Liaison Committee.

To promote participation at NAIC meetings, the agenda of the NAIC/Consumer Liaison Committee shall be set no later than 21 days prior to the next NAIC meeting by the six consumer members of the Consumer Participation Board of Trustees and the chair of the NAIC/Consumer Liaison Committee. Any amendments made to this agenda are subject to the approval of the chair of the NAIC/Consumer Liaison Committee.

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INTERSTATE INSURANCE
PRODUCT REGULATION COMMISSION

States, Strength & Speed Aligned

UPDATE ON THE INTERSTATE INSURANCE COMPACT

MISSION: The Interstate Insurance Compact ("Compact") is a key state-based regulatory modernization initiative that enhances the efficiency and effectiveness of the way insurance products are filed, reviewed and approved in the United States. The Compact's new streamlined processes provide speed-to-market for the insurance industry, thus affording consumers quicker access to more competitive insurance products. By promoting uniformity through application of national product standards embedded with strong consumer protections, the Compact is meeting the demands of consumers, industry and regulators in the ever-changing, global financial marketplace.

BACKGROUND: The Compact has been adopted by 40 States and Puerto Rico to date, representing approximately 70% of the premium volume nationwide. The Compact established a multi-state public entity, the Interstate Insurance Product Regulation Commission ("IIPRC") which serves as an instrumentality of the Member States. The IIPRC is the central point of electronic filing for asset-based insurance products, including life insurance, annuities, disability income, and long-term care insurance. By leveraging the insurance regulatory expertise of the states, the Compact is able to employ one set of uniform standards with the highest level of consumer protection on a national level through the Compact's collective framework. The Compact, funded by filing fees, implements its modernization goals without impinging on state budgets.

STATUS: In June 2007, the IIPRC became operational and received its first filings within one year of its establishment. The Compact has defined speed-to-market by providing final disposition in less than 60 days. Companies of all sizes - large, medium and small - utilize the Compact's electronic filing platform to submit product filings using the adopted Uniform Standards. There are over 60 Uniform Standards in individual life, annuity and long-term care product lines adopted and available for filing use with additional standards under development for disability income and group life and annuities. By the end of 2010, the IIPRC saw continued and significant growth with the number of registered companies and product filing submissions compared to the previous year.

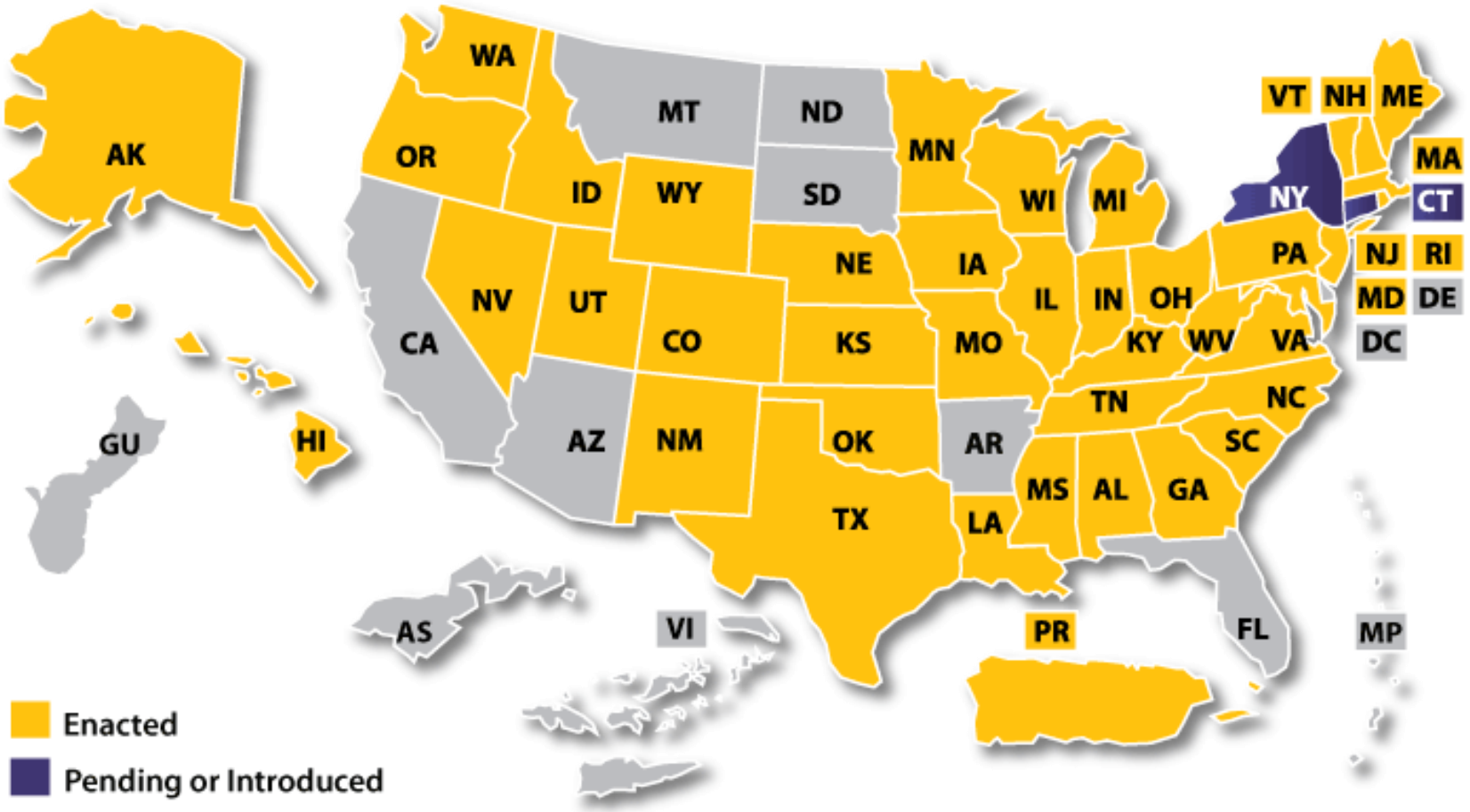
KEY MILESTONES/PLANS:

- June 2006: Inaugural Meeting of the IIPRC in Washington, DC
- December 2006: First Uniform Life Standards Adopted by Members
- June 2007: Operations Initiated On-Target/First Insurer Filings Received
- July 2007: First Filings Approved in Under 30 Days
- Spring 2008: Experienced Regulators and Actuary join Compact Operations
- Spring 2009: Focus Group Formed & Filing Fee Structure for Regional Filers is Adopted
- Summer 2009: "Mix & Match" 2-Year Timeline Removed
- November 2010: Illinois Joins the Compact; 37 Member States
- December 2010: Individual Long-Term Care Uniform Standards in Effect for Filing
- January 2011: New Jersey Joins the Compact; 38 Member States
- Spring 2011: New Product Reviewer and Actuary Join IIPRC Team
- April 2011: Disability Income Uniform Standards Exposed for Public Comment
- May/June 2011: Alabama, Nevada and Oregon Enact Compact; *41 Members States by 1/1/12*
- Fall/Winter 2011: Individual Disability Income Standards Adopted

INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IIPRC)
444 North Capitol Street, NW · Hall of the States Suite 701 · Washington, DC 20001
(202) 471-3962 · fax (816) 460-7476 ·comments@insurancecompact.org · www.insurancecompact.org

Interstate Insurance Product Regulation Compact

As of October 6, 2011



Enacted Into Law (41)

AK, AL, CO, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, NE
NH, NJ, NM, NV, OH, OK, OR*, PA, PR, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY

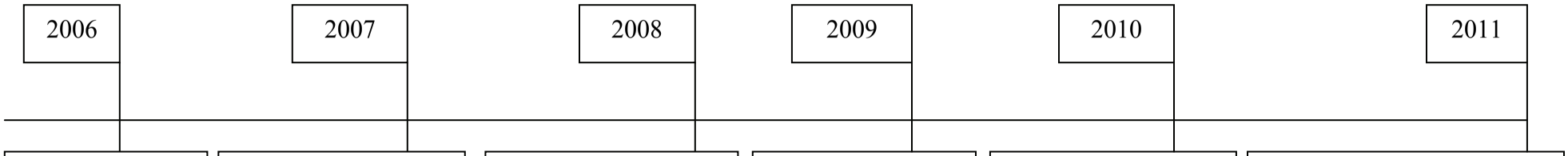
Pending or Introduced Legislation in 2011 (2)

CT, NY

*OR effective on January 1, 2012

INTERSTATE INSURANCE
PRODUCT REGULATION COMMISSION

States, Strength & Speed Aligned



2006 Milestones

- Adopted Bylaws
- Adopted Six Individual Life Uniform Standards
- 29 Compacting States
- Hired Executive Director

2007 Milestones

- Adopted 25 More Ind Life Uniform Standards
- First product filings submitted to the IIPRC for review
- First life product filings approved in under 30 days.
- 30 Compacting States
- Hired Operations Manager
- Loaned on part-time basis, three staff from Compacting States (reviewer, actuary and SERFF expert)
- 36 Product Filings received and 29 Products approved (registration not required until 2008)
- Mix and match percentage = 100 %
- Number of filings reopened (amend or update) = 11

2008 Milestones

- Adopted 4 More Ind Life Uniform Standards
- Adopted 14 Individual Annuity Uniform Standards
- 33 Compacting States
- Hired Administrative Assistant.
- Retained three consultants including 1) full-time product reviewer 2) full-time development coordinator; 3) part-time actuary.
- 106 Product Filings Received and 126 Products Approved
- 38 Registered Companies
- Average product review turnaround time = 25 days
- Mix and match percentage = 75 %
- Number of filings reopened (amend or update) = 59

2009 Milestones

- Adopted 2 More Ind Life Uniform Standards
- Adopted 3 More Ind Annuity Uniform Standards
- Product Filing Rule amended to remove 2-year timeline for "mix and match" filing process
- 36 Compacting States
- 244 Product Filings Received and 279 Products Approved
- 75 Registered Companies
- Average product review turnaround time = 28 days
- Mix and match percentage = 75 %
- Number of filings reopened (amend or update) = 185

2010 Milestones

- Adopted 2 More Ind Life Uniform Standards
- Adopted 3 More Ind Annuity Uniform Standards
- Adopted 10 Ind LTC Uniform Standards
- Total of 69 Adopted Uniform Standards
- 38* Compacting States (*including IL and NJ)
- Hired Full-Time Product Reviewer
- 362 Product Filings received and 276 Products Approved
- 113 Registered Companies
- Average product review turnaround time = 42 days
- Mix and match percentage = 55 %
- Number of filings reopened (amend or update) = 233

2011 Milestones

- Adopted 6 Ind DI Uniform Standards
- Total of 85 Uniform Standards in all Ind Product Lines
- First LTC product filing submissions approved
- 41* Compacting States (Including Oregon)
- Hired Full-Time Product Reviewer & Actuary
- 325 Product Filings received and 386 Products Approved
- 132 Companies Registered
- Average product review turnaround time = 40 days
- Mix and match percentage = 63%
- Number of filings reopened (amended or update) = 324

IIPRC UNIFORM STANDARDS

Below is a listing of all the Uniform Standards that have been adopted by the IIPRC as of November 17, 2011. For a listing of possible products that may be filed using these Uniform Standards, we recommend that you reference the TOI Link located on the IIPRC website: http://www.insurancecompact.org/documents/industry_resources_toi.pdf

IIPRC Uniform Standards	Commission Adoption Date	Effective Date of Rule	Effective Date of Amendment to Rule
INDIVIDUAL APPLICATION PRODUCT LINE			
Individual Life Insurance Application Standards	February 28, 2007	May 31, 2007	February 12, 2009
Individual Life Application Change Form Standards	February 28, 2007	May 31, 2007	Febuary 12, 2009
Individual Annuity Application Standards	October 29, 2008	February 12, 2009	
Individual Annuity Application Change Form Standards	October 29, 2008	February 12, 2009	
Individual Long-Term Care Insurance Application Standards	August 13, 2010	December 1, 2010	
Standards for Individual Long-Term Care Insurance Application Change Form	August 13, 2010	December 1, 2010	
Standards for Forms Required to be Used with an Individual Long-Term Care Insurance Application	August 13, 2010	December 1, 2010	
Individual Disability Income Insurance Application Standards	September 26, 2011	January 11, 2011	
Standards for Individual Disability Income Insurance Application Change Form	September 26, 2011	January 11, 2011	
INDIVIDUAL TERM LIFE PRODUCT LINE			
Individual Term Life Insurance Policy Standards	June 1, 2007	September 6, 2007	January 15, 2011
Individual Single Premium Term Life Insurance Policy Standards	June 1, 2007	September 6, 2007	December 14, 2008
Individual Joint Last to Die Survivorship Term Life Insurance Policy Standards	June 1, 2007	September 6, 2007	December 14, 2008
Individual Single Premium Joint Last to Die Survivorship Term Life Insurance Policy Standards	June 1, 2007	September 6, 2007	December 14, 2008
INDIVIDUAL WHOLE LIFE PRODUCT LINE			
Individual Whole Life Insurance Policy Standards	June 1, 2007	September 6, 2007	January 15, 2011
Individual Single Premium Whole Life Insurance Policy Standards	June 1, 2007	September 6, 2007	December 14, 2008
Individual Joint Last to Die Survivorship Whole Life Insurance Policy Standards	June 1, 2007	September 6, 2007	December 14, 2008
Individual Single Premium Joint Last to Die Survivorship Whole Life Insurance Policy Standards	Not Listed	September 6, 2007	December 14, 2008
Individual Current Assumption Whole Life Insurance Policy Standards and Conforming Amendments to Individual Adjustable Life Standards	September 28, 2007	January 3, 2008	December 14, 2008
Additional Standards for Graded Benefit for Individual Whole Life Insurance Policies	October 17, 2010	January 15, 2011	
INDIVIDUAL ENDOWMENT INSURANCE PRODUCT LINE			
Individual Endowment Insurance Policy Standards	September 28, 2007	January 3, 2008	December 14, 2008
Individual Single Premium Endowment Insurance Policy Standards	September 28, 2007	January 3, 2008	December 14, 2008
Individual Joint Last to Die Survivorship Endowment Insurance Policy Standards	September 28, 2007	January 3, 2008	December 14, 2008
Individual Single Premium Joint Last to Die Survivorship Endowment Insurance Policy Standards	September 28, 2007	January 3, 2008	December 14, 2008
INDIVIDUAL NON-VARIABLE ADJUSTABLE LIFE INSURANCE PRODUCT LINE			
Individual Flexible Premium Adjustable Life Insurance Policy Standards (Universal Life)	December 8, 2006	April 5, 2007	December 14, 2008
Individual Joint Last to Die Survivorship Flexible Premium Adjustable Life Insurance Policy Standards	December 8, 2006	April 5, 2007	December 14, 2008
Individual Modified Single Premium Adjustable Life Insurance Policy Standards	December 8, 2006	April 5, 2007	December 14, 2008
INDIVIDUAL VARIABLE ADJUSTABLE LIFE INSURANCE PRODUCT LINE			
Individual Modified Single Premium Variable Life Insurance Policy Standards	September 28, 2007	January 3, 2008	December 14, 2008
Individual Modified Single Premium Joint First to Die Variable Life Insurance Policy Standards	September 28, 2007	January 3, 2008	December 14, 2008
Individual Flexible Premium Variable Adjustable Life Insurance Policy Standards	December 8, 2006	April 5, 2007	December 14, 2008
Individual Joint Last to Die Survivorship Flexible Premium Variable Adjustable Life Insurance Policy Standards	December 8, 2006	April 5, 2007	December 14, 2008
Additional Standards for Private Placement Plans for Individual Variable Adjustable Life Insurance Policies	March 25, 2011	July 3, 2011	

IIPRC UNIFORM STANDARDS

STANDARDS FOR INDIVIDUAL LIFE BENEFIT FEATURES			
Standards for All Benefit Features Added by Rider, Endorsement or Amendment to an Individual Life Policy	February 28, 2007	May 31, 2007	
Standards for Accidental Death Benefits	February 28, 2007	May 31, 2007	
Standards for Accidental Death and Dismemberment Benefits	February 28, 2007	May 31, 2007	
Standards for Accelerated Death Benefits	February 28, 2007	May 31, 2007	
Standards for Waiver of Premium Benefit	February 28, 2007	May 31, 2007	
Standards for Waiver of Monthly Deductions Benefit	February 28, 2007	May 31, 2007	
Standards for Waiver of Premium Benefit for Child Insurance in the Event of Payor's Total Disability or Death	February 28, 2007	May 31, 2007	
Standards for Additional Life Insurance Benefits Provided on a Guaranteed Insurability Basis	December 1, 2007	March 11, 2008	
Standards for Additional Term Life Insurance Benefits	December 1, 2007	March 11, 2008	
Tax Qualified Plan Provisions	August 27, 2008	December 14, 2008	
Standards for Forms Used to Exclude Policy Coverage Based on the Underwriting Process	August 27, 2008	November 25, 2008	
Standards for Riders, Endorsements or Amendments Used to Effect Individual Life Insurance Policy Changes	August 27, 2008	December 14, 2008	
Additional Standards for Index-Linked Crediting Benefit Features for Individual Adjustable Life Policies	March 14, 2009	June 25, 2009	
Additional Standards for Intermediate Period Endowment Benefit Feature for Individual Life Insurance Policies (inc. Return of Premium)	March 14, 2009	June 25, 2009	January 15, 2011
Additional Standards for Overloan Protection Benefit	March 25, 2011	July 3, 2011	
Additional Standards for Change of Insured Benefit	March 25, 2011	July 3, 2011	
INDIVIDUAL VARIABLE ANNUITY PRODUCT LINE			
Individual Deferred Variable Annuity Contract Standards	May 30, 2008	September 11, 2008	June 25, 2009
Individual Flexible Premium Deferred Variable Annuity Contract Standards (with Separate and General Accts)	September 28, 2008	January 3, 2008	
Individual Fixed Premium Deferred Variable Annuity Contract Standards (with Separate and General Accts)	September 28, 2008	January 3, 2008	
Individual Immediate Variable Annuity Contract Standards	May 30, 2008	September 11, 2008	
Additional Standards for Guaranteed Living Benefits for Individual Deferred Variable Annuities	February 22, 2010	June 3, 2010	
Additional Standards for Guaranteed Minimum Death Benefits for Individual Deferred Variable Annuities	February 22, 2010	June 3, 2010	
Additional Standards for Private Placement Plans for Individual Deferred Variable Annuity Contracts	March 25, 2011	July 3, 2011	
Additional Standards for Bonus Benefits for Individual Deferred Variable Annuity Contracts	March 14, 2009	June 25, 2009	
INDIVIDUAL NON-VARIABLE ANNUITY PRODUCT LINE			
Individual Deferred Non-Variable Annuity Contract Standards	May 30, 2008	September 11, 2008	January 15, 2011
Individual Immediate Non-Variable Annuity Contract Standards	May 30, 2008	September 11, 2008	
Index-Linked Crediting Features for Deferred Non-Variable Annuities	May 30, 2008	September 11, 2008	
Index-Linked Payment Adjustment Benefit Standards	August 27, 2008	December 14, 2008	
Additional Standards for Bonus Benefits (for Individual Deferred Non-Variable Annuities)	October 29, 2008	February 12, 2009	
Additional Standards for Guaranteed Living Benefits for Individual Deferred non-Variable Annuities	February 22, 2010	June 3, 2010	
Individual Deferred Paid-Up Non-Variable Annuity Contract Standards (Commonly Marketed as Longevity Standards)	October 17, 2010	January 15, 2011	
STANDARDS FOR INDIVIDUAL ANNUITY BENEFIT FEATURES			
Additional Standards for Market Value Adjustment Features Provided Through a Separate Account	April 30, 2009	August 17, 2009	
Additional Standards for Market Value Adjustment Features Provided Through General Accounts	April 30, 2009	August 17, 2009	
Tax Qualified Plan Provisions	August 27, 2008	December 14, 2008	
Additional Standards for Waiver of Surrender Charge Benefit	August 27, 2008	December 14, 2008	
Standards for Riders, Endorsements or Amendments Used to Effect Invidual Annuity Contract Changes	August 27, 2008	December 14, 2008	
INDIVIDUAL LONG-TERM CARE PRODUCT LINE			
Core Standards for Individual Long-Term Care Insurance Policies	August 13, 2010	December 1, 2010	
Individual Long-Term Care Insurance Standards for the Outline of Coverage	August 13, 2010	December 1, 2010	

IIPRC UNIFORM STANDARDS

Rate Filing Standards for Individual Long- Term Care Insurance—Issue Age Rate Schedules Only	August 13, 2010	December 1, 2010	August 11, 2011
Rate Filing Standards for Individual Long-Term Care Insurance—Modified Rate Schedules	August 13, 2010	December 1, 2010	August 11, 2011
Standards for Individual Long-Term Care Insurance Advertising Material	August 13, 2010	December 1, 2010	
Standards for Long-Term Care Insurance Benefit Features	August 13, 2010	December 1, 2010	
Standards for Riders, Endorsements or Amendments Used to Effect Individual Long-Term Care Insurance Policy Changes	August 13, 2010	December 1, 2010	
INDIVIDUAL DISABILITY INCOME PRODUCT LINE			
Standards for Individual Disability Income Insurance Policies	September 26, 2011	January 11, 2012	
Standards for Individual Disability Income Insurance Outline of Coverage	September 26, 2011	January 11, 2012	
Standards for Initial Rate Filings for Individual Disability Income Insurance Policies	September 26, 2011	January 11, 2012	
Standards for Filing Revisions to Rate Filing Schedules in Individual Disability Income Insurance Policies	September 26, 2011	January 11, 2012	
Standards for Forms Used to Limit or Exclude Individual Disability Income Insurance Policy Coverage Based on the Underwritting Process	September 26, 2011	January 11, 2012	
Standards for Riders, Endorsements or Amendments Used to Effect Individual Disability Income Insurance Policy Changes	September 26, 2011	January 11, 2012	
Individual Disability Business Overhaed Expense Insurance Policy Standards	November 2, 2011	February 19, 2011	
NON-APPENDIX A LIFE STANDARDS			
Mortality Table Change Standards	March 28, 2008	July 7, 2008	

About SERFF

The original concept for SERFF was developed in the early 1990s by the NAIC. The Electronic Filing Submission's intent was to provide a cost-effective method for handling insurance policy rate and form filings between regulators and insurance companies. In June 1996, the SERFF Consortium, an unincorporated group of interested states and companies, was formed in response to the demand for an automated system. SERFF has been an open, cooperative partnership with the mission to fund and oversee the development of the SERFF application from its beginning. This partnership has been very successful, because this approach enables both the states and the industry to participate directly in decisions relating to the development and use of SERFF. This has allowed the states and companies to jointly exert a measure of control over a mission-critical function that otherwise could overwhelm either party's capability to respond to changing process requirements.

The SERFF system is designed to enable companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. From November, 1996, through March, 1997 the Consortium membership met monthly in Chicago and Kansas City to define the requirements of the system. During these meetings, the membership resolved a number of issues -- particularly the issue related to a central repository of filings. The Consortium also selected Lotus Notes as the development technology. During the remainder of 1997, IES/Midwest, a private sector software developer under contract to the NAIC, worked on writing the production SERFF system.

In early June 1997, members of the Consortium met in Kansas City to confirm the direction that IES/Midwest was taking with the development effort and approve continuing the contract. Later in the month the SERFF Board of Directors met in Chicago, during the NAIC Summer meeting (1997), to formally vote on continuing the project.

From October, 1997 through December, 1997 a pilot test was conducted. During this test, six states and ten companies tested the application in a production environment.

In December 1997, the consortium and the NAIC agreed that the NAIC would take over the operation of SERFF and the SERFF Board (representing the companies and states) would continue to formulate direction.

In 1999, the NAIC modified the SERFF infrastructure to allow the capability to remote host the SERFF system on a server located outside of an organization's network. States could then use SERFF without requiring huge amounts of technical support and investment costs.

During the summer of 1999, several important enhancements were noted and changed with a new SERFF release 1.4a, distributed to customers in September, 1999. The PSC, meanwhile, was evaluating the recent enhancements with the need for more functionality. One of the most influential impacts on SERFF was the decision that the system should be available as an Internet interface, with an anticipated completion date in late third quarter 2000.

Beginning in January, 2000, Commissioner Nichols and the NAIC released a "Statement of Intent" that outlined changes that will be considered in the insurance regulatory environment. Part of this document addressed the "Speed-to-Market" issues that concern rate and form filings. Key accomplishments in the area of Speed to Market include the development and implementation of Uniform Product Coding Matrices (PCM), Uniform Transmittals, Electronic Funds Transfer, and Standardized Filing Types. The Product Coding Matrices is a uniform product naming convention established to standardize lines of business. To date, 51 jurisdictions have implemented all 153 business areas (property, life and health) and leverage the PCM. The Uniform Transmittals have replaced all state specific transmittal letter requirements and have been implemented by 51 jurisdictions. In addition, all states that require fee remittance in advance of the review and approval of submitted filings now accept electronic payment via SERFF, thus further reducing the turnaround time for filings. Lastly, the states have adopted standardized filing types within SERFF, thus allowing industry users to more efficiently submit filings in multiple states simultaneously. These improvements in the product filing, review and approval, have significantly reduced

filing turnaround. For the last 12 months, on a nationwide average basis, life/health filing turnaround is 47 days and property/casualty is 28 days.

The NAIC membership and industry representatives actively discuss how changes can be made in the regulatory arena to improve the process. SERFF continues to be the automated solution to efficient rate and form filing.

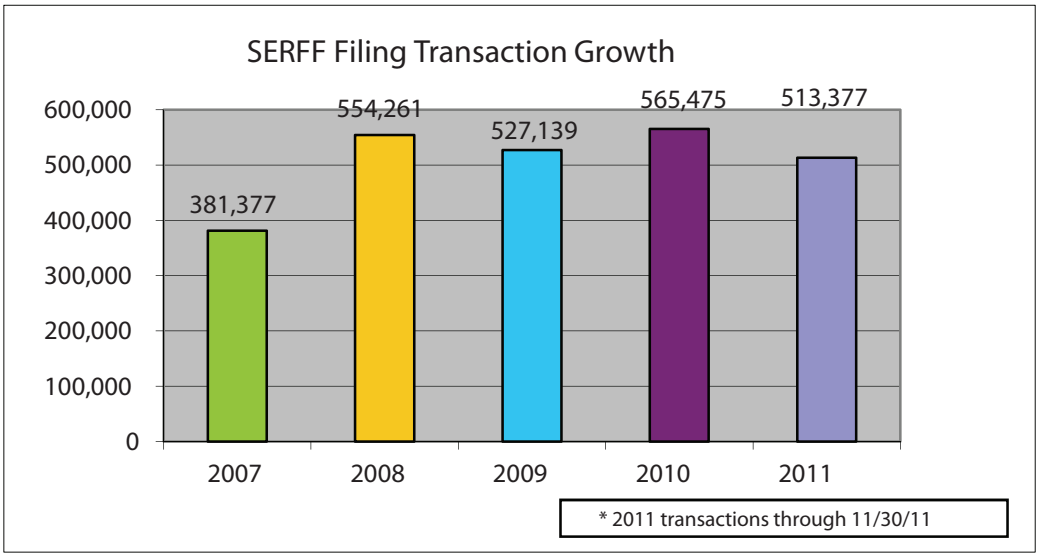
As of today, all 50 states, the District of Columbia, Puerto Rico and over 3,400 insurance companies, third-party filers, rating organizations and other companies are committed to SERFF. Reflecting on the past 10 years, SERFF has experienced tremendous growth.

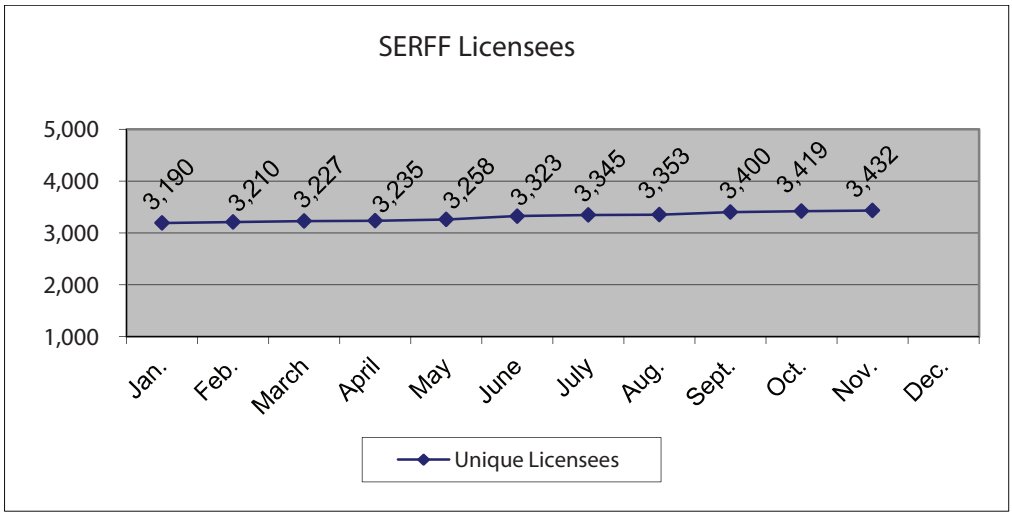
- 2001 – 3,694 Filings
- 2002 – 25,528 Filings
- 2003 – 76,932 Filings
- 2004 – 143,818 Filings
- 2005 – 183,362 Filings
- 2006 – 269,101 Filings
- 2007 – 381,377 Filings
- 2008 – 554,261 Filings
- 2009 – 527,139 Filings
- 2010 – 565,475 Filings

The NAIC members encourage insurers to become active in a voluntary SERFF program that offers a technological solution to address rate and form filing and approval process. SERFF offers a decentralized point-to-point, web-based electronic filing system. SERFF facilitates communication, management, analysis and electronic storage of documents and supporting information. The system is designed to improve the efficiency of the rate and form filing and approval process and to reduce the time and cost involved in making regulatory filings. It also provides up-to-date filing requirements when they are needed.

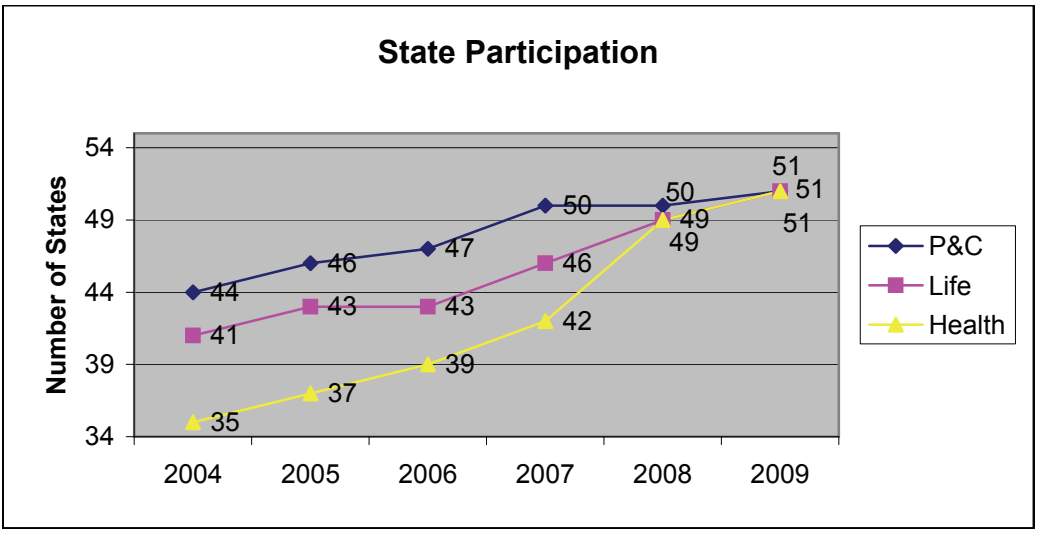
SERFF
A PRODUCT OF NAIC
Providing flexibility, promoting uniformity

SERFF Fact Sheet





- 3,432 unique licensees.
- 27 states have issued mandates for SERFF to date.



- As measured by acceptance of major lines of insurance.
- States continue to work on implementation of all lines of insurance via SERFF.

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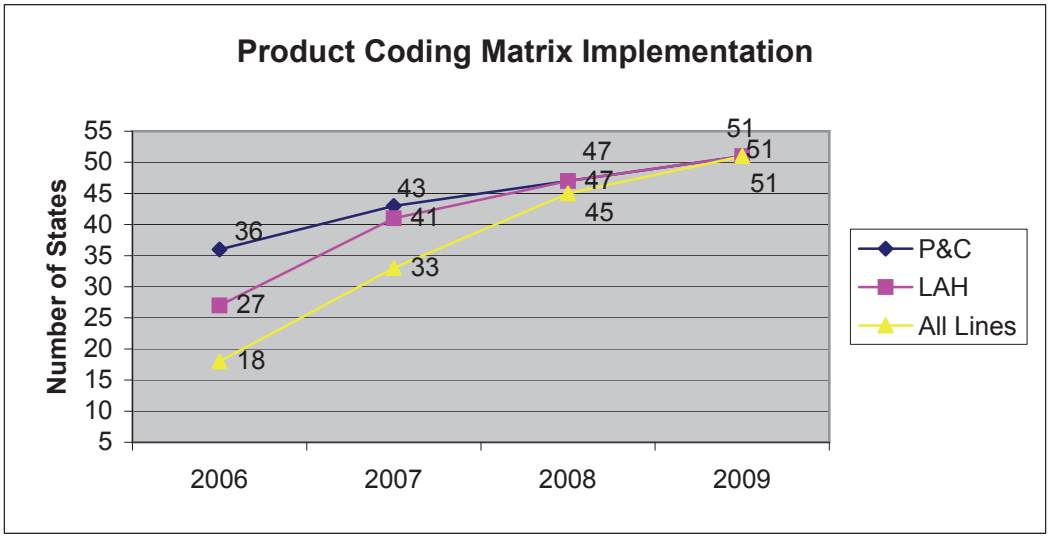
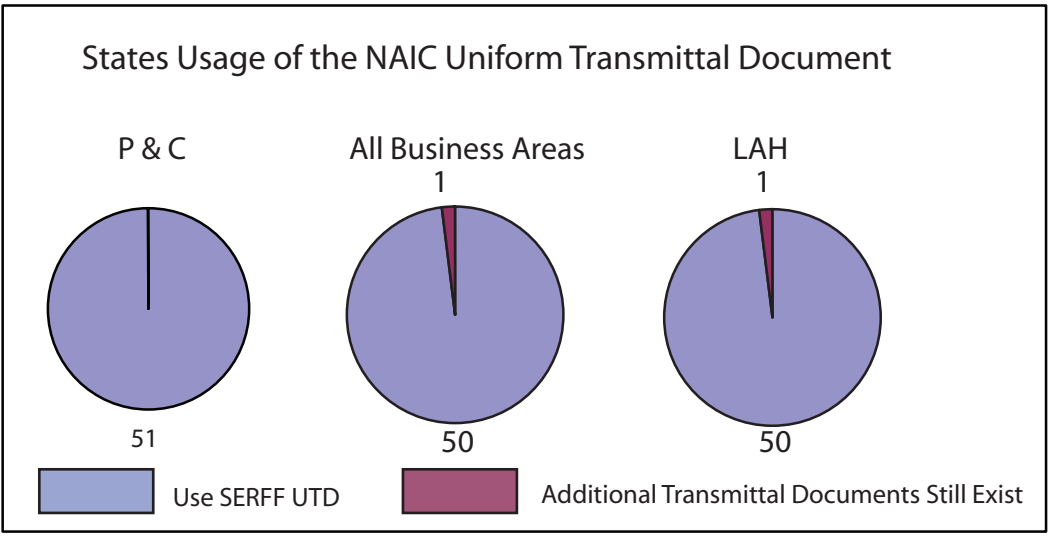
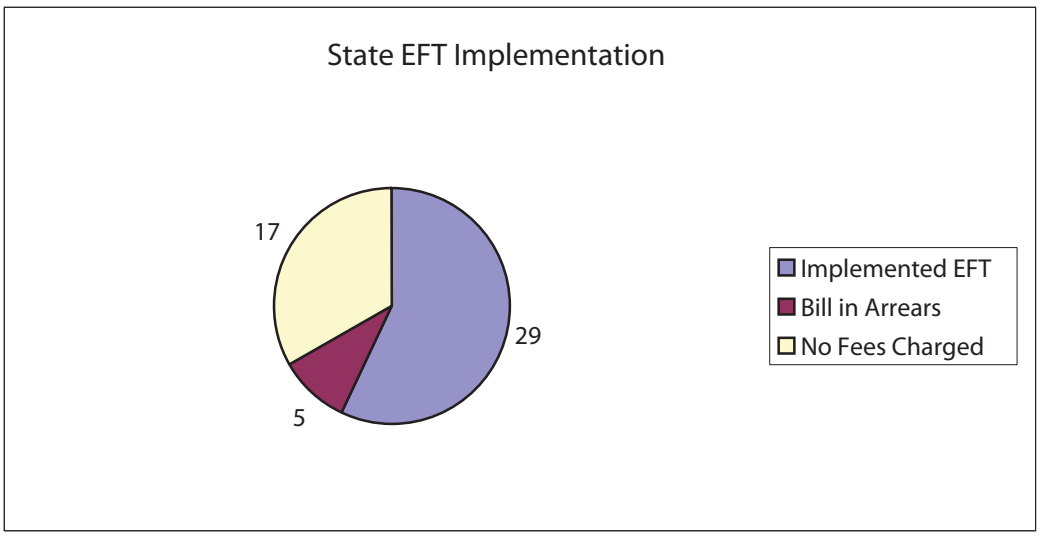


- The Product Coding Matrix is a uniform product naming convention established to standardize lines of business.
- 51 states are fully implemented.
- 153 business areas have been implemented.



- The Uniform Transmittal Document is intended to replace state transmittal documents with the NAIC's standard.
- P&C - 51 states
- LAH - 50 states
- All Business Areas - 50 states
- Florida does not accept SERFF filings and is not included in these figures.



- Each state that requires filing fees at the time of submission accepts EFT.
- The balance of the states either bill in arrears or do not charge a fee.
- Effective 1/1/11, Ohio changed from billing in arrears to requiring EFT.
- Effective 1/1/11, Alaska repealed their fee requirement.

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Average Turnaround on SERFF Filing Transactions

Life, Accident, Health - 47.37 days

Property & Casualty - 28.41 days

Filing Period - December 1, 2010 - November 30, 2011

- These turnarounds statistics reflect all filings received via SERFF for the time period noted and represent the time elapsed from submission date to disposition date, regardless of whether or not the filings required multiple communications between state and company in order to complete the filing submission and review process.

THE MARKET CONDUCT ANNUAL STATEMENT: COMES OF AGE

The New Streamlined MCAS Will Be Rolled Out April 15

By Randy A. Helder, CPCU, ARe, AU

Introduction

At the 2009 NAIC Winter National Meeting, the NAIC membership approved the 2010 budget, which included the development of a single online tool for the centralized collection of the Market Conduct Annual Statement ("MCAS") data at the NAIC. On April 15, 2011, the redesigned, self-contained system will become accessible to companies and regulators and will greatly simplify the MCAS process - companies will no longer need to download a database and e-mail attachments to multiple states while regulators will no longer need to upload submissions into their own databases and manually keep track of waiver and extension requests. The new web-based application accommodates all aspects of an MCAS filing.

Companies and regulators need to be aware of the new MCAS system. The number of states participating in MCAS has grown from 29 to 45 jurisdictions (2010 data), which opens the door to new companies that have never been required to file the MCAS and widens that door for existing companies that may have additional states in which to file. NAIC staff anticipates about 1,800 companies to file the MCAS for one or more jurisdictions this year, resulting in more than 30,000 individual filings. The new MCAS system is designed to handle this higher data volume in an efficient and user-friendly manner.

The History

The path towards an effective and uniform market conduct data began more than nine years ago and resulted in the MCAS. The MCAS was a collaboration of regulators, the industry and consumers who recognized the benefits of monitoring, benchmarking, analyzing and regulating the market conduct of insurance companies. Through teamwork, MCAS participation increased from eight states collecting limited information to nearly all of the states collecting life, annuity, auto, and homeowners insurance information.

The very nature of market conduct data makes its collection difficult. For example, claim reserving methods can vary between companies, and this affects the count of claims closed without payment. Some companies track claims by claimant, while others track claims by occurrence. Regulators created MCAS with the flexibility to allow companies to report based on their business practices. To compensate for this flexibility, ratios were developed to provide more meaningful comparisons between companies than the raw data allowed. To prevent different data definitions from one state to the next, the participating states agreed upon and published a set of common definitions organized by line of business. The definitions were broad enough to allow the flexibility necessary in the first years of MCAS.

The U.S. General Accounting Office ("GAO") reinforced the need for the MCAS when, in 2003, it issued a report titled, "Insurance Regulation—Common Standards and Improved Coordination Needed to Strengthen Market Regulation." The GAO report prompted the NAIC to work toward developing

processes and systems to identify, assess and prioritize market conduct issues. While the MCAS met many of the GAO recommendations, it needed to be national in scope, uniform in the collection of data, and consistent in the interpretation of the definitions while not placing an undue burden on insurance companies.

As a result, in 2008, the NAIC adopted the position that all of the states should use MCAS, and the data should be collected and stored in a centralized national database at the NAIC. The April 15, 2011, release of the new MCAS system will accomplish these goals.

New Efficiencies

The new MCAS collection tool is a web-based tool that will perform all the separate functions of the current MCAS. It will be easier to use than its predecessor and should require fewer company resources. The following comparison between the current MCAS and the new MCAS submission process illustrates the advantages of the new tool.

The current MCAS data collection tool is a Microsoft Access® database ("Access"). It is downloaded from the NAIC website and stored on the desktop computer of the employee responsible for the MCAS submission. The data for each state filing (currently 29 states) is collected, entered, and saved in its own separate directory on that computer. The employee copies the Certificate of Compliance wording onto company letterhead, and an officer of the company signs it. A state-specific data file and a copy of the Certificate of Compliance are emailed as attachments to each state. If a filing requires correcting, the employee must go through the entire process again.

In the new MCAS process, filings will still be handled at the state level. All filings, however, will be entered and managed through an online tool accessible from any computer via the NAIC website. The data may be manually inputted or uploaded into the tool. The primary organizing screen, or "Filing Matrix," will be a grid of states and lines of business for which a company may need to file. As the individual filings progress through input and submission, the matrix will reflect the latest status of each.

During the entry or upload phase of data collection, the data will be stored within the tool and accessible to authorized company users only. Once the company is comfortable with an individual filing, the company will be able to authorize the submission with the click of a button. At that point, the data will be released to the appropriate state database where it becomes available for review and analysis by state regulators and NAIC staff.

The former Certificate of Compliance document is now replaced with an electronic attestation. By clicking a box on the "Attestation" page, the authorized company representative attests that any information provided is complete and accurate. The attestation is completed once per reporting period and applies to all original filings and re-filings in all states for the filing period.

Even re-filings will be simpler. Currently, if there is a reporting error, a completely new filing needs to be entered in the Access database and sent back to the state that is requiring the correction. Once a state regulator receives the corrected filing, it must be uploaded it into an Access database of all company submissions. With the new MCAS tool, the company need only make the relevant change to the submitted data, click "submit," and the re-filing will be forwarded to the state database.

After a submission is validated, processed and stored in the state database, the MCAS system generates a set of company ratios for each filed line of business. A "Company Ratio Report" is available through

the online tool, where it displays the company's ratios by chosen state and line of business. When the state scorecards are released each fall showing the aggregated statewide ratios, companies can compare their own ratios to the state scorecard ratios.

Under the old MCAS process, if a company needed an extension to file, it had to contact the state and request the extension. If the company owed filings to multiple states, the company had to negotiate an extension with each state separately. Beginning in April, the company can request extensions or waivers via the MCAS submission tool. Each state's response and comments will be displayed on the request detail screen, and a state's approval will be reflected on the Filing Matrix. While state insurance regulators may only approve or deny requests for their state, they will also be able to view the waiver and extension activity a company is pursing in other states.

The new MCAS system will also free regulators from spending hours loading company data into their state databases; validating the accuracy of the data; reviewing, approving and manually tracking waiver and extension requests; and preparing scorecards. With these tasks performed by the new MCAS tool, regulators can focus on the most important part of their job: analyzing the data. Even analysis will be enhanced via the new MCAS system through new, dynamic regulator reports generated as MCAS data is submitted from companies.

National Data

This year, 45 jurisdictions are collecting and reporting MCAS data for 2010. These participating states are bound by a global sharing agreement that allows them to share company information with each other, while maintaining the confidentiality of the data. Because the data for each state resides in a state database at the NAIC, this long-standing sharing agreement makes it possible to perform analysis on a national basis.

For the past two years, the states forwarded their data to the NAIC for analysis, where work was begun to develop a national perspective of the data. For example, regulators can now determine the median industry ratios by state or by region or nationally as well. Knowing the median scores for the past two years, regulators have begun to trend the results from one year to the next. In addition, working with a greater number of companies allows analysis by categories too small to be credible on a state scale, such as by premium size or by type of organizational structure (i.e., mutual vs. stock).

Knowledge gained in working with data from the past two years is translating into specialized reports for regulators. The company-specific reports provide the data elements and ratios for each company over a range of geographical choices. Another report includes side-by-side comparisons of all the data elements collected in MCAS for all the companies, as well as company rankings based on how their MCAS ratios compare to another. Quick identification of outliers gets in-depth analysis underway sooner.

Summary reports aggregate all data from all companies on a national, regional and state basis. These reports help identify industry trends and norm. Individual companies can be compared to these trends and norms. The industry trends yield information about the effects of regional variations on market conduct; for example, the effects of a hurricane on homeowners insurance in the Southeast or an earthquake in the West.

With this large amount of data available in one location for the first time, it is anticipated that regulators will conceive of many creative ways to analyze it. The state databases will allow authorized regulators

in a MCAS participating jurisdiction to run ad-hoc queries against the centralized data collection. This ad-hoc querying ability alone will make the new MCAS system a powerful analytical tool.

Uniformity

To fully realize the analytical potential of the MCAS system, it is critical that data is uniform and consistent — not just from company to company, but from state to state and year to year — for aggregation and analysis. With the new MCAS system, no longer is the data just provided to one state for the state to use for its own purposes; now the data of one state will be aggregated with the data of other participating states and shared for analysis.

The primary oversight for ensuring uniformity is the NAIC's Market Analysis Procedures (D) Working Group (MAP). Last summer, MAP met with company representatives to discuss changes to the data elements and definitions. All parties agreed that the definitions need to be tightened and the flexibility in data reporting should diminish. An example of this is MAP's decision that all companies must report claims information only on a "claimant" basis beginning 2012.

The new MCAS tool performs standardized data validation and data quality testing as each company's data funnels through the centralized application into the state databases. Any submission with clear errors (e.g., more claims closed than pending and received during the period) is returned to the company and not submitted. Submissions with unusual data (e.g., more claims closed without payment than with payment) are submitted, but noted with a warning to the company and regulators that there might be an error. Companies with questions concerning the data to be reported should contact NAIC staff.

Going Forward

Both industry and regulators should expect many changes as the MCAS process moves forward. The new centralized MCAS system will be as powerful of an analytical tool for market conduct regulators as the financial annual statement is for financial regulators. As MCAS collects more data elements over more lines of business in more states, new techniques will be developed to analyze the data that will allow regulators to focus their resources on companies needing closer attention. Rather than reacting, regulators can be increasingly proactive.

The NAIC is ready to help with the transition to the new MCAS system. Online and classroom training opportunities are under development. For companies, webinars with live interaction are scheduled from April through June 2011. These webinars cover use of the new MCAS tool, data element descriptions and what is expected in a submission. More information about the webinars can be found at http://education.naic.org.

At the 2011 NAIC/NIPR E-Reg Conference (May 1 – 4, 2011), the Market Regulation Exchange Sessions are dedicated to the MCAS. Topics include the history, the new tool, upcoming changes and the future of MCAS. More information about E-Reg can be found at http://ereg.naic.org.

For regulators, a series of webinars and on-site training is available throughout 2011. NAIC staff and regulators from each of the NAIC zones will provide training on how to manage and analyze MCAS data. These training courses are slated for Baltimore in July, Minneapolis in August (in conjunction with the IRES Career Development Seminar), Orlando in September (in conjunction with the Association of Insurance Compliance Professionals' 2011 Annual Conference) and Denver in October. More

information can be found on the NAIC Education and Training Department's Web page at http://education.naic.org.

Extensive time and effort has been put into the new MCAS tool to balance the needs of the regulators with the constraints found within companies. The result of this time and effort will pay off in a new and improved MCAS that will provide regulators with uniform, national data and provide companies with a more efficient way to submit their data. Through the cooperation of NAIC working groups and industry, the MCAS will continue to grow and promises to be the primary source of market conduct data for use in market analysis. As always, the NAIC welcomes question. Please address your questions to mcas@naic.org.

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