NAIC
National Association of Insurance Commissioners

Market Regulation Handbook

VOLUME III

2019

NAIC
National Association of Insurance Commissioners

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Market Regulation Handbook

2019 Edition

Volume III

How to Conduct Market Conduct Examinations

This guidance is as adopted by the NAIC as of December 2018. Please note that there are modifications to the chapters that are included in this handbook during each calendar year, as such guidance is subject to the maintenance process. To address this, the NAIC has a web page dedicated to providing the holder of this manual with the latest information/interim adoptions which impact the content of this handbook.

State regulators may access updates adopted after December 2018 and *Market Regulation Handbook* Reference Documents via myNAIC on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents.

Non-regulator purchasers of the 2019 *Market Regulation Handbook* may access updates adopted after December 2018 and *Market Regulation Handbook* Reference Documents via their Account Manager login at *www.naic.org/account_manager.htm*.

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OVERVIEW OF MARKET REGULATION OVERSIGHT

VOLUME II
WHAT IS MARKET ANALYSIS

VOLUME III
HOW TO CONDUCT MARKET CONDUCT EXAMINATIONS

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VOLUME III—FORWARD
How to Conduct Market Conduct Examinations

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 regulated entity's operations; (3) timely, action-oriented reporting of examinations; and (4) cooperation and coordination among the jurisdictions with regard to conducting market conduct examinations.

This volume will provide the examiner with:

- A brief introduction and history of market conduct examinations;
- A description of various types of market conduct examinations;
- Classification, qualifications and compensation of market conduct examiners;
- Guidance on using standardized data requests in performing market conduct examinations;
- How to schedule, coordinate and communicate market conduct examinations with a regulated entity;
- An overview of sampling methodology;
- Automated examination techniques; and
- Guidance on writing an examination report.

Intended Use of the *Market Regulation Handbook*

This handbook is only a guide and should be used by each jurisdiction as a tool for developing jurisdiction-specific procedures and guidelines. To effectively use this handbook, it is recommended that each jurisdiction closely review the handbook to determine those standards that reflect the statutes and regulations of the given jurisdiction and those that do not. This handbook is designed solely to provide assistance to each jurisdiction in developing effective and consistent methodology. It does not reflect policies or procedures that are required to be implemented by any jurisdiction. It is not intended that market regulators apply any requirements to the market regulation process beyond the laws of their respective jurisdictions. To the extent possible, jurisdictions are encouraged to follow the standards established in this handbook. The text of this handbook becomes the procedure or policy of a given jurisdiction only after it has been adopted by that agency. Deviations from this handbook by an agency to accommodate the specific requirements of its own jurisdiction should not be construed as a failure of that agency to implement adequate examination or other market regulation procedures.

It is also important that each jurisdiction communicate to its market regulators the intent and scope of its market regulatory efforts. This includes direction regarding in which areas a jurisdiction's market analysis, market conduct initiatives and regulatory responses are to be concentrated and what standards and criteria are to be considered within any particular subject area. For example, a jurisdiction may wish to concentrate on market analysis of complaint data and trends in a specific line of business or a jurisdiction may wish to focus upon a regulated entity's compliance with a limited number of key components of a particular state regulation. Specific direction provided by a jurisdiction to its market regulators will serve to sharpen the jurisdiction's focus on its market regulatory activities and will also conserve jurisdiction and company staff resources.

Structure of the *Market Regulation Handbook*

Beginning with the 2018 edition of the *Market Regulation Handbook*, the subject matter of the handbook is restructured and divided into four volumes:

- Overview of market regulation oversight;
- What is market analysis;
- How to conduct market conduct examinations; and
- Review/Examination criteria for specific types of insurance and regulated entities.

The *Market Regulation Handbook* table of contents outlines the subject areas contained within each volume. The purpose of the restructuring of the handbook is to combine interrelated chapters into the broad categories outlined above and to provide regulators with functional guidance to support state insurance department market surveillance activities.

Updating the *Market Regulation Handbook*

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

Chapter 12—Examination Introduction

A. Background

History

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

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

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

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

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

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

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

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

Market Conduct Examiners

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

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

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

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

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

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

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

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

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

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

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

Examinations

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

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

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

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

B. Scope

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

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

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

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

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

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

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

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

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

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

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

C. Overview of Examination Methods

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

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

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

The *Insurance Department Resources Report*-Volume One, an annual survey of NAIC member jurisdictions, provides data regarding staffing; budget and funding; examination and oversight; insurance producers; and consumer services and antifraud. This state-by-state comparative report contains an array of valuable statistics that includes the size of budget and staff, annual budgets, revenues collected, number of insurers and producers, and the number of consumer complaints filed. The IDRR survey of 2017 data revealed that more than 70% of all jurisdictions perform market conduct reviews or examinations. Market conduct examiners are utilized by more than half of the jurisdictions. Jurisdictions may also use financial examiners, contract examiners or part-time market conduct examiners, who often also perform other functions as part of their insurance department's internal staff. Due to various forms of resource limitations, permanent full-time market conduct personnel are not always utilized.

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

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

D. Confidentiality

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

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

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

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

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

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

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

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

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

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

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

Maintaining Confidentiality

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

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

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

Level of Confidentiality

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

General Guidelines for Maintaining Confidentiality of Data

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

- As part of the examination process, examiners should be mindful not to disclose, publish or disseminate confidential information and agree to use their best efforts and take all reasonable steps to protect such confidential information from unauthorized reproduction, publication, disclosure or distribution. If state law addresses confidentiality of examination work papers, it is generally not necessary to enter into confidentiality agreements between insurance department employee examiners and the entity being examined. Any requests to enter into such agreements should be reviewed by insurance department counsel. In the event a contract examiner is being utilized, insurance department counsel should review applicable law and any contracts to determine the best course of action for protecting the confidentiality of regulated entity information.

- Examiners should be aware that it may not be appropriate to discuss, either verbally or in a written fashion, details of specific areas of an examination with any regulated entity representative. Inappropriate discussion with individuals not authorized to receive sensitive information may have a harmful affect on the company and on the examination itself. When in doubt, an examiner should exercise discretion and contact a member of senior management when discussion of sensitive information is necessary;

- Applicable state insurance department information security policies should remain in effect when using or accessing state insurance department computer resources or company information systems from any remote location;

- Examiners should ensure that hard copies of all confidential data obtained from a regulated entity are secure from unauthorized access. All physical copies of work papers drafted in the course of an examination should also be kept in a secure environment. Examiners should be aware of any statutory limitations regarding access to other types of sensitive information, such as information concerning medical test results (e.g. HIV and other laboratory test results), relating to domestic violence, and regarding mental health, alcohol and substance abuse and treatment thereof. Examiners should maintain medical records and records relating to sensitive information under lock and key, with access granted to a limited number of individuals. In any case, with any on-site examination, the department of insurance or the Examiner-In-Charge (EIC) should request a room with a locking door at a minimum, locking file cabinets to store confidential information;

- Limiting unauthorized access to confidential data includes limiting access to all forms of electronic, verbal and written confidential information stored and disseminated via hard drives, laptops, personal computers, electronic mail, the Internet, network servers, telephone communications (both land line and cellular), facsimile machines, photocopiers, scanning devices, digital images and videography, and electronic equipment, such as peripheral media read/write storage devices (CDs, diskettes, flash drives, memory sticks, thumb drives, etc.);

- Examiners should assume that no storage or transmission of confidential or sensitive data via any of the above methods is considered secure; instead, adequate encryption of data is required and secure access passwords should be established for all confidential documents and changed on a regular basis. Password-protected screensavers should also be employed and used;

- During an examination, and upon the conclusion of an examination, all written confidential material which will no longer be used should be handled in accordance with state record retention laws. If permitted by state law, documents to be destroyed should be disposed of in accordance with the document destruction procedures established by the state; and

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

Privilege

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

Some privileges which may be asserted include:

- Attorney-client privilege: Protects the actual communications between the client and lawyer and only extends to information given for the purpose of obtaining legal advice or representation. The information is generally not protected if it is available from another source and must be claimed and not waived by the client;

- Attorney work product privilege: "Tangible and intangible material which reflects an attorney's efforts at investigating and preparing a case, assembling of information, determination of the relevant facts, preparation of legal theories, planning of strategy, and recording of mental impressions." In re Grand Jury Subpoena, 622 F.2d 933, 935 (1979); and

- Self-critical analysis or self-evaluative privilege: A more recent common law and in some states, statutory privilege designed to protect qualifying internal self-evaluative documents from discovery by adverse parties. Self-critical analysis can be broadly defined as any critique by a person or entity of its own operations, policies, or processes. Note: "The Privilege of Self-Critical Analysis," 96 HARV. L. REV. 1083 (1983). Many courts have refused to acknowledge the privilege or have applied different criteria for determining when it protects the self-evaluative documents.

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

E. Disclaimers

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

F. Examination Techniques and Handbook Revisions

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

Chapter 13—Types of Examinations

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

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

A. Types of Examinations

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

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

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

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

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

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

Examples of a limited-scope examination are as follows:

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

- Re-examinations or compliance examinations—These types of examinations confirm compliance with a previously issued order of the director/commissioner or other administrative action and serve to verify that the company has initiated corrective actions for adverse findings detailed in a prior examination report.

- Desk examinations—Used as a means of follow-up on an issue found during an examination that did not rise to the level of a clear violation, but still caused the insurance department some concern.

- Small company examinations (small is defined as county mutual companies, fraternal organizations or a company that has written a predetermined premium volume)—An opportunity to review a small company's practices when the expense and time required for a traditional examination might not be warranted. Because of the potentially smaller field sizes, this is an opportunity to use ACL and other computer programs to conduct portions of the review.

B. Examination Sequence

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

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

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

C. Jurisdiction of the Examination

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

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

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

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

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

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

D. Method of Examination

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

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

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

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

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

E. Lines under Examination

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

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

F. Use of Hierarchical Description

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

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

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

Chapter 14—Examiner Classifications, Qualifications and Compensation

A. Classifications

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

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

B. Qualifications

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

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

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

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

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

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

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

C. Minimum Qualifications of Multistate Examiners

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

D. Conflict of Interest for all Examiner Classifications

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

E. Examiner Compensation

Regulators may access suggested examiner compensation information at the Market Regulation Handbook, Handbook Updates and Reference Documents link on the StateNet home page. The examiner compensation information is in the Market Regulation Handbook Reference Documents section of the web page.

Non-regulators may access the examiner compensation information on the NAIC Account Manager web page at https://www.naic.org/account_manager.htm.

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

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

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

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

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

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

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

- Lodging;
  Reimbursement should be on the basis of actual expense (receipts required) or consistent with guidelines accepted by the supervising jurisdiction.

- Meals;
  Reimbursement should be on the basis of actual expense (no receipts required) or consistent with guidelines accepted by the supervising jurisdiction.

- Travel; and
  - To Site
    Reimbursement should be on the basis of (a) airfare costs (receipts required); or (b) actual to site mileage traveled, using the current Internal Revenue Service per mile rate.

  - On-Site
    Reimbursement shall be provided for local travel, including rental car usage where reasonably appropriate.

  - Travel Frequency
    It is recommended that travel reimbursements be authorized to the examiner's domicile every other weekend. Expenses will be paid based on the lesser of airfare or mileage. This reimbursement is made in lieu of the per diem allowance. It is understood that the travel will be done with a minimum amount of work time lost.

- Incidental.
  Reimbursement should be on the basis of actual expense, yet consistent with guidelines accepted by the supervising jurisdiction.

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

Chapter 15—Standardized Data Requests

This chapter provides guidance to market conduct examiners and promotes the use of standardized data requests during market conduct examinations. Examiners should also consult the guidance offered in the Market Conduct Uniform Examination Outline, which is in Chapter 16—Scheduling, Coordinating and Communicating.

The intent is to establish a set of standardized data requests that all states can use for uniform examinations. The standardized data request layouts and the fields contained within are subject matter and/or line of business specific. They include a brief description of the data the standardized data request intends to gather and a list of possible uses for the data submitted. The type and scope of examination will determine which standardized data requests and data fields should be requested.

The following parameters were taken into consideration during the development of standardized data requests:

- An examiner can add fields that are specific to business in their state. The examiner should inform the company of additional requests and give the company a longer time period to provide the data;
- The companies are not required to maintain each field named in the standardized data requests. The examiner should review the actual data request with the company prior to the creation of any data files in order to determine which fields the company can or cannot provide. For fields that cannot be provided, the company and examiner need to determine the best way for the examiners to obtain the information needed;
- The fields are designed to mirror information normally kept in specific fields on the company's computer system. They were not meant to gather information that is kept in "memo" fields. For example, a company may keep the amount of the claim payment in a numeric field specifically marked for that purpose, but would keep all of the adjuster's notes on how the adjuster arrived at that amount in a memo or notes field. Because information contained in memo fields cannot be easily provided and can be quite large, this data should be reviewed during the actual examination and not requested in the initial data request;
- The fields selected are intended to enable the examiner to break down the file for sampling or perform 100 percent compliance tests. For example, a file of paid claims would include the claim feature code so that it would be broken down into the different feature code populations (e.g., first-party vs. third-party) and sampled; or a file of commissions paid would be reviewed directly for 100 percent licensed and appointed compliance testing; and
- The fields may also be used for completeness testing. Completeness testing for market conduct examinations differs from testing conducted for financial examinations. The market conduct examiner will normally try to compare to the financial State Pages. Since State Pages are not usually audited, results of these tests can be inconclusive. Other fields must be placed into the data request to help the examiner feel comfortable that the file is accurate and complete. These types of fields would include the NAIC company code, state, policy effective date or policy inception date.

Standardized data requests were developed to help the less experienced examiner get started. At the top of each sample data request is an explanation of what the request is and how/when to use it.

A. Standardized Data Requests (SDR)

What is an SDR?

The SDR is a list of fields that can be used to obtain data from a company for regulatory purposes. The data fields contained in the SDRs are not "mandatory" fields. Rather, they are suggested fields to enable state insurance regulators to gather information uniformly.

The SDR:

- Provides a list of suggested individual fields to give an examiner a starting point for requesting data for an examination;
- Assists with uniformity of requesting data from companies;
- Is not an "end-all, be-all" list. It does not cover all areas (especially topics such as privacy or medical malpractice, where electronic data requests are a new arena). An SDR should be considered a working document; and
- Is not intended to replace a file review. Due to the limitations of SDRs and the data files produced in response to SDRs, policy, claim or complaint files may need to be reviewed to adequately assess a company's compliance with a state's laws and regulations.

How Do I Use A Standardized Data Request (SDR)?

The following is a step-by-step guide to using an SDR, once a company has been selected for examination:

- Identify the line of business to be reviewed;
- Define the areas to be reviewed;
- Determine the examination period and the scheduling time frame;
- Designate the standards and tests that will be utilized; and
- Review applicable rules and statutes:
    - Individual state;
    - Multiple states; and
    - Language and provisions in company forms may require a higher standard than the applicable state's rules and statutes (e.g., a life and annuity company may have a higher minimum/guaranteed interest rate than required, and a property/casualty company may have a longer grace period or window for accepting past due premiums than required);
- Determine the records from which the data will be derived:
    - Policies issued or applications taken; and
    - Reported/Paid claims or denied claims;
- Identify fields needed to determine populations and samples or 100 percent compliance:
    - Policy number (for identification purposes);
    - Application, effective, paid or denied date (to determine if items are within the examination period);
    - State (also used to verify that correct data was provided);
    - Producer number (to quantify results by producer or look for patterns of practice by producers);
    - Plan code (to determine business type and policy form); and
    - Reason code (for determining populations);
- Optional additional fields:
    - Names (to easily verify that correct sample files are provided);
        - Insured; and
        - Beneficiary;
    - Interest rates;
    - Amount paid;
    - Underwriting; and
        - Riders; and
        - Endorsements;
    - Claims;
        - Insured/Claimant name;
        - Date of loss; and
        - Claim payment amount;

- Fields needed to cross-reference or join tables:
  - Policy number (to join the claim record with the policy record);
  - Insured ID (to verify completeness of data files); and
  - Producer number or department of insurance ID on business and claims lists (to determine producer identity);
- Determine the layout of the data request:
  - Customize the data request to the company;
    - Separate data requests by company systems; and
    - Separate requests by various areas to test;
  - Provide the company with specific instructions or parameters for each SDR and field requested:
    - Be aware that a company may interpret the SDR or its fields differently from a previously examined company; and
    - Be clear about what data the examiner is specifically seeking. For example, if the examiner is gathering information on replacements, clearly specify whether the company should provide data on replacements where the company is the existing insurer, the replacing insurer or both;
  - Provide the company with data specifications. Each data request is laid out in a basic structure containing:
    - Field Name—This field offers an abbreviated descriptor of the type of data being requested in eight characters or less;
    - Start—This field indicates the placement of where each field begins in the order of the data request. This is a suggested number that can vary depending on whether the data is provided. If the company does not capture a field, they will move on to the next one;
    - Length—This field suggests to the company how long the field should be. This is a suggested number that can vary depending on the data provided. This field can be altered, but should be adjusted only after discussion and agreement with the company;
      - Be sure the company knows to adjust the field lengths as needed and not to just cut off data because the company runs out of room.
    - Type—This suggests to the company the proper format for the information in a given field, i.e., alphanumeric (both letters and numbers), numeric (numbers only) or date [MM/DD/YYYY]. Generally, data fields should only be numeric if a calculation is to be performed on them;
    - Decimals—This is only used with numeric fields and tells the company how many decimal places should be in the number;
    - Description—This field provides a brief explanation of what each field should contain and if specific layouts are needed. For example, it may specify whether a particular field should contain a "yes or no" response or specify a date format of [MM/DD/YYYY]; and
    - End of record indicator—This field should contain a value for each record in a table to indicate where the record ends;
  - Provide a cover page with instructions relevant to the entire examination:
    - Company to be examined;
    - Examination period;
    - Applicable state(s);
    - Data submission protocol;
    - Data submission format;
    - Contact person at the insurance department; and
    - Due date for data requested;

- Determine how the right information can be obtained:
    - Maintain communication with the company;
        - Compliance contact (person responsible for coordinating the examination);
        - Systems contact (person responsible for pulling electronic data); and
        - Financial contact (person responsible for completing the annual financial statement);
    - Schedule a meeting or conference call to discuss; and
        - Definition and submission guidelines;
        - Fields and workarounds; and
        - Supporting documentation;
            - Code lists; and
            - Paper documents;
    - Determine how to present questions (critique forms).

Where Are the NAIC Standardized Data Requests Found?

Regulators may access NAIC standardized data requests adopted by the NAIC Executive (EX) Committee and Plenary via myNAIC at the Market Regulation Handbook, Handbook Updates and Reference Documents link on the StateNet home page. The standardized data requests are in the Market Regulation Handbook Reference Documents section of the web page. Non-regulators may access standardized data requests adopted by the NAIC Executive (EX) Committee and Plenary on the NAIC Account Manager web page at https://www.naic.org/account_manager.htm.

Revisions to the combined Producer, Commission and Complaint SDR, combined Property and Casualty Personal Lines SDR, combined Life and Annuity Insurance SDR and the combined Property and Casualty Commercial SDR were adopted in 2006 by the Market Regulation Handbook (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee. The Credit Life and Accident and Health SDR was also adopted by the Market Regulation Handbook (D) Working Group in 2006. The Title Insurance SDR and Sample Letter were adopted by the Market Regulation Handbook (D) Working Group in 2008. In 2009, revisions to the combined Property and Casualty Commercial SDR were adopted by the Market Conduct Examination Standards (D) Working Group. A health reform-related SDR and corresponding definitions were adopted at the NAIC 2015 Spring National Meeting.

Updated stand-alone Producer, Marketing and Sales, Commission and Complaint standardized data requests (which replaced the combined NAIC Producer, Commission and Complaint standardized data request adopted in 2006) were adopted by the NAIC Executive (EX) Committee and Plenary in 2017.

The combined Life and Annuity SDR adopted in 2006 was replaced by new stand-alone life claims, life declinations, life in force and life replacement standardized data requests which were adopted by the NAIC Executive (EX) Committee and Plenary in 2017 and new stand-alone annuity claims, annuity new business declinations, annuity in force, annuity payment, withdrawal and surrender, annuity plan code and annuity replacement standardized data requests, which were adopted by the NAIC Executive (EX) Committee and Plenary in 2018.

At the time of publication of the 2019 edition of the *Market Regulation Handbook,* there are 20 standardized data requests adopted by the NAIC:

1. Producer Data Request;
2. Marketing and Sales Data Request;
3. Commission Data Request;
4. Complaint Data Request;
5. Property and Casualty Personal Lines Data Request;
6. Life Claims Data Request;
7. Life Declinations Data Request;
8. Life In Force Data Request;

9. Life Replacement Data Request;
10. Annuity Claims Data Request;
11. Annuity New Business Declinations Data Request;
12. Annuity In Force Data Request;
13. Annuity Payment, Withdrawal and Surrender Data Request;
14. Annuity Plan Code Data Request;
15. Annuity Replacement Data Request;
16. Property and Casualty Commercial Data Request;
17. Health, Long-Term Care and Medicare Supplement Data Request;
18. Credit Life and Accident and Health Data Request;
19. Title Data Request and Sample Letter; and
20. Health Reform-Related Data Request and Definitions.

The NAIC updates standardized data requests periodically. When updated standardized data requests are adopted by the Market Regulation and Consumer Affairs (D) Committee, they are made available to regulators on the Handbook Updates web page, which is located on StateNet at the Market Regulation Handbook, Handbook Updates and Reference Documents link. Non-regulators may access updated standardized data requests on the NAIC Account Manager web page at https://www.naic.org/account_manager.htm.

Chapter 16—Scheduling, Coordinating and Communicating

A. Company Selection

Company Selected
Each state should develop a standard planning process for its market conduct examinations based upon statutory examination requirements, market analysis, participation with multistate actions and unusual circumstances that require immediate investigation or examination. Consideration should also be given to developing a standard planning process for the continuum of market actions, other than examinations, especially for regulatory responses that are more in-depth than inquiring about a single issue. A state will apply the criteria that it has established for calling examinations to the information developed from the standard planning process, in order to determine which insurers should be examined. An examination call sheet and supporting documentation should be collected at this time. Regulators may also refer to the items listed in the Market Conduct Uniform Examination Outline in Section R and the Reasons for Examination in Section S of this chapter.

Internal Data Requested from Insurance Department
Prior to an examination being approved, specific information should be compiled from the various sections within the insurance department. Examples of this information include licensing (insurer lines of authority; producer/agency appointments); consumer complaints (number and types of complaints); market regulation and compliance history; rate and form filings; and financial analysis and examination. A notice (e.g., via e-mail) should be sent to the sections informing them that an examination of the company will commence and asking for any other relevant information.[19]

Justification of Examination
If not otherwise documented in the NAIC Market Analysis Review System (MARS), a memorandum should be prepared by summarizing all relevant data used to determine the necessity of the response or examination. For examinations, a call sheet should be prepared—along with the examination plan and estimated time sheet—and submitted to the appropriate insurance department personnel for approval. The proposed examination memorandum is approved, disapproved or returned to staff with instructions to obtain additional information.

Development and Monitoring of Examination Plan or Continuum of Market Actions Plan
A well thought out and documented plan provides guidance for the examination team or employee (whether contracted resources or employees are used) and the insurer's examination coordinator alike. An examination plan may include a primary document that is shared with the examinee and a supplemental document to provide further guidance to the examiners. The primary document may be incorporated into the pre-examination packet or examination coordinator's handbook.

The primary examination plan should address the following, where applicable:

- Clear identification of the entity or entities to be examined, including locations or regional offices;
- Stated objectives for the examination that follow justification for calling the examination or performing the continuum of market actions;
- Estimated time frames and allowances that are allotted to each broad functional area being examined;
- Budgeted expenses for examiner work time;
- Estimated travel, lodging and meal expenses;
- Estimated incidental or administrative costs and supplies directly associated with the examination;
- A list of factors that could potentially contribute to increased examination costs, such as delays in responding to examiners' unforeseen compliance matters;
- In the case of examinations, an explanation of expense reimbursement and invoicing process;

[19] In cases of routine examinations, this information may be solicited from the various insurance department sections during the planning stages of the examination subsequent to the examination call letter being issued; however, the information should be obtained prior to the commencement of any field work.

- If available, a brief discussion of potential ways to reduce examination costs, such as conducting portions of the examination through secure electronic data processes; and
- Contact information and procedures for addressing questions, concerns or appeals about the examination or response process, examination or response plan, or subsequent examination-related invoices.

The supplemental examination or continuum of market actions planning document for the examination team or applicable examiner should be designed to focus the process on the specifically targeted areas of review. The materials provided with the supplemental document are likely to include more investigatory materials that constitute confidential investigatory materials and examination work papers. As such, the supplement should be treated accordingly. It should include:

- Directions relating to which *Market Regulation Handbook* examination standards should be incorporated into the examination;
- Market analysis-related materials that offer insight into the nature of any issues or concerns to be examined;
- If not otherwise provided, work sheets and guidance for relating state-specific laws and regulations to examination handbook standards; and
- Directions for accessing appropriate reference documents, bulletins, legal opinions, etc.

Additional considerations are appropriate for those states using contracted examiners. Prior to entering into any agreement for contracted services, it is important to consult with department of insurance legal staff to determine what applicable state requirements apply, such as "request for proposal" and contract bidding, execution and monitoring. Additionally, it is important to verify that use of contract services meets with department of insurance management approval. If not already addressed in the contract, it is appropriate to provide written directions for the contract examination team to address the following issues:

- Provisions relating to confidentiality, data protection, ownership of examination work papers, and other relevant matters such as drug-free workplace rules that may have otherwise not been included in the contract;
- Instructions for preparing billing invoices, including supporting documentation. It is generally a best practice to obtain detailed documentation of time and expense reimbursement for audit purposes. Practices may vary by state, but it is generally important to provide sufficient documentation to regulated entities required to reimburse examination expenses. That permits the regulated entity to maintain sufficient documentation for its internal and external audit purposes;
- Timing for presentation of invoices and billings. In general, more frequent invoices along with more frequent and detailed presentation to regulated entities required to reimburse expenses improves communication;
- Guidance for expense reimbursement allotments and travel, including frequency of travel, such as those established by Continental United States (CONUS) rates and/or Government Accounting Office (GAO) standards;
- Guidance relating to whether holidays, sick leave and travel time are to be reimbursed; and
- Provisions for communication and prior approval of any anticipated cost overruns or proposal for alterations of the examination work plan.

B. Scheduling Examinations

The individual responsible for scheduling examinations should consider the following elements:

1. In determining priorities, the relative significance of the following indicators should be evaluated:
    a. Statutory examination requirements;

    b. Internal complaint analysis;

    c. Compliance with applicable statutes and regulations, including producer licensing;

d. Rate and form review;

e. Market share analysis;

f. Examination findings from previous market conduct examinations;

g. Information from the commissioner of another jurisdiction;

h. Reports and analysis from NAIC information systems, including the Regulatory Information Retrieval System (RIRS), Complaints Database System (CDS), Financial Analysis and Solvency Tracking System (FAST) and email;

i. Financial analysis and IRIS ratios;

j. Information from other external sources;

k. Changes in the control environment;

l. Pre-admission;

m. Market Conduct Annual Statement; and

n. Findings from previous financial examinations.

When scheduling examinations, consideration should also be given to periodic examination of domestic insurers, even in instances where the domestic insurer is not active in the domestic market. In these instances, a multistate examination should be considered.

2. Document an explanation of the basis for calling the examination.

3. Review of current and previous examinations (examination history) for the specified company or companies as found in the Market Action Tracking System (MATS).

C. Scope of Examinations

There are various market conduct areas, which may be covered in an examination. These include, but are not limited to:

1. Company Operations/Management;

2. Complaint Handling;

3. Marketing and Sales;

4. Producer Licensing;

5. Policyholder Service
;

6. Underwriting and Rating; and

7. Claims

The areas to be covered by the examination (e.g., underwriting only or claims only), the line(s) of business, as well as the time period under review must be clearly defined. The location of the examination must be determined—e.g., corporate headquarters or regional offices. The scope should include a preliminary estimate of timing and costs.

D. Selection of Examiner-in-Charge (EIC) and Team

The EIC is the on-site supervisor of the examination team. The examination team may be comprised of one or more examiners in addition to the EIC. When selecting the examination team, states should match examiners' areas of experience to the appropriate examination.

E. Estimating Time Requirements

In estimating time requirements examiners should:

1. Identify the subject area(s) of the examination in terms of the lines of business to be covered and the functional area (e.g., marketing and sales, underwriting, claims, etc.).

2. Identify the specific survey to be performed for each line of business; i.e., the steps to be carried out to collect the necessary information. Consideration should be given to the recordkeeping system of the company so that adjustments can be made in examination procedures to accommodate the data processing methods of the company as long as the integrity of the examination is not compromised.

3. Estimate the size of the field, obtain the data and determine the sample size for each survey.

4. Estimate the length of time required for the examination. A final examination plan including an estimate of the duration and cost of the examination, should be completed by the EIC as soon as possible.

Final adjustments should be made within the first two weeks of the examination and communicated to the company. The examination plan needs to reflect actual field discoveries as to the quality and availability of data, the level of the company's cooperation, the location of the data, etc. As the examination matures, the EIC may need to adjust the examination plan. The company should be notified of any changes and the justification.

F. Calling the Examination

All jurisdictions are encouraged to utilize the NAIC Market Actions Tracking System (MATS) for announcing market conduct examinations, in addition to focused inquiries and non-examination regulatory interventions. Once the triggers, subject area and estimated duration have been identified, a market conduct examination should be entered and announced (called) via MATS. MATS is available to regulators only.

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

Insurance departments are encouraged to log examination information using MATS for market conduct examinations conducted on all types of entities. It is particularly important to include all single state examinations, regardless of scope, so that other jurisdictions can coordinate their own examination efforts and avoid the unnecessary burden of simultaneous separate examinations by multiple jurisdictions.

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

G. Notice of Examination Reported to MATS

Examinations need to be entered into MATS no later than 60 days before the expected date of the on-site examination. Exceptions to this rule are examinations that are called to respond to more immediate concerns.

1. Notify Domiciliary State (MATS PICS event subscribers will automatically be notified. Not all regulators subscribe to PICS.)

2. Notification to Company
   a. Timing of Notice—At least 60 days prior to the examination date, a notification letter should be sent to the company. This letter should specify the necessary information and arrangements referenced in Subsection (b) that follows.

      If the company demonstrates a clear need for additional time to prepare for the examination, additional time may be granted prior to the commencement of the examination. These notice periods need not be followed if: (1) there is reason to believe that advance notification to the company might result in the destruction of important records; or (2) the interest of policyholders or claimants would be prejudiced by delaying the examination of company records.

   b. Content of Notice—The notification letter should advise the company of the following information and arrangements (Some states may include this in the form of an examination coordinator's handbook or pre-examination packet.):
      1. The scope, intent and period to be covered by the examination and estimated start and end date. The duration of the examination may be adjusted based upon on-site conditions. If it becomes necessary to change the starting date, the company should be notified of the change;
      2. The legal basis for examination and cost and billing procedures;
      3. Arrangements for receiving copies of relevant company procedural guidelines, manuals, policy forms with notice of approval, advertising materials, producers' records, renewal material, methods used to solicit business, any required consumer complaint register and any other pertinent data;
      4. Requests for data that require lead time to develop—e.g., claims runs, loss and expense ratios (acquisition, administrative and claim cost), policy runs, licensed producers runs—or any alternate and/or appropriate method of isolating records, if necessary;
      5. Office space, supplies and equipment required to conduct the examination;
      6. A request that the company respond to the notification letter and furnish the name of its examination coordinator;
      7. The parameters of examiner conduct, and the procedures by which companies can report complaints against examiners and resolve problems which may develop related to company examinations;
      8. If the examination team expects to utilize audit software during the examination, the letter should include notification to the company of the intent to use the audit software. Information relative to the installation procedure should accompany the notification letter; and
      9. The pre-examination packet or examination coordinator's handbook provided to the regulated entity prior to the onset of an examination should outline state insurance department policies and procedures for maintaining the confidentiality of documentation reviewed during an examination.

H. Company Identifies Examination Coordinator(s)

Prior to the commencement of the examination, the company must identify company personnel who will have the authority and responsibility to respond to the criticisms of the examiners, as well as provide additional information as needed.

The company responds to appendices/other requested information received. The company is instructed to respond to the insurance department by a specified date with answers to various questionnaires or interrogatories contained within the preliminary pre-examination packet or examination coordinator's handbook, as well as provide any other requested information by the date specified.

I. Examination Audit Plan Drafted

1. A state shall determine the phases and/or standards of the examination that are to be reviewed. An estimate of the amount of time required to conduct each phase of the examination should be made, with the understanding that additional time may be necessary depending upon the findings of the examination.

2. The type of information to be included in an audit plan is as follows:
   a. The scope of the examination;

   b. The justification for the examination (summarized);

   c. The lines of business to be examined;

   d. Company procedures to be examined/omitted and the reasons for doing so;

   e. A time estimate for completing the examination; and

   f. An identification of factors that will be included in the billing;

3. Determine the type of report to be prepared—either one by test or one by exception.

J. Initial Examination Team Meeting, Including Contractors (Optional)

States that use contract firms must determine goals, restrictions, procedures, oversight and billing procedures. It is recommended that the insurance department meet with the examination team prior to the team going on-site. To the extent possible, instructions provided to contractors should also be shared with the company.

K. Pre-Examination Contact

Under ordinary circumstances, the EIC will contact the company coordinator prior to the beginning of the examination and make all necessary arrangements. This contact may be by telephone, a letter or a pre-examination visit. It is during this pre-examination contact that the workspace, data requests, necessary supplies, office equipment and other examination details should be discussed. The EIC will also make the necessary arrangements to begin the field portion of the examination.

L. Pre-Examination Procedures

1. Insurance Department Records Review
   a. The EIC of the scheduled examination should, prior to the examination, review the following:
      1. Prior examination reports with related correspondence directive to the company and the company's response, if any;
      2. Information from other jurisdictions applicable to the examination;

3. Information available from the NAIC, including the following, should be reviewed:
    - Examination Jumpstart Reports;
    - Regulatory Information Retrieval System (RIRS);
    - Complaints Database System (CDS) and the Complaint Index Report;
    - Market Action Tracking System (MATS); and
    - Financial Analysis and Solvency Tracking System (FAST).

    In addition to the above information, sharing of audit software applications designed for specific uses or entities should be accomplished through the use of the NAIC File Repository.
4. Consumer complaint records to determine any recent trends in the number or nature of complaints;
5. Producer licensing information; and
6. Rate and form filings.

b. The EIC should contact other department supervisors to develop additional information or guidelines for the examination. Necessary authority (e.g., warrant or subpoena) for the examination should also be secured.

c. To the extent that any of the information requested is available in the insurance department office, it may not be necessary to obtain such information at the company office.

2. Pre-Examination Visit or Telephone Call

In addition to the notification letter, it is advisable to provide further detail to the company prior to the commencement of the examination. This additional communication can be accomplished through a pre-examination visit, telephone call or combination of both. The purpose of the pre-examination visit or telephone call includes:

a. Discuss the examination process and expectations with company officials responsible for the areas to be examined and the designated company coordinator;

b. Review the company recordkeeping and computer systems. Identify normal market conduct procedures, which may require modification to accommodate the data processing methods of the company and to avoid unnecessary costs to the company. For companies that do not maintain hardcopy files, those files must be accessible via Cathode Ray Tube (CRT), micrographics, imaging, microfiche or any other medium, and capable of duplication to hardcopy if the examiners so request;

c. Request copies of previous examinations and internal audit reports;

d. Determine other branch locations, which handle business within the jurisdiction that may impact the examination;

e. Arrange for security access and working space for the examination team, along with required office supplies and equipment needed to conduct the examination;

f. Review materials requested in the notice; and

g. Discuss working hours and travel arrangements.

3. Instructions to the Examination Team
    a. The EIC should contact all examiners scheduled for the examination and convey the following information:
        1. Name and location of company;
        2. Date and time the examination will begin;
        3. Specific instructions concerning the conduct and purpose of the examination and the time period under review;
        4. Name of designated company coordinator;
        5. Scope of the examination;
        6. Administrative issues, including working hours and travel arrangements;
        7. Develop an audit trail procedure for the examination; and
        8. Organization of work papers.

    b. Prior to the start of the examination, the EIC should communicate with other members of the examination team to:
        1. Discuss all pre-examination findings and familiarize the examination team members with pertinent information developed;
        2. Outline each examiner's assignment to be completed during the examination;
        3. Receive input from the examination team as it pertains to ideas or suggestions for successful completion of the examination;
        4. Discuss maintenance of working papers to provide a record of all conclusions and supporting analyses and data. The working papers should include:
            - Summary of conclusions and the analyses that support them;
            - Factual support for the analyses, including detailed worksheets indicating individual file data; and
            - Screen prints where media is electronic;
        5. Emphasize properly documenting work papers and exceptions. Most jurisdictions document exceptions with the use of critique forms and photocopies of appropriate files and materials. Examiners should review insurance department guidelines concerning proper "chain-of-custody" for evidence, when noted exceptions might involve administrative, criminal or additional civil actions; and
        6. Examiners should be aware of requirements for the handling of confidential materials; e.g., alcohol and drug abuse medical records.

M. Data/Files

Data Requests Are Provided to the Company
Detailed instructions for data requests should be provided in the pre-examination packet or examination coordinator's handbook. States should utilize the uniform data requests or inform the company that they will be supplying alternative data requests. The request should clearly state the file type, format and medium. Examples of data requests are policy types by policy number and issue date; claim types by claim number and date received; commissions paid by name, date and amount; producer contracts by name and effective date; and policy forms by type and first date of use.

Data Received from the Company
Upon receipt of the completed data requests, the examiner should validate the data. File selection may take place in advance of the examination team's arrival or upon arrival at the examination location. The EIC may instruct the company, prior to arrival or upon arrival, of the files to be pulled or reports to be provided when the on-site examination has begun.

EIC Reviews Appendices/Other Requested Information
The EIC should review the company's responses to the questionnaires and/or interrogatories and request any additional information needed.

Samples Determined
Depending on the circumstances, the examiners will use company-provided printouts, ACL or other methods necessary to select the files for the sample or census review.

N. On-Site Coordination

1. Once the examination team has arrived on-site, the EIC should take the opportunity to introduce the examination team members. The EIC should explain the examination process to the company coordinator. The EIC should inform the company at this time if the examiners have any special needs or additional requests.

2. The EIC should notify the chief examiner of the start of the examination and report any changes or developments resulting from the preliminary meetings with the company's representatives.

3. The EIC shall be responsible for timely progress reports, including adverse findings, to the insurance department and to the company, as may be advisable.

4. The EIC shall be responsible for the efficient conduct of the examination and supervision of the examination team.

O. Request for Information

When an examiner perceives a violation of a statute, regulation or policy provision—or discovers a rating, underwriting, claim or producer licensing error—the company will be provided a written form requesting an explanation of the error or a written acknowledgment of the error. This form is commonly referred to as a criticism or a "crit" sheet. The criticism and the company's response become part of the examination documentation. The company is allowed a specified time period to respond.

1. Summary of Findings

   Upon completion of the file reviews, the examination team prepares a report of their findings. The examiners should share the summary of findings with the company.

2. Final Examination Team Meeting

   Upon completion of the field work of the examination, the EIC should offer to conduct an exit meeting with the company to discuss significant findings, explain the next steps in the examination process and allow the company to present any outstanding concerns. The EIC should not re-argue the findings of the team at this time.

P. Communicating with Company Management

1. The EIC should ensure that communication with company personnel is clear, concise and to the point.

2. The EIC should encourage an open line of communication between the examination team and company personnel.

3. The EIC should make it clear to company personnel that requests for documentation and other information should be provided in a timely manner.

4. The EIC should ensure that all communication with company personnel is well documented.

5. The EIC should deal directly with the company examination coordinator, but not allow this arrangement to restrict the examination process or excessively shield key personnel with whom examiners need to communicate.

6. The EIC should explain to company personnel that the timely completion of the examination depends on communication and cooperation.

Only through open communication between the examination team and company personnel will both parties be on the same page, thus leading to a "no surprises" wrap-up or exit conference.

Q. Post-Examination

Post-examination procedures may vary according to state examination laws or administrative procedures and requirements.

1. Wrap-Up or Exit Conference

   A wrap-up or exit conference is initiated by the examination team at the completion of the on-site examination. The company's management personnel should be included in this conference. The examination team will summarize its findings and discuss issues pertinent to the report. The wrap-up or exit conference can be accomplished face-to-face, via teleconference or via written form.

   The EIC should advise company personnel of the resolution process utilized by his/her insurance department. The process should include the following:
   a. Process used to draft the report;

   b. Timetable necessary for submitting the report to the company; and

   c. Timetable designated for the company's review of the report.

2. Drafting of the Examination Report

   The examination team will prepare the initial draft of the report. The format of the report should be in accordance with NAIC market conduct examination report guidelines and include a summary of all findings of the examination. See Chapter 19—Writing the Examination Report for guidance on writing examination reports.

3. Review of the Examination Report

   The report should be submitted to the insurance department and reviewed by designated personnel of the department.

4. Company Review and Acceptance of the Report

   The report is sent to the company. Instructions relative to the resolution of the report should be included. The timetable given to the company for review of the report should be stipulated in the instructions. Items necessary for resolution may include one or more of the following:
   a. A formal letter of acceptance;

   b. A statement of corrective actions on developed issues;

c. A letter signed by each company director acknowledging the contents of the report, where required; and

d. Any other information or acknowledgment specifically required by state statute.

5. Informal Conference on the Report

If all issues relating to the report are not mutually agreed upon, the company may request an informal conference with the insurance department. This conference should be held at the insurance department's office.

6. Formal Hearing on Report

If problems relating to the report continue to exist (following the informal conference), a formal hearing should be held to resolve any issues in the report.

7. Regulatory Action

Final regulatory disposition will be determined by the insurance department, not the examiner. A disposition may include one or more of the following items:

a. No further regulatory action;

b. Re-examination referencing issues noted in previous examination report;

c. Consent order;

d. Agreement or order of stipulation;

e. Payment of a monetary penalty; and

f. Waiver of right to a hearing.

8. Distribution of Report and Final Regulatory Action

A copy of the report should be forwarded to the insurance commissioner of the domiciliary state. Examination results should be entered into appropriate NAIC database. Additionally, final (adjudicated) actions should be entered into the appropriate NAIC database.

9. Post-Examination Questionnaire

The post-examination questionnaire is designed to aid in the final evaluation of the examination team. It is important that the coordinator identify challenges as they arise and provide feedback that improves the examination process. The questionnaire should be completed by the company's examination coordinator at the conclusion of the examination fieldwork. It may be included in the pre-examination packet/examination coordinator handbook or mailed to the company at the conclusion of the examination. A sample post-examination questionnaire is included at the end of this chapter.

R. Market Conduct Uniform Examination Outline

1. Examination Scheduling
    a. Each state shall prioritize examinations.
        1. Each state shall establish criteria for calling a market conduct examination. (See Section S of this chapter for an example of items that may be considered.) States shall establish a priority or weight for each of the criterion being considered.
        2. Each state shall prepare a schedule of examinations and select a person responsible for developing and maintaining the schedule. Exceptions may be made when an examination is called as a "no-knock" examination; and
        3. The trigger or reason for the examination shall be maintained in the examination documents, preferably the work papers.

    b. States shall utilize the NAIC Market Action Tracking System (MATS).
        1. As soon as scheduled, each state shall enter the examination into MATS, which is administered by the NAIC;
        2. Each state shall adopt a system for ensuring proper implementation and maintenance of the MATS system;
        3. Regulators are encouraged to subscribe to the MATS Personalized Information Capture System (PICS) events.

    c. Each state shall follow a timetable for entry of examinations into MATS.
        1. Examinations shall be entered into MATS no later than 60 days before the expected date of the on-site examination. Exceptions to this rule are examinations that are called to respond to more immediate conditions.

2. Pre-Examination Planning
    a. Internal planning by states on companies selected for examination.
        1. Each state shall develop a standard planning process. Many of the items reviewed may have been used in the examination priority process and may become the basis for the pre-examination planning. In addition to the items found in the examination scheduling, the following information may be considered:
            - Information from prior examinations;
            - NAIC databases;
            - Internal database, such as the complaint index;
            - Discussions with other insurance department personnel;
            - The financial statement;
            - Interview with the company; and
            - Information received from other states' examinations.

        2. The plan should be maintained in a manner that may be incorporated into the work papers.
        3. At the end of the planning process, the state shall determine the phases and/or standards of the examination that require more attention; the phases or standard that require average examination scrutiny or attention; and those that require a reduced emphasis or may be waived:
            - Special emphasis: Larger samples, more scrutiny, more examination time allotted;
            - Standard emphasis: Initial sample follows NAIC guides, average scrutiny and examination time allotted; and
            Reduced emphasis: Smaller samples, review may be limited to procedures only, reduced scrutiny and examination time allocation.

4. Each state shall prepare an examination work plan prior to the examination. The work plan or planning memorandum shall include:
    - The scope of the examination;
    - The justification for the examination;
    - A time and cost estimate; and
    - An identification of factors that will be included in the billing.

b. Each state shall develop a system to announce the examination to the selected company.
    1. The announcement of the examination should be sent to the company as soon as possible, but in no case not any later than 60 days before the estimated commencement of the on-site examination. The announcement notice should contain:
        - The name and address of the company or companies being examined;
        - The name and contact information of the Examiner-in-Charge;
        - The date the on-site examination is expected to begin;
        - The statutory authority for the examination;
        - The identification of items that will be billed to the company, if any;
        - A request for the company to name its examination coordinator; and
        - Additional information may be requested at a later date.

c. Each state shall develop a preliminary examination packet or examination coordinator's handbook that should be sent to the examination coordinator as soon as possible, but in no case not later than 30 days before the estimated commencement of the on-site examination.
    1. The preliminary information shall contain the following information:
        - General instructions;
        - The scope of the examination;
        - The materials requested to perform the examination;
        - Standardized data requests;
        - Requirements for accommodations and supplies;
        - Time and cost estimates;
        - Travel information;
        - Specific instructions regarding sampling, communications with the company and other pertinent information;
        - Location of on-site examination;
        - Security arrangements; and
        - Billing procedures.

d. Standardized Data Requests.
    1. States shall adopt a standardized data request. The standardized data request will be broad, and states may choose not to use all fields.
    2. If a state deviates from the standardized data request, it will notify the company of the deviation and may want to allow additional time for the company to provide the information.

3. Examination Procedures
    a. The state shall conduct a pre-examination conference with the company coordinator and key personnel to clarify expectations prior to the commencement of the examination.

b. The state shall develop a system for exchanging information with the company that advises them of the errors and other problems developed during the examination. The system could consist of "crit" sheets, summaries, or both. Any form of communication concerning errors should include the following information:
   1. Record numbers or other identifying factors;
   2. The examiner's statement of the problem or error and, if relevant, the applicable law and/or standard; and
   3. A request for signature and comment from the company.

c. Each state shall develop a procedure for document handling, including the removal of original documents to a location other than the state insurance department. To address the issue of confidentiality, original work paper documents shall remain at the state insurance department, especially if the examiner is a contracted employee of the state department.

d. States shall use the NAIC sampling guidelines or develop their own scientifically based sampling program.
   1. All sampling methods should be random;
   2. If using a method other than the NAIC sampling guidelines, the method shall indicate the confidence levels, tolerable error rates and include extrapolation; and
   3. All sampling methods shall avoid pre-selection; however, stratified sampling is allowed.

   (See the Sampling Chapter of this handbook for further discussion.)

e. Each state shall offer to conduct an exit conference at the end of an examination. The exit conference should offer the following:
   1. The examination status and proposed findings;
   2. The report process; and
   3. An explanation of any post-examination billing.

4. Examination Reports
   a. The states shall utilize a standard format found in the *Market Regulation Handbook,* to include the following:
      1. Title page;
      2. Table of contents;
      3. Salutation;
      4. Foreword;
      5. Scope;
      6. Executive summary;
      7. Results of previous examinations;
      8. Pertinent facts of the current examination;
      9. Summarization; and
      10. Appendices.

      The examination report may be written by test or by exception. States shall report the method utilized to the company and in the scope of the report.

   b. States shall utilize a standardized timeline as required by state statute or the *Model Law on Examinations* (#390) as outlined below:
      1. The draft report is delivered to the company within 60 days of completion of the examination;
      2. The company must respond with comments to the state within 30 days;
      3. The insurance department has 30 days to informally resolve issues and prepare a final report (unless there is a mutual agreement to extend the deadline); and
      4. The company has 30 days to accept the final report or request a hearing.

c. The states shall include the company's response in the final report. The response may be included as an appendix or in the text of the examination report. If it is not in the final report, the report should indicate that a response is available. The company is not obligated to submit a response. Individuals involved in the examination should not be named in either the report or the response, except to acknowledge their involvement.

d. States shall publish examination reports as public documents where allowed by law. States should publish examination reports on the insurance departments' websites. States shall develop a process for releasing examination results to the public. A press release may be used.

e. States shall devise an enforcement strategy; specifically, the role of market conduct activities in that effort. The primary role of examiners is to be fact-finders when determining compliance, which can then be used by the insurance department to determine sanctions or fines. An enforcement strategy should have a system in place to differentiate between willful actions and inadvertent ones, and consider appropriate administrative resolutions, whether financial or non-financial. States should also want to consider a methodology for determining the amounts of fines, based on a host of criteria—the size of the company, the company's market share, whether the problems have been corrected and any host of mitigating or aggravating circumstances. States should also be certain to communicate the basis of any assessed penalty.

f. Each state shall establish a follow-up examination process.

S. Reasons for Examination

1. Complaint Index—States should review complaints to determine where problems exist. Insurance departments may develop an index for each company measuring the number of complaints to that company's market share by premium volume.

2. Recent Complaints—An increase in recent complaints filed against an insurance company may suggest concern. In order to address those complaints, an examination may be necessary in order to obtain remedial action.

3. Market Share—Due to its volume of premium, the practices of a particular insurance company can impact a large number of consumers. If the state needs to review a particular line of business or particular type of product, the state may choose those companies with the most premium volume.

4. Financial Examination—Financial examiners may discover an issue during an examination which warrants further review from a market conduct perspective. A market conduct examination may occur simultaneously with a financial examination. The financial examiners may incorporate the findings of the market conduct examiners into the financial examination report.

5. Information from Other States—Findings by other state regulators may generate a need to discover whether the same or similar practices are occurring in another state. One state may extend an invitation to other states to participate in a multistate examination.

6. Legal Request—An insurance department's legal division may discover an illegal practice(s) which warrants further discovery through an examination.

7. Shift in Business Practices—An insurance company may change its product mix, resulting in a significant change in its operations. If a company has not adequately managed for such a change, it may not have the expertise to properly and fairly treat its consumers. An examination may address problems before such problems become widespread.

8. Principals Involved—The state may become aware that individuals have had a past history of regulatory noncompliance. The NAIC maintains information systems identifying suspect individuals and associated past regulatory actions. An examination can identify improper activity prior to its impact on a large number of consumers.

9. Information from Statistics—States may maintain several databases. For example, Missouri law requires the reporting of certain information, such as financial statements, premium volume and amounts of claims paid categorized by ZIP code, malpractice claims, etc. Statistical tests evaluate aberrations that may necessitate further discovery by means of an examination. Many states participate in the Market Conduct Annual Statement (MCAS). General information and additional detail regarding MCAS may be found on the NAIC website *https://www.naic.org/mcas_main.htm*.

10. Policy Approval Suggestions—A policy analyst may note a trend in policy form filings that may necessitate further discovery by means of an examination.

11. Request of the Director/Commissioner—The Director/Commissioner may ask for an evaluation of certain practices or certain products.

12. Result of Last Market Conduct Examination—Based upon a review of the findings of a prior examination, the state may determine the need for further review.

13. Industry Suggestion—Insurance company personnel may bring to the state's attention a particular practice or product that may need a further evaluation.

14. Member of Group Being Examined—Typically, many insurance companies operate under an umbrella holding company sharing the same personnel and similar operational management. While examining one insurance company, it may be more cost-effective to review several companies within the same group.

15. Periodic: Length of Time Since Last Examination—The mere passage of time without an examination, in conjunction with other factors, may indicate the need for an examination.

16. New Operation: Never Examined or Under New Management—Much like the shift in business practices described above, a new company or a new management team may not have the expertise to properly and fairly treat its consumers. An examination may address problems before the problems become widespread.

17. Re-Examination: Understanding at Time of Stipulation—In some cases, during the negotiation of an examination's resolution, the examined company and the insurance department will agree that some mitigating circumstance created the cited noncompliance. The company may indicate that it is now in compliance. In order to verify that remedial action has occurred and that the company has accomplished full compliance, the state may perform a second examination.

18. Evaluation of New Law—The state may target an examination in order to determine the compliance with and the effectiveness of recently enacted statutes.

19. Media—States may receive information through a news broadcast or trade journal that prompts further evaluation.

T. Market Conduct Examination Pre-Planning Checklist

Company Name: _____

NAIC Company Code: _____ NAIC Group Code: _____

Company Home Office Location: _____

Examination Site Locations: _____

I. COMPANY SELECTION

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Company selected
☐				2. Justification
☐				3. Internal data request
☐				4. Scope of examination
☐				5. Examiner-in-Charge (EIC) and team named
☐				6. Anticipated duration determined

II. COMPANY NOTIFICATION

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Notice of examination reported to MATS
☐				2. Notice of examination sent to company
☐				3. Pre-examination packet or examination coordinator's handbook sent to company
☐				4. Company appointed examination coordinator
☐				5. Company responded to appendices received

III. EXAMINATION TEAM

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Examination audit plan drafted
☐				2. Initial team meeting–contractors (optional)
☐				3. Pre-examination contact
☐				4. Pre-examination visit (optional)
☐				5. Completed all necessary travel arrangements

IV. DATA/FILES

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Data requests sent to company
☐				2. Data received from the company
☐				3. EIC review of appendices/other requested information completed
☐				4. Samples determined and sent to the company

V. EXAMINATION STAGE

Complete	Date Completed	Examiner(s)	Due Date	Task
☐				1. Request for information (crits)
☐				2. Interim conferences
☐				3. File sampling
☐				4. Summary of findings
☐				5. Final examination team meeting
☐				6. Offer to hold exit meeting

U. Market Conduct Examination Checklist

Company Name _____
NAIC Group and Company Code _____
State Certificate of Authority Number _____

Examination

✓	DATE	INITIAL	DESCRIPTION
☐	___/___/___	____	Examination Commences
☐	___/___/___	____	Examination Site Review by Section Chief
☐	___/___/___	____	Examiner-in-Charge (EIC) Weekly Report Week 1
☐	___/___/___	____	EIC Weekly Report Week 2
☐	___/___/___	____	EIC Weekly Report Week 3
☐	___/___/___	____	EIC Weekly Report Week 4
☐	___/___/___	____	EIC Weekly Report Week 5
☐	___/___/___	____	EIC Weekly Report Week 6
☐	___/___/___	____	EIC Weekly Report Week 7
☐	___/___/___	____	EIC Weekly Report Week 8
☐	___/___/___	____	EIC Weekly Report Week 9
☐	___/___/___	____	EIC Weekly Report Week 10
☐	___/___/___	____	EIC Weekly Report Week 11
☐	___/___/___	____	Examination Field Work Completed

Post-Examination

✓	DATE	INITIAL	DESCRIPTION
☐	___/___/___	____	Report of Examination Completed
☐	___/___/___	____	Peer Review of Examination Report Completed
☐	___/___/___	____	Report Extension Approved by Director/Commissioner (optional extension of 60 days)
☐	___/___/___	____	Report of Examination Filed with Insurance Department
☐	___/___/___	____	Notice to Examinee with Proposed Report (within 60 days of completion of field work)
☐	___/___/___	____	Response from Examinee Received (within 30 days of receipt of proposed report)
☐	___/___/___	____	30 Days for Rebuttal Expires
☐	___/___/___	____	Director/Commissioner's Review Completed (within 30 days of rebuttal expiration)
☐	___/___/___	____	Order to Approve, Reject/Reopen, Hearing
☐	___/___/___	____	Final Report to Examinee with Director/Commissioner's Order

U. Market Conduct Examination Checklist, cont'd

Company Name _____
NAIC Group and Company Code _____
State Certificate of Authority Number _____

☐	___/___/___	____	Update NAIC Market Action Tracking System (MATS)
☐	___/___/___	____	Company Directory Affidavits Completed and Received (within 30 days of receipt of final report)

Billing and Copies

✓	DATE	INITIAL	DESCRIPTION
☐	___/___/___	____	Billing Completed Month 1
☐	___/___/___	____	Billing Completed Month 2
☐	___/___/___	____	Billing Completed Month 3
☐	___/___/___	____	Billing Completed Month 4
☐	___/___/___	____	Circulation
☐	___/___/___	____	Examination File Copy
☐	___/___/___	____	Insurance Department Staff Copy
☐	___/___/___	____	Insurance Department Staff Copy #2 (if more than one office)
☐	___/___/___	____	Market Conduct Book Copy
☐	___/___/___	____	State of Domicile Copy
☐	___/___/___	____	NAIC Copy
☐	___/___/___	____	Other Interested States' Copies
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____
☐	___/___/___	____	_____

V. Post-Examination Questionnaire

<Date>

<Name>
<Title>
<Name of Company>
<Address>
<City> <State> <ZIP>

Dear **<Name>:**

RE: Post-Examination Questionnaire
<Examination #>
<Name of Company>

The (State) Department of Insurance has recently completed a market conduct examination of your company. The attached Post-Examination Questionnaire is designed to give us your perception of our performance during the recent examination of your company. It will allow us to evaluate our current procedures, as well as strive for improvement that should be mutually beneficial.

I appreciate you taking a few moments of your busy schedule to complete the questionnaire. As coordinator for that examination, your insight into the professionalism and efficiency with which the examination was conducted would be helpful. Please be assured your responses will only be shared with the Director's management team. To assure confidentiality, return the form to my attention with "Personal and Confidential" marked on the envelope. Please return the questionnaire to my attention at (State) Department of Insurance, P.O. Box 12345, 444 State Avenue, Anywhere, State 55555-3456 by **<Date>**. Thank you.

Very truly yours,

X. Sammy Nation, CIE
(Market Conduct Chief Examiner)

Post-Examination Questionnaire
Market Conduct Examination Evaluation
<Examination #>
<NAIC> <Name of Company>
<Date>

Examiner-in-Charge _____

Participating Examiners: _____

_____

_____

1. Did the materials provided prior to the examination provide sufficient information to allow you to adequately prepare for the presence of the examiners? ☐ Yes ☐ No
   Comments_____
   _____

2. Did the pre-examination conference help in facilitating the examination process? ☐ Yes ☐ No
   Comments_____
   _____

3. Did the examiners observe company restrictions on non-smoking areas? ☐ Yes ☐ No
   Comments_____
   _____

4. Did the examiners observe proper working hours, dress codes, use of parking facilities, use of facilities and any other company procedures (security check-in, security check-out, equipment care, maintenance, etc.) that you asked to be observed? ☐ Yes ☐ No
   Comments_____
   _____

5. Were the examiners punctual in attending to their duties? ☐ Yes ☐ No
   Comments_____
   _____

6. Did the examiner properly use the resources of the company in a considerate and ethical manner (examination-only use of telephone, copy equipment, computers, etc.)? ☐ Yes ☐ No
   Comments_____
   _____

7. Were the examiners professional in demeanor and appearance when on the job? ☐ Yes ☐ No
   Comments_____
   _____

Post-Examination Questionnaire
Market Conduct Examination Evaluation
<Examination #>
<NAIC> <Name of Company>
<Date>

8. Were the examiners positive in manner, helpful in the response to your questions, and courteous and respectful in their contact and communications with you and your staff? ☐ Yes ☐ No
   Comments_____
   _____

9. Were the examiners properly directed and supervised by the Examiner-in-Charge so that the examination was as orderly as could be expected? ☐ Yes ☐ No
   Comments_____
   _____

10. Did the examiners appear to you to work efficiently on the files sampled? ☐ Yes ☐ No
    Comments_____
    _____

11. Were sufficient documents requested and retained at one time so as to remain busy at all times?
    ☐ Yes ☐ No
    Comments_____
    _____

12. Did the examiners appear knowledgeable in the lines of business reviewed and in the work and procedures performed? ☐ Yes ☐ No
    Comments_____
    _____

13. Have you benefited from the examination performed by the examiners? ☐ Yes ☐ No
    Comments_____
    _____

14. Other constructive criticism you wish to offer (use additional paper if needed):
    _____
    _____

Questionnaire completed by:

Signature _____

Name: _____

Title/Position _____

Chapter 17—Sampling

A. Purpose of Sampling

The systematic investigation of files is an integral part of market regulation. While it is rarely feasible to review all files of an examinee, the examination must nevertheless produce credible judgments about all files. For example, a judgment might assume the form of "claims processing errors for all claims in the state of 'x' during period 'y' exceeding 'z' percent," even though all claims in a given state cannot reasonably be reviewed. Fortunately, it is not necessary to review all claim files in a given state to make such a judgment: applied statistics, a branch of probability theory in higher mathematics, provides an answer through sampling. It is important that both market conduct examiners and market analysts understand and properly apply sampling techniques. This chapter focuses primarily on sampling as it relates to proportions or percentages, although the same concepts generally apply to other statistics. For ease of reference, the term "regulator" will be used to refer to all insurance department staff who may use sampling.

Done properly, sampling permits valid generalizations or inferences about a wider population because the statistical properties governing the production of samples are known, via abstract mathematical probability theories, as well as countless empirical experiments and observations. The principles of sampling are not conceptually difficult; indeed, they are very nearly intuitive.

For example, the probability that the toss of a fair coin will result in "heads" is known to be 5. After 100 coin tosses, the proportion of tosses resulting in "heads" will be very close to 50 percent. If the proportion were 30 percent, one would likely reject the idea (or "hypothesis") that the coin is indeed fair, thus making a statistical inference[20] about the underlying process based on a sample. Because the coin has been deemed unfair, a valid generalization based on the sample (of 100 tosses) is that *future* coin tosses will also fail to produce a balanced ratio of head and tails. Of course, the inference could be wrong: in a tiny fraction of cases, even a fair coin will produce only 30 percent heads. But because the probability of this occurrence is remote (it would only happen in 0.002 percent of cases if the coin were really fair), one feels confident in making the judgment. Time and resources spent investigating the coin can be further reduced by reducing the sample size, or number of coin tosses, from 100 to 50. After 50 tosses the probability of 30 percent heads is .87 percent, and one can still be highly confident that the coin is unfair given the result.

Sampling is governed by the same principles of probability as those of a simple coin toss:

1. The probabilities of the underlying process must be known. In this context, the probability of selecting any given file from the entire population must be known. Therefore, sampling must be random. The relevant probabilities associated with non-random sampling techniques are generally unknown, and generalizations about a population from which the sample is taken cannot be made with a known probability (or confidence) of being correct.

2. Sampling methods should minimize the possibility of departures from randomness, or the introduction of statistical "bias." Significant bias will invalidate statistical inferences. For example, if a skilled magician could manipulate coin tosses in such a way that one outcome is more likely than another, the inference that the coin is unfair would be correct. Rather, the sampling process was "biased," or non-random.

[20] Statistical inferences are made by *rejecting* a proposition or hypothesis and thereby accepting a contrary, mutually exclusive alternative, with some known probability of being correct. Rarely is the process the other way around, whereby a statistical test affirmatively establishes a proposition. This is because failing to reject a hypothesis at a probability of 'x' does *not* indicate that the hypothesis is correct with a probability of 1-x. Even an unfair coin will produce 50 percent heads some times, so that an outcome of 50 percent heads does not affirmatively establish that the coin is fair, even though the hypothesis that "the coin is fair" is not rejected.

3. Inferences from samples are never made with certainty, but only with some known and calculable probability of being correct. This probability is called *confidence.* After 50 tosses of a coin resulting in 30 percent heads, the coin can be declared unfair with a confidence of 99.13 percent (or 100 – 0.87).

4. The level of confidence is largely dependent on the size of the sample. Inferences about a coin can be made with greater confidence after 100 tosses compared to 50. A confidence level of 95 percent or greater is generally accepted by most professions as sufficient to support conclusions. In some instances, a 90 percent confidence level may be acceptable; however, for regulatory purposes, a 95 percent confidence level is the initial acceptance sample size recommended.

5. Inferences are made only about the population from which a sample is taken. An inference that one coin is not "fair" does not indicate that all coins are not fair.

These principles do not mean that errors found in a non-statistical sample are not errors, but it does mean that great care must be exercised to not suggest that the errors are representative of any broader population or process. Random sampling is universally recognized in all regulatory venues as a valid science. Findings based upon non-statistical sampling methodologies may be subject to legitimate challenges when the jurisdiction attempts to affect a resolution without being able to show that the errors are representative. For example, it is unlikely that any court would accept generalized findings based on improper sampling procedures.

This chapter is designed for the non-technical reader. Technical details that may not be of concern to the general reader can be found at the end of this chapter. The discussion in this chapter is confined to the fundamentals of sampling. Regulators may confront situations where the sampling strategies presented in this chapter may require modification. Those wishing to pursue the subject further can avail themselves of a variety of textbooks. Two recommended texts are the *Handbook of Sampling for Auditing and Accounting* by Herbert Arkin (McGraw-Hill, publisher) and *Statistical Methods for Rates and Proportions* by Joseph L. Fleiss (John Wiley & Sons, publisher).

B. Sampling Generally

A sample should be a microcosm of the population or field from which it is drawn. It should be representative of all the relevant insurer processes under analysis, such as claims processing, cancellation notifications or complaint handling. The regulator should adhere to the methodology prescribed in this chapter to ensure that the sample is representative and that generalizations or conclusions about insurer processes are credible. Sampling should follow five steps:

1. Clearly and precisely define the population from which the sample will be taken. Any conclusions based on sample evidence can only be generalized back to the target population. Population definition should include the following parameters: time period under review, functional definition of the process under review and location and origin of the process.

2. Determine a sampling strategy, such as the level of confidence necessary to support conclusions, and the appropriate sample size necessary to achieve the selected confidence level.

3. Examine the files in such a way that conclusions about each file can be quantified in binary form, such as "pass/fail" or "deviates from standard/complies with statute."

4. Calculate the percentage of deviations or failures present in the sample.

5. Based on the sample results, determine a numeric interval that contains the true or population deviation rate with a known level of probability or confidence. The "confidence interval" will form the basis of any conclusions about a process.

This chapter explains a two-stage sampling method that deviates slightly from this general format. An initial sample is taken which, due to its smaller size, is used only to determine whether further investigation is merited. If so, the regulator proceeds to a second, larger sample capable of supporting conclusions about overall error rates with reasonable precision. This method is designed solely for efficiency, or as a labor-saving device, since in many instances the regulator can reasonably conclude that further investigation is unnecessary after reviewing only a relatively small sample.

In a number of states, it has become common practice to start with a standard size sample, such as 50 or 100 items, based on the overall field size of the matter under review. If the entity being examined challenges the error ratio that results from the standard size sample, the regulator must then consider pulling a larger sample. In some cases, the use of a standard size sample is a sufficient screening sample to detect anomalies. In all cases, a sample size should be selected which supports conclusions with a 95 percent confidence level. In addition, regulators should balance the costs and benefits of the sampling method used.

The most common calculations necessary to make inferences are included in various tables in this chapter. In addition, computer programs are available which can randomly select files, compute statistical formulas, develop probabilities, make complex computations and even make a sample selection. One such program, ACL, is described in further detail later in this chapter.

C. Sampling Methods

The validity of random sampling depends to a large degree on knowledge of the population. No one method works well in all cases, and different methods should be tailored for the individual circumstances presented.

1. **Random Sampling.** The most widely known method of sampling is "random sampling." All items in the target population or field (before selection) have an equal chance of appearing in a random sample. No items or units have been "preselected" out of the field. Random selection may be attained through use of a random numbers table or a random numbers generator in computer software.

2. **Systematic Sampling.** Another method of sampling is to employ a systematic interval throughout a listing of all files. To sample 50 files drawn from 5,000 files, select every hundredth file after a random start number—say the third file. There are other methods for systematic sampling, such as changing the interval after each file selection, so that, on average, every one-hundredth file is selected.

3. **Stratified Sampling.** A variety of other sampling methods can be employed to adapt the principles of random sampling to more complex situations. For example, a regulator may have reason to focus on various subgroups, or *strata*, in an overall population. If the *stratum* is not large, its members may not appear in sufficient numbers in a sample of the overall population to support credible inferences about the subpopulation. *Stratified sampling* is designed for such circumstances. A stratified sample is obtained by performing a separate and independent random sample on each subpopulation of interest. The results are then combined into a single sample. For example, if a regulator is concerned about the impact of a specific processing center on overall claims settlement practices in a state, a random sample may be drawn from the center of interest, and a separate sample drawn from the remainder of claims in a state. The items in the resulting sample must be *weighted* to reflect the proportion of each subpopulation in the general or overall population before inferences can be made about the statewide claims processes.

   If only a single claims processing center is of interest, rather than the overall population, a random sample may be drawn solely from the specific claims processing center. However, since the remainder of the population was not sampled, any conclusions based in the sample should be confined to the subpopulation from which the sample was taken. Broader generalizations will not be valid.

D. Standards

The sampling method used must be subject to the following standards:

1. **Pre-selection and Statistical Bias.** Pre-selection can introduce statistical biases into the sampling procedure, which, if significant, will invalidate results. Generally, the term deals with the avoidance of files within a universe of files from which a sample is drawn. Note that the term does **not** pertain to the process of selecting a target subpopulation of interest, a strategy that is perfectly valid. Rather, the term refers to biases introduced into the sampling process *after* the target population has been defined. Once defined, the sample should be randomly selected from all of the files in the target population.

   Thus, homogeneity of the files in a sample should not be confused with pre-selection. Homogeneity is a means of defining the universe of files from which a sample will be drawn. The tests to be applied in a particular examination may in part define the universe of files from which the sample will be drawn. The distinction between pre-selection and targeting a specific *stratum* is made through a description of the universe of files. For example, if the test in an examination is focused on redlining for a particular geographic area, files outside of the particular geographic area would not be made part of the universe from which a sample is drawn. That does not represent pre-selection as used here, since no inference based on the sample will be made about geographic areas that were excluded from the initial universe of files.

   A famous example of pre-selection resulting in significant statistical bias in a sample is the 1936 *Literary Digest* poll of voting intentions. The *Literary Digest* predicted a large victory for challenger Alfred Landon over incumbent Franklin Roosevelt, a result unambiguously refuted by Roosevelt's victory with more than 60 percent of the popular vote. The *Literary Digest* had employed the same sampling techniques that had successfully predicted the outcome of prior elections: namely, pulling a sample from list of telephone numbers and registered vehicle owners. Unfortunately, the sampling universe (telephone and vehicle owners) was significantly unrepresentative of the target population (presumably consisting of all voters), since both telephone and vehicle ownership were highly correlated with income in the 1930s. Prior to the election of 1936, voting preference was not strongly correlated with income, so that, while the bias was present in prior samples, it did not significantly impact the validity of the survey. However, in 1936, the electorate became far more polarized along socioeconomic lines, rendering the statistical bias of the sampling so significant as to produce wildly inaccurate results. Contemporary pollsters take great pains to identify not only individuals of voting age or even registered voters, but *likely* voters, since the preferences of voters differ in significant ways from non-voters.

   Pre-selection thus occurs due to the non-random selection of files within a given universe of files, whether or not the *purpose* is to attain a biased result. No pre-selection can be permitted. Generally, sample selection by the examinee should be avoided due to the difficulty in demonstrating that pre-selection has not occurred. Pre-selection is not the same as prior selection, where a sample is selected in advance of the arrival of the examination team. Should an Examiner-in-Charge (EIC) choose to select a sample in advance, precautions must be taken to ensure that the sample files are not disturbed prior to the examination review.

In a market regulation context, pre-selection is demonstrated by the regulator who avoids all files in the bottom shelf because they are inconvenient. The files on the bottom shelf may all belong to one claims person or underwriter, and that individual would thereby be deleted from the sample. Another example is the case where all complaints for a particular policy form are kept in a branch office and are consequently deleted because the regulator does not want to travel to that site. These examples are preselected based on location, but the same application is present for time, procedure or any of several other variables. The central point is that after a target population has been defined, no selection biases should contaminate the sampling process such that some items in the target population have a different probability of being selected than other items. Such biases can render the sample unrepresentative and unsuitable for making inferences about the target population.

Pre-selection can also occur due to the use of "pull lists" developed by the company's computers/computer programmers. If company programmers reduce a field of 500,000 policies to a list of 500 files from which the regulators make their selection of 50 files, there may be pre-selection. Examples of this might be where no files appear in ZIP code XXXXX, or in the time frame from May 11 to May 23, or for claims closed without payment. Regulators can guard against this outcome by reconciling data obtained during the examination with other available data sources, or via simple reasonability review of the data. For example, some insurance departments collect ZIP code data, which can be used to assess whether the pull list contains the entire population of interest. All states have access to statewide financial data, which may also be used to verify the accuracy of pull lists.

The EIC should note that it is his/her responsibility to ensure that no pre-selection has occurred. If a regulator places total reliance on the company, there would be no need for regulators to be there at all—and a self-report of the results of any sample drawn would be adequate. In all cases, the EIC should work closely with the company coordinator, system analysts and/or programmers to ensure that no pre-selection of files occurs.

2. **Confidence Level**. As discussed earlier, a confidence level is a measure of the probability that a conclusion about the true and unknown value in the overall population is correct, based on what is observed in a representative and unbiased sample. In many instances, a level of confidence is associated with a numeric interval within which, with a probability equal to the confidence level, the true value is likely to lie.

   Confidence is directly related to sample size, but it is also related to the true proportion of errors within a population of files. Larger proportions are associated with a higher level of sampling variability and, therefore, require larger sample sizes to support the same level of confidence as smaller proportions. For example, other things being equal, the confidence interval will be widest for proportions of 50 percent (or conversely, the given interval will be associated with less confidence). Smaller samples are required when the true proportion moves away from 50 percent in either direction, or toward 0 percent and 100 percent. For example, for large populations, a sample of size 1,067 is necessary to produce a 95 percent confidence interval of ± 3 percentage points when the population proportion is 50 percent. A sample of only 203 files supports an estimate of the same interval at the same confidence when the proportion is reduced to from 50 percent to 5 percent (or increased to 95 percent). A regulator may have sufficient experience to know what proportions to reasonably expect for a specific process, and determine the minimum sample size necessary to support credible estimates.

   For the first-stage acceptance sample, a minimum confidence level of 95 percent should be selected. For the second-stage sample, the regulator should use discretion in selecting an appropriate confidence level, although it should never be less than 90 percent.

While regulators may instinctively have negative feelings about certain company procedures, those instinctive feelings will not be valid in an administrative proceeding or in court unless findings can be shown valid with a high confidence level. A determination of the confidence level and margin of error should be made during the planning stage, prior to taking a sample. These two factors largely determine the appropriate sample size, and regulators should weigh the costs and benefits associated with increasing the sample size vs. acceptance of less precise estimates or a larger margin of error.

3. **Tolerance Level**. The tolerance level represents a critical threshold used during the initial acceptance sample to determine whether a process requires additional investigation. If the results of an initial sample cannot confidently rule out the possibility that the true processing error rate is above the tolerance level, a second sample of sufficient size to estimate the actual rate of processing errors should be taken.

   The tolerance level is thus used to provide parameters for a mathematical construction. This expression of tolerance has little to do with the real tolerance that a jurisdiction may have for error. From a regulatory compliance standpoint, however, the tolerance level utilized can have an additional meaning beyond its use as an indicator of the size of sample needed to establish an error rate with a sufficient confidence level. Under the *Unfair Trade Practices Act* (#880) and *Unfair Claims Settlement Practices Act* (#900), one standard for establishing a violation of these laws is that a company commits a practice "with such frequency to indicate a general business practice." Many states have included this general business practice standard (or a similar standard involving frequency) when enacting one or both of these models.

   Historically, a benchmark error rate of 7 percent has been established for auditing claim practices and 10 percent for other trade practices. Error rates exceeding these benchmarks are presumed to indicate a general business practice contrary to these laws. For uniformity in the application of these laws, and absent state case law that may apply an alternative standard, states that have the general business practice standard are strongly encouraged to utilize the 7 percent and 10 percent standards both as tolerance levels for statistical sampling purposes and as benchmarks for evaluating when violations of the state's unfair claim and trade practices statutes have occurred. [21]

   On the other hand, many other state laws are not dependent upon the frequency of commission of an act in order to constitute a violation of the law—each instance of commission of the act constitutes a separate and distinct violation. For example, conducting business in a state without a license may constitute a violation of law each time it occurs, whether it is done once or one hundred times. This may also be true for the unfair claim and/or trade practices statutes in those states that have not adopted the general business practice standard of the NAIC models. The resulting error rate relative to such laws represents the probable number of violations within the total population rather than a benchmark for evaluating whether or not a violation has occurred. While it is not strictly necessary to use the 7 percent and 10 percent tolerance levels in these circumstances, states are still encouraged to do so when calculating appropriate sample sizes for consistency in both application and presentation. For this reason, all calculations in this chapter utilize the 7 percent and 10 percent tolerance levels.

4. **Extrapolation**. Generalization or extrapolation of results beyond the field of files from which the sample is selected is not acceptable. If files are sampled from a Chicago branch underwriting office, results cannot logically be extrapolated to a branch office in Philadelphia. A sample can only be representative of the population from which it was drawn—and no other. Any alternative assumptions are very frail, insupportable and probably invalid.

[21] With respect to sampling, readers are strongly cautioned not to confuse the two quite distinct meanings associated with the terms "tolerance level" and "benchmark error rate." The former is a statistical construct with meaning only in terms of making probabilistic inferences, while the latter is a threshold used to establish the legal presumption of a general business practice. Important in this respect, the first stage sample cannot be used to establish with confidence that the true rate of noncompliance exceeds 7 percent or 10 percent. The small sample sizes only support the inference that one cannot confidently rule out such a possibility. The larger second stage sample is required to infer the actual rate of noncompliance, and determine whether this true rate exceeds some specified threshold.

E. Data Verification

In recent years, data verification processes have evolved into highly sophisticated, rigorous and organized systems for ensuring the integrity and accuracy of data. No amount of rigor in sample design can surmount data that is inaccurate: a valid sample drawn from inaccurate data will still produce invalid conclusions. A variety of data problems can introduce serious statistical biases and distortions into the sampling process. The examination process should incorporate a systematic investigation into the accuracy of data collected as part of the examination.

The most frequently used data verification procedures are related to *completeness, validity, internal consistency, duplicated or missing records and reasonability.* If a data problem cannot be remedied, procedures should be adopted to minimize the risk of statistical bias, and such procedures, along with their justification, should be explained in the examination report.

1. **Completeness.** Data from which a sample will be taken should include the entire universe of files or target population. To ensure completeness, such data should be reconciled with control totals, if available. Most states have access to a variety of data that can serve this purpose. All states can obtain statewide data from the financial annual statement, including aggregate annual premiums written and earned, loss paid and incurred and additional expense items. Where the population to be sampled matches that captured on the financial annual statement, examiners should try to test for completeness. Because of the way annual statement data is reported, it can be difficult to match dollar for dollar. Examiners should keep this in mind when trying to test for completeness. For example, if the target population is all paid claims, the amounts in the examination data file should roughly reconcile with the paid loss amounts reported on the annual statement and what was reported on the Market Conduct Annual Statement (MCAS). Similarly, regulator complaint data provided by an insurer can be reconciled to each insurance department's recorded complaints.

   Reconciliation is a time-consuming, and thus expensive, process for insurance regulators and companies. Reporting systems and standardized data request parameters change over time and it can be difficult to precisely reconstruct some records. Market regulation records are, by their nature, different from financial records. Reconciliation of market regulation records to the annual financial statement and the MCAS is a difficult and expensive process. The regulator should consider whether reconciliation is necessary in all samples. For example, if the regulator has a high confidence level in the company data, and the initial numbers provided are roughly consistent with annual statement data, it may not be necessary to test for completeness. On the other hand, if the regulator has evidence that the data provided from the company is incomplete or inaccurate, the need for reconciliation is increased.

   Many states collect data beyond the data available to all states. If an insurance department collects policy or exposure counts, these data can reliably verify the completeness of any analogous data provided during an examination. Each state should systematically determine which control totals may be available, and implement a quality control strategy that utilizes such data.

2. **Validity.** Data fields should be systematically checked to determine that all values are valid and that all codes used correspond to the reporting specifications. Validity is generally determined in a *prima facie* sense: values are wrong "on their face" in that the true value cannot logically be as reported. For example, data that include codes that are not specified on the reporting protocols are simply "wrong," and must be recoded. A payment reported under an automobile no-fault policy for an accident that occurred in an at-fault state will generally be incorrect.

   As with all data problems, data records containing invalid values should not be discarded, because doing so would pose a risk of significantly biasing the subsequent sample. Rather, every effort should be made to determine the true values and then recode the data as necessary.

3. **Internal Consistency.** Examiners should identify ways to ensure that each data record is internally consistent, such that values reported in different data fields are not logically contradictory to others. Similar to *validity,* inconsistency is determined on a *prima facie* basis: a data record is internally inconsistent when two or more values cannot logically be *simultaneously* correct. For example, if a data record for a private automobile insurance policy reported policy limits of $50,000 per occurrence, but the paid loss amount is reported as $70,000, the necessary conclusion is that one or both of these values are incorrect. Such inconsistencies, *when relevant to defining the universe to be sampled or to a process under investigation,* should be recoded to correct values prior to taking a sample.

4. **Duplication of Data Elements.** Duplicate items in a population from which a sample will be taken must be removed prior to sampling. The presence of a significant amount of duplicate data fields could introduce significant statistical bias into the sampling procedure. Random sampling is predicated on the fact that each item in a population has an identical probability of being selected. If an item appears three times in a dataset, the probability that it will be sampled is three times larger than that for a single item.

   Duplication is a particular challenge in performing analysis of accident and health carriers. The process to remove all duplications can be extremely challenging and time-consuming. In this type of examination, the regulator must balance the time and cost of attempting to remove all duplications with the information sought by the query. If the regulator has a high degree of confidence in the overall data provided, it may make sense to factor in the existence of duplicates.

   Duplication is defined with respect to the universe being sampled. For example, some insurers capture data by *claimant* rather than by *occurrence.* Three claims arising from a single automobile accident may appear in triplicate in a dataset. This does not constitute duplication if the intent is to sample the universe consisting of *all claimants.* However, if the target population consists of *all occurrences* from which claims arise, the duplicate records must be removed prior to sampling. Failure to do so could bias the sample in a number of obvious and not so obvious ways. For example, payouts for claims consisting of multiple claimants are very likely to be significantly higher than overall average payouts. There may very well be geographic correlates associated with the types of accidents likely to produce multiple claimants. Since it is extremely unlikely than all possible biases associated with duplication can be identified and corrected, the most prudent strategy is to remove the duplicates from the data prior to sampling.

5. **Missing Data Elements.** Missing data elements can potentially bias a sample in the same manner as duplicate items, if the data elements are relevant to the definition of the population from which the sample will be taken. For example, if the target population is *paid claims*, but the dataset contains a portion of claims for which payment status is not recorded and so are excluded from the sample, the sample will potentially be biased. Bias will occur if the relevant characteristics of the subset of items for which the information is missing differs on average from the overall population of paid claims. Since both the likelihood and degree of such potential differences are generally unknown, potential bias cannot be ruled out in a non-arbitrary way.

   Ideally, no relevant data elements should be missing, although some small amount is often tolerated in many data quality control systems. If the percentage of missing elements is believed to be tolerable, an explicit explanation should be provided in the examination report, including a specification of the percentage of data that it was necessary to discard.

6. **Reasonability.** Reasonability checks identify anomalous data values that deviate significantly from averages, or "what one would expect to see." Reasonability checks can be performed by examining the upper and lower extreme values for each data element, and comparing these values to the average value for the entire dataset. Values that appear unreasonable should be investigated to determine that they are correct. For example, an average annual premium for an automobile policy issued by a company being examined may be $800, with the highest extreme reported as $5,000 and the lowest extreme reported as $30. Such values are not *prima facie* invalid, but they are anomalous to such an extent as to merit further investigation.

Data elements that are missing or inaccurate, but which are not relevant to defining a population, drawing a sample, or to the process under investigation, can safely be ignored. For example, if it appears that a substantial proportion of paid loss amounts are reported incorrectly in the data, but the sampling universe consists of all closed claims regardless of payment status, the data inaccuracies will not bias the resulting sample. Sampling proceeds without respect to reported loss amounts, and all files from the population "all closed claims" still have an equal chance of selection. An exception to this rule may be those instances in which the data reporting is so inaccurate as to suggest that errors are systematic and that the core data handling capacities of the company being examined are significantly flawed.

F. Problem Data and Departures from Random Sampling

In some cases, complete and accurate data which form the universe of files to be sampled cannot be obtained. In these instances, a regulator has one of two choices:

1. Redefine the target population to accommodate the portions of the data that are complete, accurate and available. If the new target population is narrower than the original population, conclusions based on the sample can be made only about the narrower population. If the new target population is broader than the initial population, conclusions can still be made about the initial population, if the members of the initial population are sufficiently represented in the sample.
    a. **Examples of Narrower Population.** The initial desired population is all claims in a state. However, data from one claim processing center is found to be corrupt and cannot be reproduced. The new population to be sampled then becomes all claims in a state, except those processed at the center producing the corrupt data. The subsequent sample indicates that 13 percent of claim files contain errors (+/– 'x' percent). The only valid generalization from this sample is that 13 percent of the claims from the centers sampled, not 13 percent of all claims in the state, contain errors. Nothing can be meaningfully said, based on the sample, of the processing center that was excluded from the initial population.

    b. **Examples of Broader Population.** The initial target population was all *paid claims*, but the data elements relating paid claims failed numerous data integrity checks and the problems could not be remedied. Because the data fails to reliably distinguish claims closed with payment from claims closed without payment, the population may be redefined as all *closed claims.* Paid claims, of course, are an element of the new population. If paid claims appear in the subsequent sample in sufficient numbers, generalizations about error rates associated with paid claims can still be valid. However, the confidence interval and margin of error for the subpopulation (paid claims) must be calculated separately based on their numbers in the sample, error rate and population size. This procedure is not uncommon, and the reader has no doubt seen polls in the popular press that provide estimates for subpopulations in an overall sample, such as those defined by ethnicity or gender.

2. If data is corrupt and the population cannot be meaningfully redefined in a way to effectuate the purposes of an examination, no valid sampling can occur. This chapter does not recommend any form of non-random sampling from a given population. As discussed throughout this chapter, departures from randomness can introduce significant statistical biases into the sample, rendering the sample unrepresentative of the general population. In addition, since the probabilities of non-random sampling outcomes are unknown, no calculable level of confidence can be attached to conclusions.

    Even in this instance, the regulator is not totally without recourse. Every effort should be made to investigate essential insurer processes—even in those instances when valid sampling cannot be performed. However, a strong caveat is that generalizations or extrapolations from findings will be invalid. Evidence of error is strictly limited to the actual errors identified, and no claims about overall error rates can be made. If 50 violations are identified in 20 files that are non-randomly selected, the examinee can only be meaningfully cited for 10 discrete violations, not for 50 percent of the entire population of files.

There may be many situations suitable for non-random investigative techniques. Random sampling is unnecessary for processes in which each discrete violation is the target of the investigation, rather than an overall violation rate in a defined population. For example, it may not be possible to obtain data for a population consisting of all advertising materials used in a state over a specified time period, and thus there may be no way to randomly sample from this population. However, if 7 violations are identified among the advertising materials that are available, the examinee is noncompliant in seven known instances, even though no knowledge is gained about the overall rate of noncompliance.

The examination process is heavily reliant on random sampling, since market conduct audits are generally tailored to identify systemic process failures rather than discrete or incidental violations. Nevertheless, there may still be many instances in which other investigative techniques are appropriate. The caveats repeated throughout this chapter are intended to alert regulators to the lack of validity of generalized conclusions derived from non-random samples. Nothing in this chapter, however, precludes non-random investigative techniques, so long as generalizations are avoided.

G. Sample Sizes

As with the example of the coin, larger sample sizes lend themselves to greater confidence in conclusions. One would feel less confident basing conclusions about the fairness of a coin after only 5 flips as compared to 50. Because probabilities are known, a precise level of confidence can be calculated for any given sample size, if the sample is produced by a random process. Generally, statisticians accept a 95 percent confidence level as sufficient to support scientific findings. Very rarely are confidence levels below 90 percent considered "statistically significant."

The term confidence, in the statistical sense, is always related to a specified level of precision (or margin of error) of an estimate calculated from a sample. Confidence and precision are inversely related: other things being equal, less confidence is associated with more precise estimates. For example, in many popular presentations of sample results, an estimate is presented with a confidence of 'x' percent and a margin of error (or confidence interval) of ±'y' percentage points. That is, the real (and unknown) population proportion is known to lie within the margin of error with a probability of 'x' percent. Conversely, the probability that the true value lies outside of the margin of error is (100 – 'x' percent), since the two outcomes are mutually exclusive and jointly exhaustive (i.e., the proportion must either lie inside or outside of the interval). A given sample will support a conclusion with a narrower margin of error, but with *less* confidence. For example, for a sample size of 500 for which a proportion is calculated at 50 percent, one is more confident that the population proportion is between 45 and 55 (or ±5 percentage points) than between 49 and 51 (±1 percentage point). Both precision and confidence are governed by sample size.

The sample size, confidence level and margin of error are always calculated in the context of a specific target population, and are not applicable to any specific subpopulation within the target population. For example, if an EIC attempts to sample all fire claims of 20XX for a company on a countrywide basis, and even if a rather large sample of 500 files is selected, very few files for any one jurisdiction will likely be present. Let's assume only 7 files were reviewed for Jurisdiction A. Although a regulator can make generalized statements about the overall claims practices of the company countrywide, very little can be said of its practices in Jurisdiction A on the basis of only 7 files. To make accurate statements on the procedures in Jurisdiction A, a much larger sample of Jurisdiction A claims must be reviewed.

Large all-purpose samples, intended to give blanket coverage over a wide range of variables, will usually fail in testing specifics. When gross categories are used (countrywide), little can be deduced about specifics. The same is also true of time sampling for a 3-year period, then discussing a single year, and category "sampling" for all fire coverages, then attempting a discussion of homeowners policies. Thus, the regulator should carefully delineate the target population prior to the adoption of a particular sampling strategy. If necessary, a particular subpopulation can be oversampled or specifically targeted to produce sample sizes necessary to support conclusions, as per the discussion of stratified sampling.

H. Initial Sample

A minimum confidence level of 95 percent is used to make inferences from the small first-stage sample. Due to the relatively small sample size, the estimate made from the first-stage sample has a wide confidence interval (or margin of error). Thus, the small sample is insufficient to produce an accurate "point estimate," or a precise estimate of the true population proportion. Instead, the first-stage sample is designed to rule out the possibility that a given error rate is above a specified threshold. If this possibility cannot confidently be ruled out, the regulator proceeds to the larger second-stage sample capable of supporting more precise estimates with a high degree of confidence.

The sample sizes indicated in the Acceptance Samples Table (AST) will produce a one-tailed lower 95 percent confidence limit of no more than 4.5 percentage points for claims, and 5 percent for non-claims. In some instances, the samples were adjusted somewhat to reduce the likelihood of "false positives," or instances in which a process that is in compliance will still trigger a second sample. In addition, sample sizes for non-claims processes are larger than the corresponding samples for claims.[22]

The "p-values" in columns E and J are equal to (100 percent confidence level), and represent the probability that the number of errors found in the sample would have occurred if the true or population error rate were at least equal to the tolerance level (i.e., 7 percent of claims, 10 percent of non-claims). For example, in a sample of 76 drawn from a population of 200, the probability of finding two *or fewer* errors is 4.8 percent *if the sample were taken from a population with an error rate of 7 percent.* A second sample is triggered when the p-value exceeds 5 percent. This is the point at which the confidence level (100 percent p-value) is less than 95 percent and the process error rate is below the critical threshold. Column F indicates when an additional sample is necessary for tests utilizing a 7 percent tolerance level, while Column K uses 10 percent. The p-values are cumulative probabilities derived from the hypergeometric distribution.

The AST represents the generally recommended sample size for most applications. However, the regulator has some discretion in the selection of the initial sample size. There may very well be instances in which greater precision is desired, particularly if examining a critical issue or process likely to represent a high probability of consumer harm. If sample sizes significantly different from those listed in the AST are selected, the regulator should be prepared to provide explicit justification with respect to the substantive issues being investigated.

Slightly larger samples can reduce the likelihood that an initial sample fails to detect a practice that is noncompliant (i.e., "false negatives"). Ideally the likelihood of false positives, where a compliant process fails the first round of sampling, should also not be high. Increased precision associated with larger sample sizes can reduce the likelihood of both types of inference errors (sometimes referred to as "false alarms" or "failed alarms"). If the regulator is less concerned about the risk of false positives, significantly smaller samples can be used.

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	Error	% Error	P-Value, Pop=.05	Add for Claims	Sample (n)	Error	% Error	P-Value, Pop=.10	Add for Other

[22] The 95 percent confidence limits become wider as the true population proportion increases, and are at their widest when the population proportion is at 50 percent. The value of the interval is symmetrical for proportions greater or less than 50 percent (i.e., the margin of error or confidence interval will be the same for proportions of 30 and 70 percent, 20 and 80 percent, etc.) This result may seem counterintuitive, but it is attributable to the fact that the sampling variability of a proportion is greatest when the population proportion is 50 percent, and at its minimum when the true proportion is 0 or 100 percent (in which case, there would be 0 variability in the sample estimate across different samples, all of which would precisely replicate the population). Thus a slightly larger sample is required for a tolerable error of 10 percent compared to 7 percent.

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	Error	% Error	P-Value, Pop=.07	Add for Claims	Sample (n)	Error	% Error	P-Value, Pop=.10	Add for Other
200	76	0	0.0%	0.1%	No	79	0	0.0%	0.0%	No
200	76	1	1.3%	1.0%	No	79	1	1.3%	0.0%	No
200	76	2	2.6%	4.8%	No	79	2	2.5%	0.3%	No
200	76	3	3.9%	14.9%	Yes	79	3	3.8%	1.4%	No
200	76	4	5.3%	32.6%	Yes	79	4	5.1%	4.7%	No
200	76	5	6.6%	54.9%	Yes	79	5	6.3%	12.2%	Yes
400	82	0	0.0%	0.1%	No	84	0	0.0%	0.0%	No
400	82	1	1.2%	1.1%	No	84	1	1.2%	0.1%	No
400	82	2	2.4%	4.8%	No	84	2	2.4%	0.4%	No
400	82	3	3.7%	13.6%	Yes	84	3	3.6%	1.6%	No
400	82	4	4.9%	28.3%	Yes	84	4	4.8%	4.8%	No
400	82	5	6.1%	47.0%	Yes	84	5	6.0%	11.4%	Yes
500	83	0	0.0%	0.1%	No	86	0	0.0%	0.0%	No
500	83	1	1.2%	1.2%	No	86	1	1.2%	0.1%	No
500	83	2	2.4%	4.9%	No	86	2	2.3%	0.4%	No
500	83	3	3.6%	13.5%	Yes	86	3	3.5%	1.5%	No
500	83	4	4.8%	27.9%	Yes	86	4	4.7%	4.5%	No
500	83	5	6.0%	46.0%	Yes	86	5	5.8%	10.6%	Yes
1,000	105	0	0.0%	0.0%	No	113	0	0.0%	0.0%	No
1,000	105	1	1.0%	0.3%	No	113	1	0.9%	0.0%	No
1,000	105	2	1.9%	1.5%	No	113	2	1.8%	0.0%	No
1,000	105	3	2.9%	5.0%	Yes	113	3	2.7%	0.2%	No
1,000	105	4	3.8%	12.0%	Yes	113	4	3.5%	0.7%	No
1,000	105	5	4.8%	23.4%	Yes	113	5	4.4%	2.0%	No
1,000	105	6	5.7%	38.2%	Yes	113	6	5.3%	4.8%	No
1,000	105	6	5.7%	53.0%	Yes	113	7	6.2%	9.8%	Yes
2,000	107	0	0.0%	0.0%	No	114	0	0.0%	0.0%	No
2,000	107	1	0.9%	0.3%	No	114	1	0.9%	0.0%	No
2,000	107	2	1.9%	1.5%	No	114	2	1.8%	0.0%	No
2,000	107	3	2.8%	4.9%	No	114	3	2.6%	0.2%	No
2,000	107	4	3.7%	11.7%	Yes	114	4	3.5%	0.7%	No
2,000	107	5	4.7%	22.5%	Yes	114	5	4.4%	2.1%	No
2,000	107	6	5.6%	36.7%	Yes	114	6	5.3%	5.0%	No
2,000	107	7	6.5%	52.2%	Yes	114	7	6.1%	10.0%	Yes
3,500	108	0	0.0%	0.0%	No	115	0	0.0%	0.0%	No

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	Error	% Error	P-Value, Pop=.07	Add for Claims	Sample (n)	Error	% Error	P-Value, Pop=.10	Add for Other
3,500	108	1	0.9%	0.3%	No	115	1	0.9%	0.0%	No
3,500	108	2	1.9%	1.5%	No	115	2	1.7%	0.0%	No
3,500	108	3	2.8%	4.8%	Yes	115	3	2.6%	0.2%	No
3,500	108	4	3.7%	11.5%	Yes	115	4	3.5%	0.7%	No
3,500	108	5	4.6%	22.1%	Yes	115	5	4.3%	2.1%	No
3,500	108	6	5.6%	35.9%	Yes	115	6	5.2%	4.9%	No
3,500	108	7	6.5%	51.2%	Yes	115	7	6.1%	9.8%	Yes
5,000	108	0	0.0%	0.0%	No	115	0	0.0%	0.0%	No
5,000	108	1	0.9%	0.3%	No	115	1	0.9%	0.0%	No
5,000	108	2	1.9%	1.6%	No	115	2	1.7%	0.0%	No
5,000	108	3	2.8%	4.9%	Yes	115	3	2.6%	0.2%	No
5,000	108	4	3.7%	11.6%	Yes	115	4	3.5%	0.8%	No
5,000	108	5	4.6%	22.2%	Yes	115	5	4.3%	2.1%	No
5,000	108	6	5.6%	36.0%	Yes	115	6	5.2%	4.9%	No
5,000	108	7	6.5%	51.2%	Yes	115	7	6.1%	9.9%	Yes
10,000	109	0	0.0%	0.0%	No	116	0	0.0%	0.0%	No
10,000	109	1	0.9%	0.3%	No	116	1	0.9%	0.0%	No
10,000	109	2	1.8%	1.5%	No	116	2	1.7%	0.0%	No
10,000	109	3	2.8%	4.8%	No	116	3	2.6%	0.2%	No
10,000	109	4	3.7%	11.3%	Yes	116	4	3.4%	0.7%	No
10,000	109	5	4.6%	21.6%	Yes	116	5	4.3%	2.0%	No
10,000	109	6	5.5%	35.2%	Yes	116	6	5.2%	4.7%	No
10,000	109	7	6.4%	50.2%	Yes	116	7	6.0%	9.5%	Yes
20,000	109	0	0.0%	0.0%	No	116	0	0.0%	0.0%	No
20,000	109	1	0.9%	0.3%	No	116	1	0.9%	0.0%	No
20,000	109	2	1.8%	1.5%	No	116	2	1.7%	0.0%	No
20,000	109	3	2.8%	4.8%	No	116	3	2.6%	0.2%	No
20,000	109	4	3.7%	11.3%	Yes	116	4	3.4%	0.7%	No
20,000	109	5	4.6%	21.7%	Yes	116	5	4.3%	2.1%	No
20,000	109	6	5.5%	35.2%	Yes	116	6	5.2%	4.8%	No
20,000	109	7	6.4%	50.2%	Yes	116	7	6.0%	9.6%	Yes
50,000	109	0	0.0%	0.0%	No	116	0	0.0%	0.0%	No
50,000	109	1	0.9%	0.3%	No	116	1	0.9%	0.0%	No
50,000	109	2	1.8%	1.6%	No	116	2	1.7%	0.0%	No
50,000	109	3	2.8%	4.8%	No	116	3	2.6%	0.2%	No
50,000	109	4	3.7%	11.4%	Yes	116	4	3.4%	0.8%	No

Acceptance Samples Table										
	Claims					Other				
A	B	C	D	E	F	G	H	I	J	K
Pop. (N)	Sample (n)	Error	% Error	P-Value, Pop=.07	Add for Claims	Sample (n)	Error	% Error	P-Value, Pop=.10	Add for Other
50,000	109	5	4.6%	21.7%	Yes	116	5	4.3%	2.1%	No
50,000	109	6	5.5%	35.2%	Yes	116	6	5.2%	4.8%	No
50,000	109	6	5.5%	48.8%	Yes	116	7	6.0%	9.6%	Yes

I. Additional Sample

If the initial acceptance sample indicates that an additional sample is necessary to more precisely estimate the level of error in the field of files from which the sample was drawn, several options are available. There are a variety of ways to select such an additional sample. The sampling method selected should be described in the examination report. In conformity with generally accepted practice, the report should also include the confidence limits associated with any estimate.

J. Sampling Topics and Tables

1. **Sample Sizes.** Numerous software packages can easily calculate necessary sample sizes. Alternatively, sample sizes can be estimated with the formula presented in Section M of this chapter, although the formula is only an approximation to the more complex algorithm used to produce the table, and which is implemented in most auditing software.[23]

   Sample size for testing proportions, such as error rates in a population of files, is governed entirely by the following four parameters:

   a. **Population size.** The larger the population, the larger the necessary sample. When the population is sufficiently large, further population increases have minimal impact on sample size.

   b. **Desired margin of error or precision.** Sample size is inversely related to the margin of error. The smaller the desired margin, the larger the necessary sample.

   c. **Confidence level.** More confidence requires larger samples.

   d. **The (unknown) error rate or proportion in the population to be estimated.** Necessary sample sizes are largest when the actual error rate in a population to be sampled is 50 percent and declines as the error rate approaches 0 percent and 100 percent (see below).

   Of these four parameters, values for only two parameters are established by the regulator: the "desired margin of error or precision" and the "confidence level." These two parameters can have a significant impact on necessary sample sizes. Regulators should carefully weigh the costs and benefits when making sampling decisions, such as whether gains in precision or higher confidence or merited by the cost of producing and investigating a larger sample of files.
   In selecting a sample size, the regulator must estimate the true population proportion, or the actual percentage of files in the population that that contain errors. Differences in the sampling variability

[23] The table was produced in SAS via an iterative algorithm that employed the cumulative hypergeometric probability function (SAS function "*probhypr*"). Most auditing software generates sample sizes using the same or closely similar probability distributions. Because the hypergeometric calculations are complex and labor intensive, the normal approximation to the hypergeometric is often employed when the sample sizes must be calculated manually. This is the formula presented below following the table. Since the formula is only an approximation, sample sizes produced by it will differ somewhat from those displayed in the table, as well as sample sizes generally returned by computer software.

associated with different proportions can be substantial. For example, when sampling from a population of 5,000 files, a sample size of 200 is necessary to obtain a margin of error of 3 percent when the population proportion is 5 percent. However, the necessary sample size to achieve the same margin of error increases to 917 when the true proportion is 50 percent. If the initial guess about the population proportion is far off, the resulting estimates produced from the sample may have a significantly wider margin of error than anticipated. One conservative approach is to always select the sample size associated with a proportion of 50 percent. However, a significant amount of labor can be saved by using any information available that indicates that the true population proportion is greater than or less than 50 percent. For example, the estimate produced from the initial acceptance sample may be used in calculating the subsequent sample size. Final confidence limits must be calculated *after* the sample is obtained, using the sample proportion as a substitute for the (unknown) actual proportion.

K. Considerations for Selecting Sample Sizes

The rationale for the two-stage acceptance sampling technique discussed in this handbook is that the possibility that a process exceeds a specified error rate can be ruled out without having to draw a large sample in every case. In some instances, a small sample can effectively identify insurer processes that are likely to be compliant, even though the sample cannot produce very precise point estimates of the actual population proportion since the confidence interval or margin of error will be large. For example, the recommended first-stage sample sizes in the AST are designed to accommodate a confidence level of 95 percent, with a corresponding (one-sided) confidence limit (or margin of error) of 4.5 percent for claims and 5 percent of non-claims.[24]

However, there is an additional decision risk associated with the first-stage sample. While a regulator can be reasonably confident that a process is compliant if the sample proportion is less than the lower boundary of the confidence limit, the converse is not true. The fact that a sample proportion exceeds the lower confidence limit does *not* indicate that a company process is *noncompliant.* Rather, all that is determined in this situation is that the possibility that the process is noncompliant cannot be ruled out with much certainty (but it is not thereby "ruled in," as it were). The first-stage sample is, therefore, generally unsuitable for making a determination that a process is noncompliant.

There are, therefore, two types of risks associated with inferences based on the initial sample. First, the process may in fact be compliant, but the process fails the initial test, leading a regulator to draw the larger second sample. Alternatively, the process may be noncompliant, even though the sample indicates that it is compliant. This second probability is minimized by use of the 95 percent confidence limits, but the risk is not reduced to zero. Statisticians call these types of incorrect conclusions *Type I* and *Type II* errors:

1. **Type I Error.** "False alarm" or "false positive." A "null hypothesis" is rejected when it should be accepted. For regulatory purposes, this error occurs when a regulator proceeds to the second larger sample when, in fact, the process is compliant.

2. **Type II Error.** "Failed alarm" or "false negative." A "null hypothesis" is inappropriately accepted. For example, the insurer process passes the initial test and is not further investigated, even though the process is not compliant.[25]

[24] A one-sided or "one-tailed" 95 percent confidence interval is essentially a one-sided interpretation of a two-sided 90 percent confidence interval. This is a valid interpretation since inferences are made only about whether the sample error rate exceeds the lower bound. The likelihood that the true value exceeds the upper bound is not relevant to the decision at hand.

[25] Strictly speaking, the "null hypothesis" in this handbook is that "the true proportion is greater than 7 (or 10) percent" rather than "the true proportion is less than or equal to 7 percent." Thus, the terms "Type I" and "Type II" above should really be reversed. For expository reasons, a terminology consistent with the verbal meaning of the terms "false alarm" or "false positive" is adopted to avoid conceptual confusion. In reality, a Type I error or "false positive" in this context is the erroneous rejection of the hypothesis that a process is noncompliant (or H0: p>.07), though this might be better thought of conceptually as a Type II error ("false negative" or "failed alarm").

A Type I error results in wasted time and resources, in the sense that a large sample is gathered to investigate a company process that was, in fact, compliant. A Type II error leads to a failure of regulatory oversight, in that problem areas of company operations will remain uninvestigated. Unfortunately, there is a strict trade-off associated with the two categories of inference errors: *for a given sample size*, *minimizing the risk of a Type I error maximizes the risk of a Type II error, and vice versa.* However, inference risks are calculable, and can be managed by altering decision rules for a given sample size. Alternatively, the risk of both types of errors can generally be reduced by increasing sample sizes. If the initial sample size is substantially increased, the whole rationale of two-stage sampling is defeated.

The trade-off between Type I and Type II risks might be clarified by a more mundane example. If the sensitivity of a smoke alarm is calibrated too high, there is a high probability of "false alarms." The alarm may sound in the presence of normal environmental smoke, such as that produced from cooking. Clearly, it is unlikely that the alarm will fail in the event of a house fire, but it is also very likely that a high number of false alarms will reduce the alarm's efficacy. In response, a frustrated homeowner might decide to remove the battery, thus reducing the risk of a Type I error to zero. In the event of a real fire, the probability of a Type II error is thereby increased to one, since the now powerless alarm will necessarily fail to detect a hazardous fire.

A rational sampling approach should carefully balance the costs and benefits associated with each type of risk, such as regulatory resources diverted from noncompliant areas or additional expense associated with unnecessary sampling versus the potential consumer harm resulting from regulatory oversight failures. Indeed, regulators may rationally adopt differing sampling strategies to alter Type I and Type II trade-offs depending on the context. For example, given a company process for which failure would entail a high risk of consumer harm, a regulator may tolerate an elevated Type I risk in order to reduce a Type II risk.

Researchers are generally concerned with Type I risks to an extent that Type II risks are commonly ignored in a wide variety of research fields. When Type II risks are made an explicit part of research design, a level of 20 percent is generally considered acceptable, although often a much higher level is tolerated (compared to a 5 percent maximum for Type I risks).

Regulators, however, are much more concerned with Type II risks, or the risk of failing to detect a noncompliant process (a "failed alarm"). Therefore, the risk trade-off associated with permitting a larger number of errors in the sample is generally unacceptable. As such, it is generally preferable to negotiate inference risks by adjusting sample sizes rather than altering decision rules for a given sample size. In many instances, efficiency gains can be obtained with modest sample size increases, which can reduce the risk of *both* types of inferences.

Use of Smaller Samples. One method used by some auditors (see, for example, the *Financial Condition Examiners Handbook*) utilizes much smaller samples than the sample sizes recommended by this handbook. A process is deemed reliable if zero errors are found in the sample. Given the decision rule, a sample size is selected that reduces the probability of zero sample errors to less than 5 percent when the true error rate equals the tolerable level or critical threshold. Thus, the Type I risk of the method equals that of the method prescribed in this chapter.

For example, if zero errors were found in a sample size of 38 drawn from a population of 200, a regulator could be at least 95 percent confident that the true error rate is not greater than or equal to 7 percent (p-value is 4.7 percent). Similarly, with a sample size of 27 taken from the same population, zero errors would occur only 4.7 percent of the time if the true error rate was 10 percent.

However, Type I risk is significantly greater than risks associated with larger samples. For claims, the Type I risk for each population size exceeds 71 percent for processes that have an actual error rate of only 3 percent, which is well below the 7 percent critical threshold. Similarly, the Type I risk for non-claims processes is more than 83 percent for processes with a 5 percent error rate. Large Type I risks are inherent in small samples due to a large margin of error.

This method is not recommended for general use, since it does not finely discriminate between compliant and noncompliant processes, except when the true error rate is well below 3 percent.[26] As such, significant efficiency gains—which constitute the rationale of two-stage sampling—are unlikely to be realized, since a second-stage sample will be triggered in most instances. Regulators should use this method only in those instances in which they have reason to believe that the true error rate is low.

L. ACL and Sampling

One common auditing software package widely used by regulators is audit command software (ACL). This section discusses the sampling routines available in ACL.

ACL employs the same one-tailed confidence methodology for acceptance sampling that is described in this chapter, and it is, therefore, well-suited for examination and analysis purposes. Sample sizes in ACL are calculated by entering a confidence level (e.g., 90 percent or 95 percent), the population size, the upper error limit (or tolerance level) and an "expected error rate." The expected error rate is a way to establish a margin of error, and is *not* the population proportion assumed in calculating the sample size. Rather, the sample size is calculated assuming that the population proportion equals the tolerance level, or "upper error limit." ACL returns a sample size large enough to produce a maximum margin of error of (tolerance level – expected error rate).

For example, the ACL manual describes the following scenario:[27]

Population = 40,000
Confidence = 95%
Upper Error Limit = 5%
Expected Error Rate = 2%

ACL returns a sample size of 184, with a margin of error of no more than 3 percent (5% – 2%). The maximum allowable errors in the sample is four, such that if the sample contains four or fewer errors, the hypothesis that the true error rate is greater than 5 percent can be rejected with at least 95 percent confidence.

The following table displays the probability distribution for these results in a format similar to the AST table shown previously in this chapter. The cumulative probability column displays the percentage of samples (if taken over time) that would contain the corresponding number of errors *or fewer, if the population error rate equaled the tolerable error, or 5 percent.* For example, six or fewer errors would be obtained in 18.2 percent of samples. The 95 percent confidence limit is the point at which this probability falls below 5 percent (100 – 95), which occurs when the number of errors is less than or equal to four. Thus, with four errors in the sample, it can be concluded with 95.6 percent (100 – 4.4) confidence that the true error rate is less than 5 percent, and does not exceed the critical threshold.

[26] A point made in Arkin, Herbert. 1982. *Sampling Methods for the Auditor: An Advanced Treatment.* New York: *McGraw-Hill.*
[27] *ACL for Windows Command Reference.* 1996. Vancouver: ACL Software, page 451.

Probability Distribution if Population Proportion is 5%				
Population	Sample	Errors	% Errors	Cumulative Probability
40,000	184	0	0.0%	0.0%
40,000	184	1	0.5%	0.1%
40,000	184	2	1.1%	0.5%
40,000	184	3	1.6%	1.6%
40,000	184	4	2.2%	4.4%
40,000	184	5	2.7%	9.8%
40,000	184	6	3.3%	18.2%
40,000	184	7	3.8%	29.4%
40,000	184	8	4.3%	42.5%
40,000	184	9	4.9%	56.0%
40,000	184	10	5.4%	68.5%

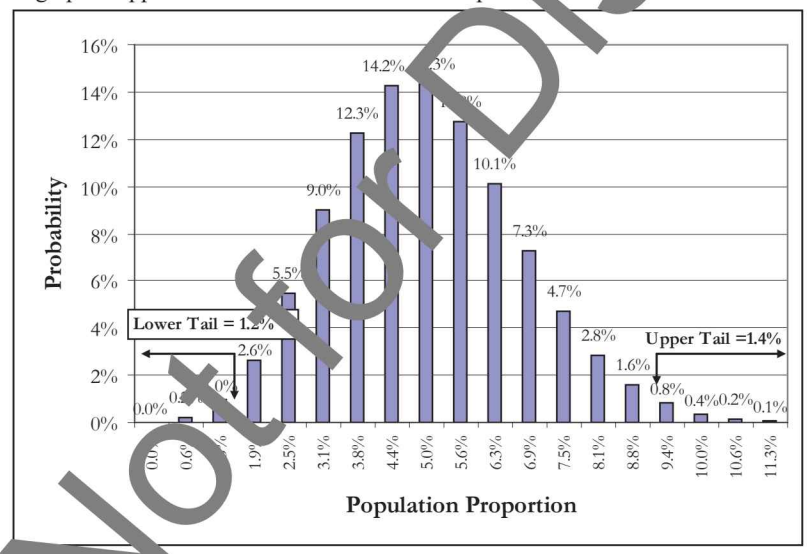
To generate sample sizes roughly equivalent to those contained in the AST, enter a confidence level of [illegible] percent and the upper error limit for claims or non-claims processes (7 percent or 10 percent). Since the AST was initially constructed using a 4.5 percent margin of error for claims, the "expected error rate" for ACL is 2.5 percent (upper error limit—margin of error) = (7% – 4.5%) = 2.5%. ACL's sample size will not exactly duplicate those listed in the AST, since the sample sizes in the AST were adjusted for Type I risks.

Because the ACL routine is a one-tailed test appropriate for acceptance sampling, confidence limits must be modified for the second stage sample, which generally employs a two-tailed test. That is, during the second-stage sampling, the concern is generally not whether the population proportion exceeds some specified value. Instead, the second-stage sample is designed to establish *upper and lower* bounds within which the true value may lie.

For example, assume that eight errors are discovered in a sample size of 160. Substituting the sample error rate of five percent for the unknown population error rate, the following probability distribution is obtained. To obtain a confidence level of *at least* 95 percent that the true proportion lies within an interval around 5 percent, the sum of the probabilities of both upper and lower bounds cannot exceed 5 percent (100 – 95 percent confidence level = 5 percent). The minimum of a 95 percent confidence interval around 5 percent is, thus, 1.3 percent and 8.8 percent. The actual confidence limit is the sum of the probabilities of the upper and lower tails, or the areas that fall outside of the confidence interval: [100 – lower tail probability – upper tail probability] = [100 – 1.2 – (100 – 98.5)] = (100 – 1.2 – 1.5) = 97.3%.

Probability Distribution if Population Proportion is 5%				
Population	Sample	Errors	% Errors	Probability
40,000	160	0	0.0%	0.0%
40,000	160	1	0.6%	0.3%
40,000	160	2	1.3%	1.2%
40,000	160	3	1.9%	3.9%
40,000	160	4	2.5%	9.3%
40,000	160	5	3.1%	18.4%
40,000	160	6	3.8%	30.7%
40,000	160	7	4.4%	44.9%
40,000	160	8	5.0%	59.3%
40,000	160	9	5.6%	72.0%
40,000	160	10	6.3%	82.1%
40,000	160	11	6.9%	89.4%
40,000	160	12	7.5%	94.1%
40,000	160	13	8.1%	97.0%
40,000	160	14	8.8%	98.5%
40,000	160	15	9.4%	99.3%
40,000	160	16	10.0%	99.7%
40,000	160	17	10.6%	99.9%
40,000	160	18	11.3%	100%

The probabilities are displayed graphically below. In this chart, probabilities are non-cumulative, and represent the probability of a single proportion. The confidence interval is the area of the graph excluding the upper and lower tails, or between 1.9 percent and 8.8 percent inclusive. Alternatively, the normal approximation formula given in Section M yields a confidence interval of 1.6 percent and 8.4 percent, which is very close to the more exact hypergeometric limits. The normal approximation works well because, as the reader will note, the shape of the distribution in the graph is approximates the normal or "bell-shaped" curve.



To estimate a sample size sufficient for a two-tailed test, the confidence level entered into ACL's one-tailed test must be increased. To calculate a sample for a 95 percent confidence interval for a two-tailed test, enter a confidence level of 97.5 percent, such that [2 * (100 – 97.5) = 5%].

The sample sizes produced by ACL are somewhat larger than those produced by the hypergeometric distribution, since the ACL algorithm utilizes a slightly different probability distribution.

M. Sampling Formulas

1. Formulas:

   A formula for approximating the required size of the second-stage sample to produce estimates with a given level of confidence and precision is:

$$S = \frac{Nz^2P(1-P)}{(N-1)e^2 + z^2P(1-P)}$$

   where:

   N = Size of the population from which the sample will be taken
   S = Sample size
   Z = Standard normal deviate (or standard deviation). For a desired confidence level of 95 percent confidence, use z=1.96.
   P = The unknown population proportion to be estimated. Regulators should use their best judgment, as well as evidence from the initial sample, to select a value for P.
   E = Margin of error or degree of accuracy of the sample estimate expressed as a proportion (for example, use .05 instead of 5 percent)

   The desired outcome is to produce a sample of sufficient size to support a conclusion with 95 percent confidence that the true proportion is within ± '*E*', or the margin of error, of the sample proportion. The actual margin of error depends on the accuracy of the initial guess for the population proportion. As discussed above, the margin of error increases as the true proportion approaches 50 percent. If the initial guess was 10 percent, but the resulting sample proportion was 50 percent, the confidence limits will be significantly wider than initially anticipated. Confidence limits, therefore, must be calculated after the analysis of the sample is completed.

2. Confidence interval formula:

$$E = Z\sqrt{\frac{P(1-P)}{S}}\sqrt{\frac{N-S}{N-1}}$$

   where:

   E = Margin of error
   Z = The standard deviation of the sampling estimate. Use z=1.96 for a 95 percent confidence interval.
   P = The sample proportion (as a substitute for the unknown population proportion)
   S = Sample size
   N = Population size

   The formulas for sample size and confidence interval are for samples taken from small populations. The term $\sqrt{\frac{N-S}{N-1}}$ is the population correction factor. As populations increase in size, the term has less impact on the resulting estimate. For example, with a sample size of 300 and population size of 500, the term reduces to .63. If the population size is increased to 5,000, the term is .96, and it quickly approaches 1 at

50,000 (or .997). Thus, for populations greater than 50,000, the term can safely be dropped from the equation, since further increases in population have little impact on the margin of error, or the necessary sample size. In other words, a sample sufficient for sampling from a population of 50,000 will also be sufficient for sampling from a population of 50 million. In each case, the population is "large enough," and the formula for "large populations" can safely be used, which calculates a sample size without reference to the population size.

3. Skip interval formula:

$$I = (\frac{2N}{S}) - 1$$

where:

I = Skip interval
N = Population size
S = Sample size

4. Procedure:

   a. Determine the sample size.

   b. Determine the skip interval.

   c. Using a table of random numbers, or a random number generator, select the sample indicated.

   d. Apply test(s) to sample and tabulate raw frequency expressing each frequency as a proportion.

   e. Using the 95 percent confidence interval formula, calculate an interval for each population proportion.

5. Calculation example:

   From a population of 20,000 homeowners insurance policy files, investigate the accuracy of rating procedures. Using the sampling formula, find sample size as follows:

$$S = \frac{(20{,}000)(1.96^2)(.5)(1-.5)}{(20{,}000-1)(.05^2)+(1.96^2)(.5)(1-.5)}$$

   S = 376.9, or 377

   After the sample size is determined, the skip interval formula for a sample size of 400 yields:

$$I = \frac{2(20{,}000)}{400} - 1 = 99$$

From a random number table, select 400 numbers between 1 and 99 (ignore those numbers that fall outside the range of 1 to 99; e.g., disregard 138, 191, 295, 0, etc.) For sake of illustration, suppose the first 10 numbers are:

K1 – 03	K2 – 16
K3 – 12	K4 – 55
K5 - 56	K6 – 33
K7 – 57	K8 – 18
K9 – 25	K10 – 23

Begin the selection process by skipping the first three files and selecting the fourth file, then skip the next 16 files and select the 21st file and so on.

Suppose the following results were tabulated from the sample of 400 files.

	(a)	(b)	(c)
Category	Count	Percent (P) (Column a ÷ sample size)	95% Confidence Interval
Policies with rate overcharge	21	5.25	2.16
Polices with rate undercharge	14	3.50	1.78
Policies with non-premium error	10	2.50	1.51
Policies with insufficient information	10	2.50	1.51
Total rated incorrectly	55	13.75	3.44

Using the 95 percent confidence interval formula, the confidence interval for 5.25 would be

$$1.96\sqrt{\frac{(5.25)(94.75)}{400}}\sqrt{\frac{20{,}000-400}{20{,}000-1}}$$

1.96 x 1.115 x .99 = 2.16 (rounded)

Thus, a regulator can be 95 percent confident that the proportion of policies with a rate overcharge is between 3.09 (column b – 2.16) and 7.41 (column b + 2.16).

Chapter 18—Automated Examinations Tools and Techniques

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

A. Purpose of Automated Examinations

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

B. Automation Tools

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

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

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

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

b. Complaints Database System (CDS)
CDS has been operational since 1999 and is only available to regulators. Complaint information is recorded identifying the type, reason and ultimate disposition. Reports readily provide the number of complaints and are useful for analyzing trends related to complaints for an individual or company.

c. Regulatory Information Retrieval System (RIRS)
RIRS has been operational since the 1960s and was implemented as an electronic database in 1985. RIRS is a regulator-only NAIC database containing final, adjudicated regulatory actions against insurance or non-insurance entities and includes both licensed and non-licensed entities. This system enables state insurance regulators to track, on a nationwide basis, the regulatory history of individuals and entities affiliated with the insurance industry. The origin, reason and disposition of the regulatory action are recorded in the database.

d. 1033 State Decision Repository
The 1033 State Decision Repository (SDR) application allows regulators to enter and search for 1033 decisions, which state regulators have made for individuals who have requested to work in the business of insurance but have been prohibited to do so by Section 1033 of the Violent Crime Control and Law Enforcement Act of 1994. 1033 waivers and denials which were previously located in the Special Activities Database (SAD) were migrated to the 1033 State Decision Repository on December 1, 2016. The SAD database was no longer functional as of December 2, 2016.

e. State Producer Licensing Database (SPLD)
NAIC owns and NIPR helps maintain a comprehensive state producer licensing database called "SPLD" for the exclusive use of state regulators. This NAIC database contains all of the information in the Producer Database (PDB), plus all state submitted regulatory actions and confidential information available only to regulators. SPLD is a regulator-only database accessible through iSite+ and not subject to the Fair Credit Reporting Act (FCRA).

To search for producers via iSite+:

- Log into the regulator-only portion of myNAIC and select iSite+ from the login categories;
- Select the Search – Individual Entity under the Tool tab;
- Enter the known criteria for the entity (e.g., last name, first name) and select Search; and
- Select the Licensing link next to the appropriate entity.

The examiner may need to review the basic demographic data to verify the correct entity was selected.

f. Financial Applications
The Financial Applications section contains the annual statement financial information for insurance companies that report to the NAIC. The most useful financial application for market conduct examiners is the annual statement Pick-a-Page. In Pick-a-Page, the State Page exhibit of direct written premiums in any particular state can be obtained.

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

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

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

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

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

3. TeamMate™

TeamMate is a Windows-based file repository and auditing software package that states may purchase to assist them in conducting examinations. This software enables the examiners to compile examination workpaper documentation into a paperless electronic file. The software package tracks completion and review of examination procedures and is capable of including the examination documentation (Word documents, spreadsheets, watermark images, etc.) entirely within the program. The TeamMate audit management software has two models, a distributed version and a centralized version. As of June 2018, the NAIC utilizes the centralized model.

To assist in the utilization of TeamMate for market regulation purposes, the NAIC has developed Market Regulation TeamMate TeamStores. The NAIC Market Regulation TeamStores were developed to provide the states with uniform procedures that mirror the market conduct examination standards found in Chapters 20-32 of the *Market Regulation Handbook*.

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

4. Spreadsheets

Spreadsheet applications are computer programs for creating and manipulating spreadsheets. Data in a spreadsheet can be defined and formulas created for calculations, etc. The most popular spreadsheet application is Microsoft Excel.

5. Databases

Database software provides for queries and reports to be created against a database. One example of a database application is Microsoft Access.

6. Word Processing Software

Word processing software facilitates the creation of letters and other documents. Sample text is included in this chapter.

7. Market Conduct Sampling Utilities Program (MCSU)

The Market Conduct Sampling Utilities program (MCSU) is a Microsoft Excel program designed to assist regulators in testing random sampling tolerance and confidence levels. Determination of sample size and probability of the accuracy of sampling results can be readily calculated using this program. The MCSU conforms to the methodology of the revised Chapter 17—Sampling as adopted by the Market Regulation Handbook (D) Working Group in 2006. The MCSU Excel program and accompanying Help File are available to regulators in the Reference Documents section of the Market Regulation Handbook web page on StateNet.

8. State Systems

The examiner should identify what information is stored electronically in their state systems and whether it can be extracted for automated testing. If a company's data will be tested against the state's data, the initial request for data sent to the company should consider the state's data format to simplify testing. For example, producer name fields should be requested in the same format as it is maintained in the state; e.g., last name, first name.

9. Computer System Size Limitations
Examiners should be aware that email servers may have a standard size limitation for receiving and sending data. When sending an attachment through email, Internet servers may have a size limit on files that can be attached to the email. If the file exceeds this size limitation, then a compression utility tool, such as WinZip or WinAce, can be used in order to send the file. If the sender is using a compression utility tool to send the information, the receiver must also have the same software on their computer system in order to open the compressed file type (.ZIP, .RAR, etc.) to a readable document.

If an email cannot be sent due to server limitations on file size, there are other options available to the examiner. Sending the file through File Transfer Protocol (FTP) is another option. The only drawback to this method is acquiring a password, which can sometimes pose time restrictions. The best solution is to post the file on a secure Internet website. The examiner could send the file to a web server, create a link to that file and other examination team members may be allowed access to the file. If the information is sensitive, the examiner will need to establish a secure site, with the file available only for people who have access to the secured site.

Another option available to examiners is to copy the file to a portable electronic device.

C. Reference Tools, Training and Assistance

The following references, training and assistance are available to assist examiners with the utilization of automated tools.

1. NAIC-Sponsored Training
The NAIC provides a variety of training opportunities and educational events which may prove beneficial to examiners. Available training includes classes for Introduction to ACL, Introduction to ACL—Market Conduct and Advanced ACL. In addition, web-based instruction for NAIC systems is available as well as regularly scheduled events such as the annual NAIC/NIPR Insurance Summit Conference. Information on technical training may be found on the Education and Training website *http://www.naic.org/education_technical_training.htm*. Some examples of NAIC application technical training include:

- Using TeamMate Electronic Work Papers (EWP)—Students will learn the basics of working a TeamMate Financial Exam with EWP; and
- Market Action Tracking System (MATS) Exam Call and Update—Chief Examiners & Market Regulation staff will learn the process of calling a Market Action, and once trained will be able to use the system to update market reports and exchange exam-related information among examiners as a collective team.

2. NAIC File Repository
The NAIC File Repository is designed to allow state regulators to submit files or download files from a centralized location at the NAIC. Various programs and test files can be sent to the repository for other states to download. States are encouraged to share files via the file repository. The file repository is accessed via iSite+.

3. Internet
The Internet has a wealth of information related to the use of software and can provide specific formulas or macros for some functions. Many chat rooms and bulletin boards exist where advice can be sought for problems encountered during an automated examination.

4. IIPRC
The Interstate Insurance Product Regulation Commission (IIPRC) is a valuable resource for market regulators in compacting states when they are working with IIPRC-approved products. The IIPRC website, *www.insurancecompact.org*, contains pertinent information about the Compact law, uniform standards and reviewer checklists. Market regulators can visit the website to learn more about the IIPRC's processes and procedures, including the mix-and-match process that allows an IIPRC-approved product component—such as an application, policy, rider, amendment or endorsement—to be used or "mixed and matched" with a compacting state-approved product component. The IIPRC office staff and reviewers are easily accessible to respond to

regulator questions about the uniform standards or questions regarding a product filing submitted to and/or approved by the IIPRC. Contact information for the IIPRC office can be found on the IIPRC website. Compacting states have one or more designated representatives that actively participate in IIPRC meetings and activities and may also be a good resource to provide guidance on working with IIPRC-approved products.

5. State Insurance Departments/NAIC Staff
State regulators and NAIC staff are available to provide guidance to regulators about automated examination procedures and processes. For the names of individual contacts within the NAIC or at state insurance departments, please contact the NAIC Market Regulation Department at 816-842-3600 or via the NAIC website at *www.naic.org*.

6. NAIC Help Desk
The NAIC Help Desk is available to assist regulators as needed. Regulators may contact the Help Desk at 816-783-8500 or at *help@naic.org*.

D. Data Requests and Access

This section provides examples of data requests that may be used in a market conduct examination and the corresponding automated techniques used to perform the review. Typically, the file requests can be sent to the company with the notification letter or a computer/technical contact person can be requested in the notification letter and the requests can then be sent directly to them. It is best suited to have a technical contact person involved directly in all pre-examination meetings with the company to avoid confusion.

The data requests are basically the same requests that are used when asking the company for hardcopy computer print outs. But, by asking for the information in data files, the examiner can now easily test 100 percent of populations and quickly pull statistically sound random samples to be used to review actual hardcopy files.

1. Example of a Standardized Data Request for ABC Insurance Company
Please provide the following data files for the examination period of Jan. 1, 2011 through Dec. 31, 2011. The files will be used on a PC, so please provide the information on a CD. The files should consist of fixed length records in the layouts shown. The file format requested, in the order of preference, is delimited (comma or tab) text files or a Microsoft Access database. If a company's computer systems use different field sizes, please submit the company's data files and send revised file layouts with the files.

Complaints—Please provide a list of all complaints received from [state name] policyholders from the period of Jan. 1, 2011 through Dec. 31, 2011. Please include both complaints received directly and those forwarded from the [state name] insurance department.

Please note that an updated stand-alone Complaint Standardized Data Request (SDR) was adopted by the NAIC in 2017. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Complaint SDR replaces the Complaint SDR portion of the combined Producer, Commission and Complaint data request dated 2006. Non-regulators may access the updated Complaint SDR at https://www.naic.org/account_manager.htm. Some field names from the updated Complaint SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
CmpCsNo	1	10	A	Company complaint case number for the complaint
CmpFirst	11	15	A	First name of complainant
CmpMid	26	15	A	Middle name of complainant
CmpLast	41	30	A	Last name of complainant

CmpOrg	61	20	A	Origin of complaint (company direct, department of insurance, Better Business Bureau, social media, Internet, etc.)
CmpRecDt	81	10	D	Date complaint received [MM/DD/YYYY]
PolNo	91	10	A	Policy number
CmpTrnTp	101	5	A	The manner in which the complaint was transmitted to the company (phone, visit, letter, etc.)
CmpRsn	106	30	A	Reason for complaint **If codes are used, please include a list of complaint reason codes along with their meanings**

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

2. Data Formats

There are a number of different formats in which the data can be provided. Consideration should be given as to what format the company can provide, what software program the examiners will be using to view the data, how much space will be available on the examiner's hard drive and how the company will transfer the data to the examiners.

Recommendation—ASCII delimited, ASCII fixed length and text files are the best data formats to use when requesting information. Each of these can be used in any of the current software packages available. ACL, Microsoft Access and Microsoft Excel, etc., are the easiest formats for companies to provide. These formats require little to no additional formatting, compress well and most company mainframe computer systems can download directly into these formats. However, if the files are used in any software package besides ACL, duplicates of the file will be made when the files are saved in the corresponding software package's format. ACL will only make duplicates of ASCII files.

ASCII Delimited Files—These are called delimited files because a field separator character separates the fields. To facilitate with the reading of these files, ACL uses a Delimit Utility.
Two common delimited file types include:

- CSV – Comma Separated Values; and
- TSV – Tab Separated Values

Example:
"987654321","JONES, THOMAS P","21","19850505","","[illegible]
"876543210","MILLER, BEVRA K","21","19960814","","[illegible]00000000"
"765432109","NOBEL, RICHARD C","21","19890906","","[illegible]00000000"
"654321098","PRICE, MARLENE","21","19940428","","0000[illegible]000"
"543210987","RICE, WILLIAM P","21","19860102","","0000000[illegible]
"432109876","SMITH, BRIAN K","21","19900424"[illegible]C","19961204"
"321098765","TAYLOR, CARL R","21","19870407"[illegible]"00000000"
"210987654","WILLIAMS, CLIFFORD","22"[illegible]20060[illegible]","","00000000"

ASCII Fixed Length—Every record in a record defined as fixed length and the fields are continuous but the same size in each record. The file must be separated into individual fields in ACL and given headings/names. This does not change the data. ASCII fixed length files take up the least amount of room on a hard drive and are the best method of compressing data for file transfer.

Example:
987654321JONES,·THOMAS·P·····2119850505·00000000
876543210MILLER,·BEVRA·K·····2119960814·00000000
765432109NOBEL,·RICHARD·C····2119890906·00000000
654321098PRICE·,MARLENE·····2119940428·00000000

543210987RICE,·WILLIAM·P·····2119860102·00000000
432109876SMITH,·BRIAN·K·····2119900424C19961204
321098765TAYLOR,·CARL·R·····2119870407·00000000
210987654WILLIAMS,·CLIFFORD·····2219890605·00000000

EBCDIC—EBCDIC data, encoded according to the Extended Binary Coded Decimal Interchange Code (EBCDIC), refers to printable characters. This data type is the norm for all IBM mainframe and minicomputers. The length of this data type is a maximum of 32,767 bytes.

More Difficult to Use—Data files can also be requested in Microsoft Access, Microsoft Excel, etc. These packages are more conducive to small populations, files without date fields and computers with larger hard drive space. There are also issues to deal with when using this requested data with ACL.

Microsoft Access—Using the Data Definition Wizard, Microsoft Access and XML data can be imported and defined directly, without the need for pre-processing. ACL maintains the integrity of the source data and allows the user to specify whether to keep field header information. The user can also specify which Microsoft Access table to be utilized. Installation of Microsoft Access on a computer to use files of these formats is not necessary.

Microsoft Excel—Using the Data Definition Wizard, Microsoft Excel data can be imported and defined directly, without the need for pre-processing. ACL maintains the integrity of the source data and lets the user specify whether to keep field header information. The user can also specify which Microsoft Excel worksheet to be utilized. Installation of Microsoft Excel on a computer to use files of these formats is not necessary. Problems with Microsoft Excel include: Microsoft Excel tends to corrupt date fields, and Excel 2003 is limited to 65,536 rows or records in any one file. When using Excel, special attention should be given to potential technical challenges with date fields. While Excel versions 2010 and later have a row or record limit of over one million, computer memory effectively limits the number of records to a smaller number depending on the amount of data per record/row. Unless ODBC is used to read Microsoft Excel data in ACL, dates can display incorrectly. When Microsoft Excel data is imported, Microsoft Excel and the transferring technology use the system date format. If this format differs from the **Date Display Format** that the user sets in ACL, the dates from the Microsoft Excel data may display incorrectly in ACL. To avoid this problem, in ACL, select **Tools** » **Options**, then click the **Date** tab and enter a date display format to match the system date. To find the system date, select **Start** » **Settings** » **Control Panel** » **Regional Options**.

3. Common Issues

a. How a regulator can save space on a hard drive:
   - Request that files be sent pre-sorted. For example, the files can be sorted by claim number or sorted by company code, then by policy number. ACL note: ACL will require that a new file is made for each different sorting;
   - Include all companies in the review in one file with a company code to distinguish each company. ACL note: This will make any procedures performed in ACL run a little slower, but it can save space; and
   - Request that the files come in a delimited format.

b. Documentation:
   If using ACL, for any procedure or function performed, a "Log" screen will be shown that documents what was performed. The command logs records and displays the commands issued and the results obtained during a data analysis project. The log can be exported to any of the following file types:
   - HTML – Exports the results from the selected commands as an HTML file;
   - Log File – Saves the selected commands and command results to a new ACL command log file (.log) and adds it to the **Overview**;

- Script – Creates a script from the selected commands and adds it to the **Overview**;
- WordPad – Copies the selected portions of the command log to a new Microsoft WordPad document; and
- Text – Saves the selected portions of the command log as a text file.

c. Record Count:
If using ACL, once a data file is brought in and the field names set, the program will automatically indicate the population size and will show it on the status bar at the bottom of the screen. If using Microsoft Access when opening the table or running a query, the program will either show the record count at the bottom of the screen or a message box will appear that displays the number of records after the query has been run.

E. Validation of Data

Common concerns related to automated examinations are how regulators can ensure accurate and complete data is sent for examination purposes. Examiners are encouraged to identify the information maintained by their state, which can be cross checked against data files submitted by a company. Annual statements and other reports may be useful in determining whether accurate and complete data is provided.

1. Control Totals
The company should provide the total value of several key fields when data is provided for examination. Once the data is converted into a software program, the totals of those key fields should be calculated to ensure there is a complete data conversion. If there are discrepancies in any of the totals, the examiner and company must determine the cause of the discrepancy and make corrections as needed.

2. Data Quality Analysis
After data is converted into a software package, a cursory review of the data should be conducted. The examiner should ensure each field appears to contain correct data; i.e., dates should appear in date fields, numeric amounts in dollar amount fields, etc.

The following functions can assist in verifying data quality:
- ACL: the Sequence, Verify and Statistics functions found in the Analyze menu;
- Microsoft Excel: the Validation function found in the Data menu; and
- Microsoft Access: create validation rules when converting by selecting the Database Utilities function in the Tools menu and then selecting Convert Database.

F. Sampling

The concept of automated examinations assumes a portion or all of an examination will be conducted electronically. Although the automated examination concept can be used to sample an entire population of data, the need for sampling a portion of the records/files will continue. For instance, examiners may want to test a sampling of paper files against electronic files to ensure the electronic files are maintained in an accurate and complete manner. Examiners should reference the chapter on sampling, for a more complete description of the purpose of sampling and the various sampling techniques.

1. Sampling with ACL
Record sampling treats each record equally, resulting in a sample that is unbiased (i.e., is not biased on the value in the records). Therefore each record has an equal chance of being selected.

In random sampling, the population ("p"), number of items ("n") to be selected and a random seed are specified. ACL then uses the random seed to generate "n" random numbers between zero and "p." If the same random number is selected more than once, the duplicate choices are replaced with unique random numbers. This means that in Random Record samples, the same record will never be selected more than once.

2. Example of Pull Lists
When an examiner needs to sample paper files, it is common for a list to be created and provided to the company for recovery. Electronically, a sample of records may need to be selected for the examiner to scrutinize when the application of an automated test is not feasible or recommended. The use of automated tools, such as ACL and Microsoft Excel, is encouraged for the creation of pull lists or electronic samples.

If utilizing Microsoft Excel, a pull list can be created as follows: (Note: This requires the Analysis ToolPak Excel Add-in):

- From the Tools menu, select Data Analysis. A box will appear with a list of options; select Sampling. The Sampling dialog box will appear;
- Enter the input range. The input range should be a numeric field (i.e., policy number) from which the sample will be generated. In addition, the regulator should determine if periodic or random sampling should be utilized. If periodic sampling is selected, the regulator should enter the distance between files selected (i.e., every 10); and if random sampling is selected, the regulator should enter the number of samples desired. Enter the desired output range in the output options;
- Microsoft Excel will create a new worksheet providing a list of the sample; and
- If manual files are required, the worksheet page then can be printed off and provided to the company.

G. Complaint Handling

Note: This automated analysis is only useful in reviewing companies with automated complaint registers.

Complaint Handling Standards

____ All complaints are recorded in the required format on the company complaint register.
____ The company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules, regulations and contract language.
____ The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations.

Data File Supplied by the Company
A list of all complaints received during the examination period, both directly and from the insurance department, provided in the following format.

Please note that an updated stand-alone Complaint Standardized Data Request (SDR) was adopted by the NAIC in 2017. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Complaint SDR replaces the Complaint SDR portion of the combined Producer, Commission and Complaint data request dated 2006. Non-regulators may access the updated Complaint SDR at https://www.naic.org/account_manager.htm. Some field names from the updated Complaint SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE*	DESCRIPTION
CmpFirst	1	15	A	First name of complainant
CmpMid	16	15	A	Middle name of complainant
CmpLast	31	20	A	Last name of complainant
CmpCvgTp	51	10	A	Type of coverage (life, health, dental, home, auto, etc.)
CmpRecDt	61	10	D	Date complaint received [MM/DD/YYYY]
PolNo	71	10	A	Policy number
CmpTrnTp	81	1	A	The manner in which the complaint was transmitted to the company (phone, visit, letter, etc.)

CmpRsn	86	30	A	Reason for complaint **If codes are used, please include a list of complaint reason codes along with their meanings**
CmpRsl	116	30	A	Complaint resolution **If codes are used, please include a list of complaint resolution codes along with their meanings**
CmpLtrDt	146	10	D	Date complaint resolution letter sent, if applicable [MM/DD/YYYY]
CmpOrg	156	20	A	Origin of complaint (company direct, department of insurance, Better Business Bureau, social media, Internet, etc.)

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

Data File Supplied by the Consumer Services Division of the Insurance Department
A list of all complaints received on this particular company during the examination period, provided in the following format.

Please note that an updated stand-alone Complaint Standardized Data Request (SDR) was adopted by the NAIC in 2017. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Complaint SDR replaces the Complaint SDR portion of the combined Producer, Commission and Complaint data request dated 2006. Non-regulators may access the updated Complaint SDR at https://www.naic.org/account_manager.htm. Some field names from the updated Complaint SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
CmpFirst	1	15	A	First name of complainant
CmpMid	16	15	A	Middle name of complainant
CmpLast	31	20	A	Last name of complainant
CmpCvgTp	51	10	A	Type of coverage (life, health, dental, home, auto, etc.)
CmpRecDt	61	10	D	Date complaint received [MM/DD/YYYY]
PolNo	71	10	A	Policy number
CmpRsn	81	30	A	Reason for complaint **If codes are used, please include a list of complaint reason codes along with their meanings**
CmpRsl	111	30	A	Complaint resolution **If codes are used, please include a list of complaint resolution codes along with their meanings**
CmpOrg	141	20	A	Origin of complaint (company direct, department of insurance, Better Business Bureau, social media, Internet, etc.)

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

Tests:

1. Comparison of Insurance Department/Company Records: The insurance department's file can be compared to the company's file to ensure that the complaints forwarded by the insurance department are being accurately recorded. This can be done by comparing either the complainant's name or policy number fields in each file. This can help determine if the complaints are being properly recorded.

2. Formal Complaint Records: The NAIC Complaints Database System (CDS) contains closed consumer complaints against firms and individuals involved in the insurance industry. These complaints are broken down by state, line of business, type of complaint and disposition. These numbers are then compared to premium written to give a more accurate measurement of the insurer's comparative performance in the

marketplace. This comparison is called the "complaint index." These reports should be reviewed to determine if there is a pattern of specific types of complaints or if the particular state being reviewed has a high complaint index compared to the other states.

3. Type of Complaint: With the file supplied by the company, counts can be run by type of complaints. Any patterns or unexpected results in the type of complaints can be reviewed.

4. Disposition: With the file supplied by the company, the number of days between the date of complaint and the date of response by the company can be calculated. This can be used to determine if the time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations on promptness. A random sample of closed complaints can be taken to see if the company has taken adequate steps to finalize the complaint.

H. Producer Licensing

The area of producer licensing is ideal for automated procedures. Examiners can easily compare the records of licensing/appointments against the company's records to determine if violations exist. Comparisons can be made to the company's producer records, new business records (to determine when applications are written) and/or commission records to ensure compliance. Data related to commission records or applications written is not reflected in the NAIC State Producer Licensing Database (SPLD). Only lines of authority and license classes licensed or appointed for are shown in the SPLD.

1. NIPR Gateway

The Gateway facilitates the electronic exchange of producer information between state insurance regulators and the entities they regulate. The goal is to simplify communications and to distribute information electronically, including licensing applications, appointments/terminations and the Address Change Request (ACR). Designed to improve the effectiveness and efficiency of the state licensing process, the key benefits of the Gateway are reduction in paperwork, data entry and costs; development of national standards regarding electronic transmission of licensing data; faster turnaround time; and increased revenue.

2. Comparison of Insurance Department/Company Records

- Example using Microsoft Excel; and
- Example using ACL Audit Software.

Producer Licensing Standards

____ No one other than a duly licensed producer may solicit, procure, receive or forward applications for insurance.

____ No insurer licensed to do business in the state may pay commissions or make any consideration of anything of value to an unlicensed person, firm or corporation.

Data Files Supplied by the Company:

1. Producer Licensing—List of producers licensed in this state to solicit business during all or part of the examination period, provided in the following format.

   Please note that an updated stand-alone Producer Standardized Data Request (SDR) was adopted by the NAIC in 2017. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Producer SDR replaces the Producer SDR portion of the combined Producer, Commission and Complaint data request dated 2006. Non-regulators may access the updated Producer SDR at https://www.naic.org/account_manager.htm. Some field names from the updated Producer SDR are provided below.

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
CoCode	1	5	A	NAIC company code
PrCode	6	9	A	Company internal producer, CSR or business entity producer identification code **If more than 1 producer of record, repeat this field as necessary and include a revised file layout**
NPN	15	7	A	National producer number
PrFirst	22	15	A	First name of producer or CSR
PrMid	37	15	A	Middle name of producer or CSR
PrLast	52	20	A	Last name of producer or CSR or name of business entity producer
PrAddr	72	25	A	Producer's, CSR's or business entity producer's street address
PrCity	97	25	A	Producer's, CSR's or business entity producer's city

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date

2. Commissions—List of all persons/agencies, appointed and unappointed, to whom commissions were paid on business written in this state during the examination period, provided in the following format.

   Please note that an updated stand-alone Commission Standardized Data Request (SDR) was adopted by the NAIC in 2017. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Commission SDR replaces the Commission SDR portion of the Combined Producer, Commission and Complaint data request dated 2006. Non-regulators may access the updated Commission SDR at https://www.naic.org/account_manager.htm. Some field names from the updated Commission SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
CoCode	1	5	A	NAIC company code
PrCode	6	9	A	Company internal producer, CSR or business entity producer identification code **If more than 1 producer of record, repeat this field as necessary and include a revised file layout**
NPN	15	7	A	National producer number
CommPrem	22	11	N	Commissionable premium amount paid on this policy or certificate
PremPdDt	33	15	A	Date commissionable premium paid [MM/DD/YYYY]
CommAmt	48	11	N	Commission amount paid or credited
CommPdDt	59	10	D	Date commission paid or credited [MM/DD/YYYY]
CommPayee	69	1	A	Describes to whom the commission was actually paid. Indicate (P) if the commission was paid to the individual producer, (A) if the commission was paid to an agency, or (O) for other
CommTyp	70	20	A	Commission type paid (first year, second year, override, service fees, contingent fees, bonuses, other monetary compensation and other non-monetary compensation)

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

3. New Business Written—List of all automobile policies issued as new business in the state during the examination period, provided in the following format (for this example, automobile policies were used; however, any line of business could be used):

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
Co Code	1	5	A	Company code (if file contains more than one company)
Pol Prefix	6	4	A	Policy prefix (if any)
Policy No	10	9	A	Policy number
Policy Type	19	5	A	Type of policy (standard, preferred, etc.)
Inception Date	24	8	D	Policy inception date (CCYYMMDD)
Garaged Street Address	32	25	A	Street address of location where primary car is garaged
Garaged City	57	25	A	City where car is garaged
Garaged County	82	25	A	County where car is garaged
Garaged State	107	2	A	Two letter state code for where car is garaged
Garaged Zip Code	109	5	N	ZIP code where car is garaged
Rating Territory Code	114	10	A	Code specifying rating territory (Please provide list of codes)
BI Limits Per Person	124	7	N	Applicable bodily injury limits per person, do not use dollar signs, decimals or commas
BI Limits Per Accident	131	7	N	Applicable bodily injury limits per accident, do not use dollar signs, decimals or commas
UM/UIM Limits Per Person	138	7	N	Uninsured/Underinsured motorist limits per person, do not use dollar signs, decimals or commas
UM/UIM Limits Per Accident	145	7	N	Uninsured/Underinsured motorist limits per accident, do not use dollar signs, decimals or commas
Agent/Producer Code	152	10	A	Producer's company code number or social security number

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

Data Files Supplied by the Insurance Department's Licensing Division:

4. Licensed Producers—List of all producers licensed with the insurance department to solicit business during the examination period for the company, provided in the following format.

   Please note that an updated stand-alone Producer Standardized Data Request (SDR) was adopted by the NAIC in 2017. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Producer SDR replaces the Producer SDR portion of the combined Producer, Commission and Complaint data request dated 2006. Non-regulators may access the updated Producer SDR at https://www.naic.org/account_manager.htm. Some field names from the updated Producer SDR are provided below:

FIELD NAME	START *	LENGTH *	TYPE**	DESCRIPTION
NPN	1	7	A	National producer number
PrFirst	8	15	A	First name of producer or CSR
PrMid	23	15	A	Middle name of producer or CSR
PrLast	38	20	A	Last name of producer or CSR or name of business entity producer
LOBLic	58	30	A	Lines of business licensed to write
PrAptDt	88	10	D	Producer's, CSR's or business entity producer's appointment date with **this** company [MM/DD/YYYY]
ResLicSt	98	2	A	Resident license state abbreviation
PrTrmDt	1000	10	D	Producer's, CSR's or business entity producer's termination date with **this** company [MM/DD/YYYY]

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

Tests:

Look for unlicensed/unappointed producers:

1. Compare the company's Producer Licensing list to the insurance department's Licensed Producers list, extracting any producers on the company's list that are not on the Department's list.
2. Compare the company's Commissions list to the insurance department's Licensed Producers list, extracting any producers on the company's list who are not on the insurance department's list.
3. Compare the company's New Business Written list to the insurance department's Licensed Producers list, extracting any producers on the company's list who are not on the insurance department's list.

Look for producers writing/soliciting business prior to being licensed/appointed:

1. Compare the company's commissions list to the insurance department's Licensed Producers list, extracting any producers on the company's list who received commissions prior to the appointment date on the insurance department's list.
2. Compare the company's New Business Written list to the insurance department's Licensed Producers list, extracting any policies on the company's list with policy effective dates prior to the corresponding producer's appointment date on the insurance department's list.

I. Marketing and Sales

1. Advertisement Approvals

The approach for determining advertising approval compliance will vary based on the method the insurance department uses for maintaining policy form approvals.

Please note that an updated stand-alone Marketing and Sales Standardized Data Request (SDR) was adopted by the NAIC in 2017. Regulators can access the SDR in the Market Regulation Handbook Reference Documents web page on StateNet. The updated Marketing and Sales SDR replaces the Marketing and Sales SDR portion of the combined Producer, Commission and Complaint data request dated 2006. Non-regulators may access the updated Marketing and Sales SDR at https://www.naic.org/account_manager.htm. Some field names from the updated Marketing and Sales SDR are provided below.

Assumption #1—Insurance department records pdf files of approved advertising and electronic tracking by form number and approval date.

1. Secure an electronic listing of approved form numbers and date of approval.
2. Secure from the company a corresponding electronic listing of advertising form numbers and dates first used.

3. Run a comparison that would produce a listing of all company-identified advertising forms, which do not match with the insurance department's listing.
4. Run a comparison that would produce a listing of all company-identified advertising forms which were utilized prior to the date of approval in the insurance department's listing.

Assumption #2—Insurance department records include scanned text of all approved advertising materials, in addition to form number and approval date.

1. Follow procedures under Assumption #1 to verify that form number and date of use match insurance department records.
2. Secure an electronic copy of the insurance department's scanned text of all advertising forms approved for the company being examined.
3. Secure an electronic copy, or manually scan in, all advertising materials being utilized by the company being examined.
4. Run a comparison that would produce a list of all forms in which the text does not match the insurance department's approved copy.

Assumption #3—Insurance department records include imaged copies of all advertising forms approved, in addition to form number and approval date.

1. Follow procedures under Assumption #1 to verify that form number and date of use match insurance department records.
2. Secure an electronic copy of the insurance department's imaged advertising approvals.
3. Secure electronically imaged copies of all advertising forms from the company being examined, or image copies of all materials provided.
4. Run a comparison that would produce a list of all forms in which the images do not match with the insurance department's images of the approvals.

2. Unfair Discrimination

As when looking at insurance company files manually, the examiner will need to be fairly innovative when using automation to discover unfair discrimination. This is especially true in marketing and sales, where companies tend to be less automated. Unfair discrimination may more easily be found using automation when reviewing many different records of insureds. Finding evidence of unfair discrimination may typically occur when performing the tests in the underwriting/rating and claims review sections.

When performing the tests in the underwriting/rating and claims sections, the examiner should stay alert for potential cases where insureds were treated differently from other insureds. For example, in underwriting and rating, the examiner may discover a homeowners insurance application that had identical characteristics to a declined application that was located in a ZIP code with a high percentage of minorities, older homes, etc. The use of ACL will help the examiner segregate insureds who have the same characteristics as other insureds, but were treated differently.

ACL's Classify command can be used to identify many different unique identifiers when looking for discriminatory practices. This use of ACL can allow the examiner to see unique patterns in lines of business; Standard Industrial Classification (SIC) codes; plan codes; territories; and other information that would not have been identified elsewhere. ACL and the examiners are limited if the company does not retain such information in their database.

3. Internet Advertisements

Examiners should use the Internet to review an insurer's online advertisements. In addition to obtaining a list of advertisements from the company, the examiner should choose their Internet provider's search engines to find applicable sites. Reviewing paper copies of the insurer's Internet advertisements can be done if the examiner does not have access to the Internet; however, it is recommended that an actual online review be made. This is because of the media capabilities and interactive nature of many sites.

In addition to looking for a company name, the examiner may wish to consider searching for applicable product types, affiliated entities, managing agencies, etc. Not all "hits" will constitute advertisements. For example, corporate information for investors or the public, news releases and community service-related website may be sponsored by, or refer to, the insurer being examined. Examiners should note and record the source or web address (URL) of any particular website in question to determine whether the advertisement was authorized by the insurer. Advertising standards found in the applicable sections of this handbook should apply to Internet advertisements. In general, the same rules prohibiting misleading, deceptive or false advertising should apply.

4. GeoAccess® Program (Managed Care Mapping Tool)

The Managed Care section uses GeoAccess® software. Some states use GeoAccess® software primarily for reviewing HMO networks for compliance with travel distance standards. GeoAccess® makes additional software packages that can also be utilized by a state. The following GeoAccess® software packages are commonly used: DataCleaner, GeoCoder and GeoNetworks:

a. Primary Usage

A state may receive data files from each HMO that list the number and ZIP code of all enrollees, and the name, address and specialty type/facility type of all participating providers. DataCleaner is used to clean up each provider file. The following tasks, unique to DataCleaner, are performed:

- Address information is standardized. DataCleaner matches the submitted address to internal systems data. The internal systems data is all of the official United States Postal Service (USPS) addresses for each state. If the submitted data is not an exact match to the USPS systems data, DataCleaner fixes it, if possible. If it is not possible to match the submitted address, an error message will be generated. The state can return non-standardized records to the HMO to correct.

- Duplicates are identified and removed. Name, license number, type and standardized address are used to identify unique providers. Any duplicates are flagged and can be left in the data file at the user's option. It is suggested that the state removes duplicates.

- Geocodes are assigned. DataCleaner attaches longitude and latitude coordinates to each record. Geocoding can be performed at the ZIP code level or at the street address level. The geocodes are stored in the systems data of the GeoCoder software.

GeoNetworks is used to "populate" each enrollee file. "Populate" means there is a unique record for each enrollee. If the submitted data shows one record for the ZIP code 65202 containing 10 enrollees, the "populated" enrollee file contains 10 records for the ZIP code 65202, with each record representing a person. This keeps the submitted enrollee files to a minimum size for ease of transmitting). GeoNetworks can then be used to geocode the enrollee file, using the same GeoCoder system data that DataCleaner accesses when geocoding is performed in DataCleaner.

Finally, GeoNetworks is used to compare the populated and geocoded enrollee files to the cleaned and geocoded provider files. GeoNetworks functions like a comparative database. Each record in the enrollee file is compared to each record in the provider file. The software retains how far each enrollee would have to travel to get to each provider. (Some states use travel distance standards rather than travel time standards.) The software then summarizes results according to the user's preference for state, county or city summarization.

A final product is a report that shows a list of each county in which enrollment was submitted and the portion (percentage) of enrollees that meet the travel distance standard specified by the user. The reports can be customized to show other information as well, including the number of enrollees and providers in each county, the type assigned to each county (urban, rural or suburban/basic) and the average distance an enrollee in each county has to travel to get to the specified provider type.

The following is an example of how the GeoNetworks program has been used by the Missouri Department of Insurance, Financial Institutions and Professional Registration:

> *In the past, the Missouri DIFP ran GeoNetworks reports for 63 provider types per HMO network. The DIFP has established a unique standard for each provider type. The DIFP varies the standard for each provider type depending upon the county type. For example, enrollees in an urban county must be within 10 miles of their PCP, suburban/basic PCP access standard is 20 miles and rural PCP access standard is 30 miles. GeoNetworks can run a single PCP report for all three access standards simultaneously.*

Finally, map view features in GeoNetworks permitted the Missouri DIFP to examine circumstances under which an exception to the regulatory distance standard should be made. GeoNetworks was used to compare an HMO's provider data to all providers in Missouri. For example, the distance standard for OB/GYNs in rural counties is 60 miles. In some counties, there are no OB/GYNs within 60 miles. GeoNetworks allows the Missouri DIFP to locate the nearest OB/GYN based upon state data and compare that to the nearest OB/GYN with whom the HMO secured a participation contract. The regulation stipulates that an exception would be granted if the HMO's OB/GYN were no further than 25 additional miles past the nearest possible provider.

b. Secondary Usage

States have discovered that the DataCleaner and GeoNetworks are useful software packages for tasks other than HMO network analysis. A state can track HMO enrollment by ZIP code on a quarterly basis. DataCleaner is used to convert quarterly enrollment submissions to county, regional and metropolitan area enrollment charts. These charts are used in an HMO's annual report and are available on a custom basis to the general public. GeoNetworks is used to print service area maps for each HMO and regional enrollment maps.

c. Support

Training is available for all the GeoAccess® software packages. Complete information regarding GeoAccess® software products is available at *https://www.optim.com*.

J. Policyholder Service

1. Policyholder Service Practices

a. Calculation of Nonforfeiture Benefits

Standard: The company correctly calculates the benefit amount when a policy is switched to a reduced paid-up status.

Data File Supplied by the Company
Request a listing of all life policies that were switched to reduced paid-up during the examination period. The data should include the policy number, insured name, cash value, reduced paid-up amount, application date, insured's age, rate, etc.

Test:
Use ACL to produce a list of policies where the amount of benefit after being switched to the reduced paid-up status is not consistent with the other policies with the same characteristics and cash value amounts.

b. Premium Billing

In reviewing an insurer's procedures related to premium billing, the examiner should look to applicable state laws to determine, contractually, what is or isn't allowed and what forms of disclosure are necessary. Once this information is determined, an automated checklist can be devised to cite relevant components of the statutes to use as a guide to determine adherence to the statutes, rules or regulations.

Once this initial review has been undertaken, the examiner's review of the insurer's files must be based upon applicable state underlying laws. For instance, what types of disclosures are required to be provided to the insured or policyholder? Is the insured or policyholder aware of the triggers for premium billing? That is, does the insured or policyholder understand that the premiums are billed monthly and that they must pay by a certain date, or risk the coverage being canceled? Does the insured or policyholder understand the role of the grace period and how it may or may not affect the policy, which they have placed on a premium billing cycle? Are premium finance methods being utilized? Are such methods consistent with the plan?

Assuming that the law allows and sets limited parameters for premium billing plans, the examiner must determine if the insurer provides "clear language" to the insured or policyholder so that the insured/policyholder understands the terms and conditions of the selected premium billing plan. The examiner should look for such disclosure statements and signatures of the policyholders, which detail that the terms and conditions were disclosed and that the insured or policyholder understood them. The examiner should determine who explains the plans. Is it an agent or finance officer? How knowledgeable is this individual? Has the individual been trained or certified? The examiner should ascertain the qualifications of those providing guidance and advice to the insured or policyholder.

The examiner's review of premium billing should be thorough but limited. The examiner must determine if the premium billing plan adheres to the law, if the insured or policyholder is properly instructed regarding what the plan entails, if the documentation in the insurer's file is adequate to indicate the insurer's adherence to the law and in the event a state law is silent, was the insured or policyholder adequately advised by a knowledgeable company representative of the terms and conditions of premium billing?

c. Refunds of Premium/"Free Look" Periods

Evaluation in this area can be made by using several essential fields:

- Date of application;
- Date of policy issue;
- Effective date of policy if different from policy issue date;
- Date policy was delivered or mailed;
- Date of cancellation request from insured;
- Date policy was cancelled;
- Date of premium refund; and
- Actual premium refund.

The following computed fields should be calculated using ACL, Microsoft Excel or Microsoft Access:

- Cancellation date minus the issue date or effective date;
- Date of cancellation minus delivery/mail date of the policy;
- Premium refund date minus the date of cancellation request from insured or the date the policy was canceled; and
- The appropriate premium refund amount (using a short rate or pro rata refund table).

Using the above fields, perform the following analysis:

- Determine the population using the cancellation date minus the issue date or effective date to find the policies which should have had refunds. Analyze for refunds owed but not made or refunds made when not owed.
- Compare the premium refund due to the actual refund amount.
- Compare the various computed number of day fields to see trends and verify company procedures in handling "free look" periods and premium refunds.
- Develop mean, mode and standard deviation for number of days for premium refund made and determine any possible cash flow issues including cash flow underwriting.

K. Underwriting and Rating

1. Comparison of Insurance Department/Company Records

a. Rate Approvals and Filings

Standard: The company uses only rates that have been properly filed with the insurance department.

Data File Supplied by the Company:
All new business written during the time frame of the examination. Included in this data should be the effective date of the rates used to calculate the premiums. Download from the insurance department a listing of rates filed for use by the company. The download should include the effective date of the new rates.

Tests:

1. Run a comparison to ensure the rates used on the policy were filed and approved prior to the effective date of the policy.
2. Use the Classify command to identify the number of different rate edition dates used during the time frame of the examination.
3. Use the Join command to load the rates filed with the insurance department and those used in the company data.
4. Produce a report where the effective dates of the policy were prior to the date the rates could be used.

b. Policy Form Approvals and Filings

Standard: The company uses only forms that have been properly filed with the insurance department.

Data File Supplied by the Company:
All new business written during the time frame of the examination. Included in this data should be the effective date/version date of the forms and form numbers used as part of the policy. Download from the insurance department a listing of form numbers filed for use by the company. The download should include the effective date of the forms.

Tests:

1. Run a comparison to ensure the forms used on the policy were filed and approved prior to the effective date of the policy.
2. Use the Classify command to identify the number of different form edition dates used during the time frame of the examination.
3. Use the Join command to load the forms filed with the insurance department and those used in the company data.
4. Produce a report where the effective dates of the policy were prior to the date the forms could be used.

c. Rating Practices

Standard: The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan.

Data File Supplied by the Company:
Homeowners New Business Written—List of all new business homeowners policies issued in this state during the exam period, provided in the following format:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
Policy No	1	9	A	Policy number
Insured's City	10	30	A	City where property is located
Insured's County	40	30	A	County where property is located
Township/Village	70	30	A	Township/Village where property is located if applicable
Zip Code	100	5	A	Zip code where property is located
Class	105	5	A	Public protection class code

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

Test:
Determine that the correct protection class is assigned to a homeowner's policy based upon city, county/township/village and ZIP code by comparing company data to ISO protection class codes maintained in the insurance department's Property and Casualty division.

ISO protection class codes should be kept in a database format. Both of the ISO protection class codes and the company's homeowners new business can be analyzed using Microsoft Access or ACL. By comparing or linking the policies' City, County, Township/Village (if applicable) and ZIP Code fields to the corresponding ISO City, County, Township/Village (if applicable) and ZIP Code fields, it can be determined if the Protection Class Codes match. A separate list can be generated for the policies where the Class Codes do not match. The company or the examiner can then determine by looking at the policy file if the class code is correct or in error.

d. HMO: Average Age

To ensure the appropriate amount of premium is being charged for a group of individuals, the examiner may want to re-calculate the average age used when calculating the group's premiums. This may be accomplished by obtaining the group census information from the underwriting file and from the computer system, if available. A comparison to the information in the hardcopy of the census and the information in an automated rate calculation program using a sampling method can be completed.
If there is not an automated rate function, the examiner should re-calculate the average age using the census form from the file. It may be necessary to enter the birth date or age information into a spreadsheet for calculation. Once the information is available in an electronic form, either by downloading the information from the rate calculation program or by entering the data into a spreadsheet program, the function of determining the average age is fairly simple. The following example shows how Microsoft Excel can be used to calculate the average age.

First, choose Insert from the menu and then choose Function. Use the Statistical category and the AVERAGE function options. To calculate the average age, either highlight the beginning and ending field or enter the beginning and ending cell (include a colon between the first and last field) in the Number 1 field.

Once the average age is calculated, it can be compared to established rates to determine if there are discrepancies.

e. Premium Audits

Standard: The company conducts premium audits within a specified time frame.

Data File Supplied by the Company:
List of all policies on which premium audits were required. Fields should include the date the premium audit was due and when the premium audit was completed.

Tests:
1. Run a comparison to calculate the number of days between the date the premium audits were due and when they were actually received.
2. The examiner can calculate the average number of days for the company to perform the premium audit and use the Stratify command to analyze the premium audits that took longer than the average.

f. Underwriting Practices

Standard: The company underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Data File Supplied by the Company:
Homeowners New Business Written—List of all new business homeowners policies issued in this state during the examination period, provided in the following format:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
Policy No	1	9	A	Policy number
Policy Type	10	10	A	Type of policy (Preferred, standard)
Year of Construction	20	4	N	Year the dwelling was constructed
Zip Code	24	5	A	Zip code where dwelling is located
Policy Inception Year	29	4	N	Year the policy was written

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is character, numeric (text), numeric or date.

Test:
For companies where the preferred program is a function of the age of the dwelling, it can be determined if newer dwellings (under 20 years of age) are being underwritten as preferred policies correctly. In Microsoft Access, Microsoft Excel or ACL, the age of the dwelling can be calculated for all policies written. Then it can be determined if all dwellings that are under 20 years of age are using the "Preferred" policy form. Any policies that have dwellings that are under 20 years of age but are not using the "Preferred" policy form can be pulled out and investigated.

The ZIP code information can be utilized for those policies that erroneously did or did not receive the preferred policy form. A count can be run to see what the percentage of errors by ZIP code is to the total business written. This could detect redlining.

g. Risk Selection (Declinations, Rejections, Terminations)

Standard: Policies can only be canceled within 59 days of the effective date of the policy unless certain conditions exist.

Data File Supplied by the Company:
List of all policies canceled by the company for the time frame of the examination. The listing should include the effective date of the policy, cancellation date and reason code.

Tests:

1. Calculate the number of days between the date of effective date of the policy and the cancellation date.
2. Filter out all policies canceled after the first 60 days and classify according to the reason code to insure policies were not improperly canceled.
3. If the data includes amount of original premium, term of the policy, amount of unearned premium refunded, date of refund and short rate/pro rata factor used, the examiner can recalculate the unearned premium and compare it to the amount refunded.
4. A regulator should use the Count command to identify how many (what percentage) of the total number of canceled policies have the characteristics on which focus is deemed necessary.
5. The examiner can also use the Classify command to identify the number of unique cancellation reasons to ensure they have a list of all reasons used.

h. Coverage Analysis

Standard: Insurers are required to issue auto policies with Uninsured/Underinsured motorist (UM/UIM) limits, which are equal to the Bodily Injury (BI) limits on the policy, unless the named insured specifically requests, in writing, to reduce the limits or to waive the coverage entirely.

Data File Supplied by the Company:
New Business Written—List of all new business automobile policies issued in this state during the examination period, provided in the following format:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
Co Code	1	5	A	Company code (If file contains more than one company)
Pol Prefix	6	4	A	Policy prefix (if any)
Policy No	10	9	A	Policy number
Policy Type	19	5	A	Type of policy (standard, preferred, etc.)
Inception Date	24	8	D	Policy inception date (CCYYMMDD)
Garaged Street Address	32	25	A	Street address of location where primary car is garaged
Garaged City	57	25	A	City where car is garaged
Garaged County	82	25	A	County where car is garaged
Garaged State	107	2	A	Two letter state code for where car is garaged
Garaged Zip Code	109	5	N	Zip code where car is garaged
Rating Territory Code	114	10	A	Code specifying rating territory (Please provide list of codes)
BI Limits Per Person	124	7	N	Applicable bodily injury limits per person. Do not use dollar signs, decimals or comments
BI Limits per Accident	131	7	N	Applicable bodily injury limits per accident, do not use dollar signs, decimals or commas
UM/UIM Limits Per Person	138	7	N	Uninsured/Underinsured motorist limits per person, do not use dollar signs, decimals or commas
UM/UIM Limits Per Accident	145	7	N	UM/UIM motorist limits per accident, do not use dollar signs, decimals or commas
Agent/Procedure Code	152	10	A	Producer's company code number or SSN

* Start and Length only used if sending the file as an ASCII text file. ** Type: Whether the field is alphanumeric (text), numeric or date.

Tests:
Look for policies with Uninsured/Underinsured motorist (UM/UIM) limits less than Bodily Injury (BI) limits, for both per person and per accident limits:

1. Run a comparison on the company's New Business Written list, extracting any policies where UM/UIM limits are less than BI limits.
2. Send the list of extracted policies to the company for them to produce the actual waivers signed by the policyholders.

L. Claims

1. Claims Practices

a. Acknowledgments

Standard: The initial contact by the company with the claimant is within the required time frame.

Data File Supplied by the Company:
All claims closed with payments during the time frame of the examination.

Tests:

1. Calculate the number of days between the date the company received notice of the claim and the initial contact by the company with the claimant.
2. Several jurisdictions recognize both a telephone call and a letter as suitable means for notification.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.
4. Stratify the dates for the number of days it took the company to acknowledge the claim and investigate patterns of untimely response.

b. Settlement Time Per Policy

Standard: Claims are resolved in a timely manner.

Data File Supplied by the Company:
All claims for the line of business under review for the time frame of the examination.

Tests:

1. Calculate the number of days between the date the company had all of the information to make proper payment and the date the claim was settled.
2. Many computer systems will contain the dates the company first received notice or when a claim was set up, but may not include the actual date that the company had all of the required information. The examiner will need to inquire as to what information is actually available.

c. Benefit Payment/Calculations—Denials

Standard: The denial letters by the company with the claimant are within the required time frame.

Data File Supplied by the Company:
All claims denied during the time frame of the examination. The data should include the date of claim, the date the company received all information to pay or deny the claim, and the date the denial was sent.

Tests:

1. Calculate the number of days between the date the company received notice of the claim and the initial contact by the company with the claimant.
2. Several jurisdictions recognize both a telephone call and a letter as suitable means for notification.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.
4. Use the Classify command to review all of the unique reason codes in the population to ensure all are accurate.

d. Mandated Benefits—Status Letters

Standard: The company sends status letters to the insureds as required by regulation.

Data File Supplied by the Company:
All claims with the dates of all correspondence mailed to the insured.

Tests:

1. Calculate the number of days between the dates of the correspondence sent to the insured to determine if correspondence is being sent within the required time frame.
2. It is important to note that some jurisdictions recognize both a telephone call and a letter as suitable means for notification. This may be difficult to determine in the data.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.

e. Deductible Refunds

Standard: The deductible reimbursement to the insureds upon subrogation recovery is made in a timely and accurate manner.

Data File Supplied by the Company:
A listing of all subrogation files for the time frame of the examination.

Tests:

1. Calculate the number of days between the date the company received the subrogation amount and the date the company provided a refund to the insured.
2. Several jurisdictions recognize both a telephone call and a letter as suitable means for notification.
3. Examiners should spot-check the computer system to ensure the dates in the company's computer system are in fact the date the calls were made and letters were sent.

f. Median Settlement Time

The examiner can use automation techniques, such as ACL and Microsoft Excel, to calculate the median settlement time, which in turn can be used to indicate general business practices of the company.

Chapter 19—Writing the Examination Report

This chapter explains how to prepare an examination report and record examination findings so that a company's performance can be assessed and any recommended actions can be made. This chapter also provides guidance regarding an insurance department's policy on review and distribution of an examination report. Regardless of the number of jurisdictions participating in an examination, whenever possible, a single report should be issued.

A. General

1. Objectivity

   The language of the report should reflect the same objectivity as was used in the fact finding and information gathering processes of the examination. Phrases such as "random sample" may be used to emphasize objectivity. When the scope of the examination is to target certain areas, that should be indicated in the report. The report must be a factual recording of the findings. The use of words such as "some, many, several and few" must be minimized.

2. Privacy

   When providing individual file numbers that were found to contain exceptions, be mindful of not violating the confidentiality of individual policyholders.

3. Use of Jargon

   Keep the needs of the various individuals who will review and utilize the report in mind. Whenever possible, the use of insurance industry jargon within the report should be either avoided or explained.

4. Report Types

   There are two approaches to report writing: the report by exception and the report by test. The two report types are not mutually exclusive.

   a. Report by Exception

      The report by exception has been the accepted method of examination reporting since the inception of market conduct examinations. In this type of report, only exceptions or errors are noted. The advantage of this type of report is that it can be relatively brief. One concern that has been expressed regarding this type of report is that it is not possible to tell which tests have been applied during the examination. Another concern is that items considered insignificant or resolved by the examiners are not reflected and other readers may place a different value on the unreported information.

   b. Report by Test

      The report by test is a recent development wherein each test applied during the examination is stated and the results are reported, whether good or bad. Exceptions are noted as part of the comments for the applicable test. The advantage of this type of report is that it is clear what tests have been applied. The report format tends to reduce report production time. The principal concern with this type of report is that it is likely to be lengthier than the traditional report by exception. There is also concern that entities being examined may use the report for advertising purposes; however, this may be addressed by stating in the report, if necessary, that it may not be used for such purposes.

B. Content of the Report

1. Preliminary Information

   This information should be contained in the first few pages of the report.

   a. Title Page

      1. Type of examination;

      2. Company name and home office address. If examined location is different, also include that address;

      3. NAIC group and company code numbers;

      4. NAIC Market Action Tracking System (MATS) action number;

      5. An "as of" date, to indicate the end of the examination time period covered; and

      6. List of participating jurisdictions.

   b. Table of Contents

   c. Salutation

      Addressed to the director, superintendent or commissioner of the jurisdictions participating in the examination, stating that pursuant to their instructions, an examination of the company has been performed.

   d. Foreword

      A statement that the report is:

      1. By exception—and that additional practices, procedures and files subject to review during the examination were omitted from the report if no improprieties are indicated; or,

      2. By test—and that all tests applied during the examination are reported.

   e. Scope of Examination

      1. Cite specific statutory authority;

      2. List the time period covered by the examination;

      3. Briefly outline the examination purpose(s);

      4. Cite error tolerance used and that any error which appears to be a pattern error or general business practice has been included;

5. List areas to be covered, such as company operations/management, underwriting, policyholder service, claims, marketing and sales, producer licensing and complaint handling; and

6. Failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

2. Profile Facts

This section should contain a brief profile of the company that may include, but is not limited to, the following:

a. Company history or U.S. Securities and Exchange Commission (SEC) Form 10-K information;

b. Affiliated companies;

c. Jurisdictions where company does business. Indicate if certificates of authority are reviewed as part of the examination;

d. Premium volume;

e. Major lines of business;

f. Market share comparison in major lines of business, citing source of statistics; and

g. Market approach, e.g., agents, brokers and direct response.

3. Executive Summary

The executive summary should highlight the principal areas of concern noted in the examination report without repeating the findings of the examination. It should be a briefer and simpler version of the original report. The executive summary should provide an overview to the reader of the significant results of the examination without requiring the reader to review the report in its entirety.

The executive summary is usually no longer than 10 percent to 20 percent of the original report. Particular attention may be given to those activities that involve significant consumer harm or that relate specifically to the reason for the calling of the examination. After presenting a summary of the report, an executive summary may conclude with a paragraph explaining the recommendations for regulatory enforcement action.

The executive summary should contain the following language:

> Various noncompliant practices were identified, some of which may extend to other jurisdictions. The company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the [insert state] insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

4. Previous Examination Findings

Previous examination findings are a summary of pertinent results of prior examinations, company responses and disciplinary action taken (which have become public record), as they relate to the current examination results.

5. Pertinent Factual Findings

Depending on the size and content of the report, separate sections may be appropriate for: company operations/management; complaint handling; marketing and sales; producer licensing; policyholder service; underwriting; and claims. Recommended corrective action to deal with significant problem areas may follow finding descriptions or may be included in the summary section. If a general problem is cited which has subsequently been corrected, the report should clearly state that the correction has been made to the satisfaction of the examiner.

a. Report by Exception

If there are no exceptions to note in particular areas, that section may be eliminated from the report. The report should include the sample size and number of files in error for each area examined. Errors would include inconsistencies with the company's manuals and filings. The error ratio (percentage of files reviewed that were in error) for the jurisdiction's statutes, rules and regulations or generally accepted practices should be provided. Brief explanations of particular statutes, rules and regulations that have been violated may help keep the report less technical and easier to follow. Specific areas of performance that were evaluated (in which exceptions were found) should be identified.

b. Report by Test

Each test utilized should be stated with the statutory, rule or regulatory basis noted. The results of each test should be listed with comments pertinent to the examinee's performance under the test. One advantage of the report by test is that information which may not be useful in preparing one aspect of a report may change the focus of an examination or may be helpful for other regulatory purposes. For example, an examiner might find insufficient "errors" in marketing to give rise to an exception report, but then discover that the errors arose in connection with a particular producer. The nature of the inquiry into the insurer may shift to an analysis of its supervision of its agents; while the information also becomes useful for evaluating disciplinary proceedings against the individual.

6. Summarization

a. Examiners' comments may be presented to emphasize significant problem areas found during the examination and/or to emphasize company noncompliance with recommendations of prior examinations;

b. Summary of recommendations, if applicable;

c. A report submission page, listing all examiners who participated in the examination and all signatures of Examiners-in-Charge (EIC) for each jurisdiction participating. If the EIC wishes, a brief acknowledgment of the courtesy and cooperation of the officers and employees of the company may be included; and

d. A statement of verification, where required, signed by the EIC, which attests to the truth and accuracy of the report.

7. Appendices

Appendices may include time studies and other necessary documentation.

C. Review of the Report

The insurance department should advise the company examined of its policies and procedures for:

1. Conducting informal meetings or conferences with the company to discuss findings and corrective action programs.

2. Reviewing the report with the company before it is printed in final form.

3. Mailing the report to the company and receiving the company's comments.

4. Filing the report and any company comments.

5. Finalizing and filing the report, and determining whether or not it will become a public document.

6. Providing formal rebuttals or conducting formal hearings to review company objections to official filing of the report after it is printed in final form.

7. Advising who will be responsible for printing the report and how many copies will be needed.

8. The submission of a post-examination questionnaire (optional).

D. Distribution of the Findings

1. Any distribution of the filed report may include the examiner's report, the company's comments and objections, and any results of insurance department comments and orders or stipulations.

2. Examination results are to be entered in the appropriate NAIC database.

3. Final (adjudicated) actions should be entered into the appropriate NAIC database.

E. Information on Examinations Conducted by Other States

1. A report of market conduct examinations, as well as summarized examination findings of past examinations conducted in other jurisdictions, can be obtained via MATS.

2. Examiners may wish to contact either the EIC or the individual identified in MATS for further information regarding particular examinations.

3. The RIRS contains a history of regulatory actions taken by individual jurisdictions on reported companies and agents.