NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Market Regulation Handbook

2023

Volume I – IV

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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Information about statutory accounting principles and the procedures necessary for filing financial annual statements and conducting risk-based capital calculations.

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Market Regulation Handbook

2023 Edition

This guidance is as adopted by the NAIC as of December 2022. 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 interim updates 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 2023 *Market Regulation Handbook* may access interim handbook updates via the online subscription service (OSS) for paying customers and *Market Regulation Handbook* Reference Documents via the NAIC Account Manager login at *www.naic.org/account_manager.htm*.

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VOLUME I—FOREWORD
Overview of Market Regulation Oversight

The original *Market Conduct Examiners Handbook* was developed as a collaborative effort by jurisdictions actively involved in the market conduct examination process. In 2005, the *Market Analysis Handbook* and the *Market Conduct Examiners Handbook* were merged into the *Market Regulation Handbook* (handbook). The NAIC model statutes and regulations have served as the basis for the handbook, because insurance statutes in many jurisdictions have evolved from NAIC model laws. The *Market Conduct Surveillance Model Law* (#693), which was jointly adopted in 2004 by the NAIC and the National Conference of Insurance Legislators (NCOIL), contemplates that state insurance departments will use this handbook as a resource for developing a baseline understanding of the insurance marketplace through market analysis, which will serve as a basis for further market surveillance activities such as additional investigation or market conduct examinations designed to address compliance problems. As outlined in later sections of this handbook, these activities may be initiated by a single state, or may be coordinated among a number of jurisdictions.

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 was 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.

Updates to the *Market Regulation Handbook*

This handbook is updated and released on an annual basis. Instructions for accessing the updates on the NAIC website are located at the front of the most recently published *Market Regulation Handbook*.

Chapter 1—Introduction

A. Resources Available to Market Regulation Professionals

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

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

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

Core Competencies
Core competencies were developed by regulators to meet expectations from consumers, the insurance industry and all interested parties for effective state-based regulatory oversight of the insurance marketplace. Core competency standards are uniform standards that measure an individual state insurance department's overall ability to effectively and efficiently regulate the insurance marketplace. The four broad categories of core competency are set forth below. The currently adopted core competency standards are contained within Chapter 5 of this handbook.

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

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

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

The Market Actions (D) Working Group consists of a minimum of 16 members and their alternates, and provides policy oversight and direction to the Collaborative Action Designees (CADs), facilitates interstate communication, recommends appropriate corrective actions, coordinates collaborative state regulatory actions and facilitates the use of a broader continuum of market actions. The Working Group focuses its efforts on those nationally significant insurers that exhibit characteristics indicating current or potential market regulatory issues that impact multiple jurisdictions.

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

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

Market Analysis Prioritization Tool (MAPT)
The Market Analysis Prioritization Tool (MAPT), released in 2006, expanded upon the Market Analysis Company Listings[1] by creating a scoring system so companies can more easily be prioritized. MAPT is designed to provide regulators with a web-based tool that serves as a starting point in the analysis process by prioritizing companies for further analysis. This prioritization of companies allows states to better focus their resources and to develop more efficient regulatory policies and practices. MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. Key market regulation components vary by line of business. They include, but are not limited to: losses, expenses and premiums; enrollments, market components, regulatory actions, complaints, examinations and demographics.

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

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

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

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

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

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

The NAIC Market Regulation Department offers education and training to regulators and non-regulators in various formats: instructor-led sessions, webinars, online training and web-based "on-demand" training. Some of the areas/topics in which the Market Regulation Department has provided training include Baseline Analysis, Market Analysis Techniques, Producer Licensing, Consumer Assistance Training, Market Conduct Examinations and Market Conduct Annual Statement data collection and analysis. Other NAIC education and training topics will continue to be added in the future.

The NAIC Financial Regulatory Services Department provides technical expertise in areas of financial regulation, solvency regulation, financial reporting, as well as other financial-related expertise.

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

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

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

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

Financial Analysis
Financial reporting and analysis information is shared with the NAIC, which assembles a wide range of data compilations on a multistate basis. An insurance department's financial analysis and examination staff can provide valuable assistance in interpreting this information. Additionally, market regulators are encouraged to coordinate with a company's domestic financial regulator to obtain information related to the company's group capital calculations, liquidity stress test results, corporate governance and Own Risk and Solvency Assessment (ORSA).

Rates and Forms Information
Tools such as the System for Electronic Rate and Form Filing (SERFF) and the insurance department posting of state filing review requirements provide a wide range of new data in formats that are more readily comparable across state and regional lines. As of April 2023, 53 jurisdictions including the District of Columbia, Puerto Rico, Guam and the Virgin Islands accept rate and form filings via SERFF. More than 7,000 insurance companies, third-party filers, advisory organizations and other companies make filings electronically through SERFF to the individual jurisdictions. SERFF processed 520,910 transactions in 2022.

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

C. myNAIC

MyNAIC was created by the NAIC in June 2016 to serve two purposes: 1) it is a web page from which publicly available NAIC tools can be accessed, and 2) it serves as a web page which allows regulators to have a single page from which to access regulator-only NAIC/NIPR/Compact tools. Regulators may access myNAIC by clicking the myNAIC link on the Regulator tab at *www.naic.org*; then clicking on "Login" in the upper right corner of the myNAIC public applications web page. The applications on the myNAIC regulator-only web page are based upon the roles associated with a regulator's myNAIC password and user ID.

D. Center for Insurance Policy and Research (CIPR)

The Center for Insurance Policy and Research (CIPR) provides research and education to drive discussion and advance thought leadership and action on current and emerging insurance issues among state insurance regulators, the insurance industry, academics and other policymakers. This is achieved through a series of integrated research activities including: 1) hosting policy-focused sessions on key topics at NAIC National Meetings, the NAIC Insurance Summit and virtual webinars; 2) publishing CIPR-developed research on NAIC key initiatives as well as facilitating the wide distribution of rigorous, high-quality research from the academic community regarding insurance regulatory issues through the *Journal of Insurance Regulation* and the Research Fellows program; 3) application of research findings to regulatory operations via various training curriculums; and 4) the maintenance of numerous issue briefs on the CIPR website that explain complex insurance issues and link to relevant state insurance supervisory activity, with these topics linked to the extensive NAIC library collection.

The CIPR website contains research content touching all aspects of insurance regulation. The Insurance Topics & Regulatory Priorities section of the website contains issue briefs for dozens of key insurance regulatory issues. The Events & Education section lists information on CIPR events, both in-person and online. The *Journal of Insurance Regulation s*ection provides open access to this NAIC peer-reviewed journal, featuring evidence-based research from academics and other experts. The NAIC Library section contains the NAIC archives, including the complete collection of the NAIC Proceedings, as well as thousands of other insurance-related resources, and the CIPR Newsroom section provides access to a complete listing of CIPR research content. The Fellows Program section showcases current fellows and their research outputs, and the Catastrophe Modeling Center of Excellence section provides regulators with tools and technical expertise to facilitate understanding of the use of catastrophe modeling by the insurance industry.

E. The Interstate Insurance Product Regulation Commission (Compact)

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

The Compact website is *www.insurancecompact.org* and includes the Compact legislation, as well as the Compact's bylaws, annual reports, budgets, uniform standards, operating procedures and other relevant tools, tutorials and information. In June 2007, the Compact became operational and received its first product filings. As of April 2023, over 380 companies have filed one or more product filings with the Compact for approval since June 2007. The uniform standards require that all forms submitted for approval to the Compact have a form identification number in the lower left-hand corner, where the form number must include a prefix of "ICCxx" (where "xx" represents the appropriate year the form was submitted for filing). Within the NAIC System for Electronic Rate and Form Filing (SERFF), compacting states have read-only access to product filings submitted to the Compact for approval and use in their respective state (each compacting state administers the roles and access to the Compact information stored within SERFF). Regulators may want to refer to the Compact map on the Compact website, which shows the compacting states in yellow.

The uniform standards are the applicable content requirements for Compact-approved products rather than state-specific content requirements and laws. When working with a Compact-approved product, market regulators should be familiar with the uniform standards as they are the applicable requirements of the provisions and content of the Compact-approved forms.

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

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

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

As of April 2023, the Compact has adopted over 100 uniform standards covering a wide range of products and benefit features for the four individual asset-based insurance product lines authorized by the Compact as well as for group life, annuities and disability income insurance products, specifically for employer/employee groups. As authorized by the Compact, the Compact reviews rate filings for individual long-term care and disability income insurance products, as well as advertising associated with Compact-approved individual long-term care insurance products.

F. Other Regulatory Sources

Federal Regulators and Databases
Expanded information sharing with federal regulators assists both state and federal regulators in conducting more efficient and effective oversight. States can enhance information sharing by reporting information to federal databases, such as the National Practitioner Data Bank (NPDB), which contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers and suppliers. To eliminate NPDB data reporting/querying overlap with the Healthcare Integrity and Protection Data Bank (HIPDB), the U.S. Congress passed Section 6403 of the *Affordable Care Act of 2010* (ACA), Public Law 111-148. As a result of the legislation, effective May 6, 2013, NPDB operations were consolidated with those of the former HIPDB. Information previously collected and disclosed by the HIPDB is collected and disclosed by the NPDB. Regulators may also pursue access to other federal databases (for example, the FBI database for producer licensing purposes). Each state should have ongoing arrangements with the various federal financial services regulators to share consumer complaint information arising out of cross-sector market activities.

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

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

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

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

G. Industry Sources

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

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

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

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

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

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

H. Public Information Sources

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

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

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

Trade Press/Research Papers
Trade publications and academic research papers inform regulators about emerging issues and other regulatory concerns.

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

I. Company Self-Audits

Self-audits, when made available to regulators, can provide information about how particular market problems have been addressed by insurers on a voluntary basis. The growing use of self-audits and voluntary accreditation programs, such as the National Council on Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) has the potential of providing regulators important information about companies. Many of these organizations require companies to actively monitor their compliance practices and take appropriate

corrective actions when necessary. This information can provide useful insights regarding a company's commitment to establishing and maintaining a culture of compliance designed to continually improve their market conduct and compliance practices.

Chapter 2—Continuum of Market Actions

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

A. Considerations

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

1. Questions to Evaluate

Consumers

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

Regulators

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

Regulated Entities

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

Actions

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

2. Scale of Response

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

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

3. Goals of Response

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

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

4. Measures of Success

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

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

5. Assigning Regulatory Staff

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

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

B. Market Actions

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

A brief discussion of each category follows. Examples are provided only for clarity and should not be considered the sole use for each type of response. Note: The principles outlined in Section D Confidentiality in Chapter 12—Examination Introduction of this handbook can also be applied to the continuum of market actions.

1. Contact with the Regulated Entity

Contact with the regulated entity will include the following components:

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

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

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

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

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

Correspondence

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

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

Practical examples of using correspondence include:

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

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

Interrogatories

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

Practical examples of using interrogatories include questionnaires regarding:

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

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

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

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

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

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

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

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

Practical examples of contacting other stakeholders:

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

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

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

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

Practical examples of targeted information gathering include:

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

Policy and Procedure Reviews

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

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

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

Reviews of Self-Audits and Self-Review Documents

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

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

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

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

Voluntary Compliance Programs Review

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

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

Practical examples of reviewing voluntary compliance program documents include:

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

2. Examinations

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

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

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

Timing of Examination

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

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

Examination Type

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

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

Location of Examination

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

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

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

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

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

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

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

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

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

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

Practical applications of information sharing include:

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

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

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

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

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

C. Closure

No matter which continuum of market action option is used to address a situation, regulators will be faced with the decision of how to bring closure to an issue. Each jurisdiction has different considerations and methods for bringing closure to an issue. In some instances, taking enforcement or disciplinary action, or even initiating civil litigation, may be necessary to achieve compliance or resolve the issue. On other occasions, the following listed methods of closure may be appropriate:

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

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

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

1. Closure Without Initiating Action or Litigation

Determining That No Further Action Is Necessary

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

Communicating the Insurance Department's Position

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

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

Practical examples of insurance department communications include:

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

Providing Information to Producers

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

Practical examples of producer outreach include:

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

Referral to Other Agencies, Fraud Prevention Divisions or Law Enforcement

Occasionally, regulatory issues or concerns may cross agency boundaries within the state. Common examples include securities, banking, motor vehicle registration and financial responsibility, health and human services, consumer protection functions of attorneys general, and senior protection agencies. It is helpful to know who

within the state insurance department may have established channels of communication with other applicable agencies. It is also helpful to have a general understanding of the functions within those agencies and how they might apply to insurance.

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

Initiating Consumer Outreach or Education

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

Practical examples of consumer outreach or education initiatives include:

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

Ongoing, Nonstructured Monitoring

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

Requesting Legislative or Regulatory Rule Changes

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

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

Practical examples of requesting legislative or regulatory rule changes include:

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

2. Closure Through Enforcement Methods, Disciplinary Action or Litigation

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

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

Informal Agreements

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

Voluntary Compliance Plans

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

Administrative Complaints

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

Cease and Desist Orders

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

Ongoing Monitoring/Self-Audit

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

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

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

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

Administrative Fines and Penalties
An administrative adjudication should follow insurance department or state guidelines. A typical action would follow the filing of a petition or formal complaint against the regulated entity, setting a time and place for an administrative hearing. The regulated entity would be provided an opportunity to offer testimony and evidence before a hearing officer, who would decide the outcome of the action. Likewise, the regulatory representative would present evidence and request a finding or determination along with a request for resolution. Occasionally, a voluntary consent agreement may be reached prior to an administrative hearing. A regulated entity could be required to pay both restitution and a penalty so that actual financial harm is repaired and the entity is also punished for the violations that caused the financial harm.

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

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

Chapter 3—Market Regulation Investigation Guidelines

A. Background and Introduction

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

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

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

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

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

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

B. Guidelines for Conducting Market Regulation Investigations

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

- As to the subject of any examination, investigation, or hearing being conducted by him, the commissioner may subpoena witnesses and administer oaths or affirmations and examine any individual under oath or take depositions and, by subpoena duces tecum, may require and compel the production of records, books, files, documents, and other evidence;

- Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a circuit court. Witness fees, mileage and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized and shall be paid by the person being examined if in the proceedings in which such witness is called such person is found to have been in violation of the law or by the person, if other than the commissioner, at whose request the hearing is held;

- Subpoenas of witnesses shall be served in the same manner and at the same cost as if issued by a circuit court. If any individual fails to obey a subpoena issued and served under this section with respect to any matter concerning which he may be lawfully interrogated or required to produce for examination, on application of the commissioner, the circuit court of the county in which is pending the proceeding at which such individual was so required to appear or the circuit court of the county in which such individual resides may issue an order requiring such individual to comply with the subpoena and to testify or produce the evidence subpoenaed. Any failure to obey such order of the court may be punished by the court as a contempt thereof; and

- Any person willfully testifying falsely under oath as to any matter material to any such examination, investigation, or hearing shall, upon conviction thereof, be guilty of perjury and punished accordingly.

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

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

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

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

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

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

- Information concerning the subject of the investigation from applicable NAIC databases. The NAIC maintains several databases which contain information, which may be of assistance to the investigator. Those databases consist of the following:
    - Regulatory Information Retrieval System (RIRS);
      RIRS contains regulatory actions taken by participating state insurance departments against producers, companies and other entities engaged in the business of insurance. Note that the absence of information on a particular entity should not be taken as conclusive, that no disciplinary action has been taken. Not every state participates actively and fully in RIRS.

    - Other NAIC databases; and
      There are other NAIC databases which also may be of assistance to the investigator. These are the Complaints Database System (CDS), the Market Action Tracking System (MATS) and the State Producer Licensing Database (SPLD). Information found in these databases includes regulatory actions, closed complaints, financial and market conduct examinations, relationships between entities, and suspicious or fraudulent activity. Information contained in the SPLD also contains licensing and appointment information on insurance producers.

    - Interstate Insurance Product Regulation Commission (Compact) product filings (via SERFF).
      The uniform standards, rather than state-specific content requirements/laws, are applicable to products approved by the Interstate Insurance Product Regulation Commission (Compact). Compacting states have access through the NAIC System for Electronic Rates and Forms Filing (SERFF) to product filings submitted to the Compact for approval and use in their respective jurisdiction and may wish to view the approved forms, filing correspondence, notes from reviewers, checklists and supporting documentation. The Compact office should be included when a compacting state(s) is concerned that a Compact-approved product or advertisement constitutes a violation of the provisions, standards or requirements of the compact (including the uniform standards).

- Discussions with other insurance department personnel;

- Any departmental records, such as financial examinations and/or producer licensing and investigation files;

- Information received from other states;

- Any information received from law enforcement and/or other state or federal regulatory agencies. Other federal and state regulatory agencies have databases that may assist the investigator, for example, the Federal Trade Commission (FTC) and Financial Industry Regulatory Authority (FINRA); and

- If possible, any information that can be requested from the entity being investigated should be gathered before a field investigation is commenced. The information requested may be broad or very specific depending on the type of investigation being conducted. Reviewing and analyzing all available information concerning the subject of the investigation prior to the start of a field investigation will allow the investigation to be conducted in a more comprehensive and expedited manner.

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

- The justification for the investigation;

- The scope of the investigation;

- A time and cost estimate; and

- What costs, if any, can be billed to other sources.

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

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

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

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

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

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

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

- Corrective action plan;
- Referral to appropriate law enforcement or other regulatory agencies, if warranted and/or required by law;
- Restitution; and
- Information-sharing with other states.
  All states should report any significant findings to other affected states, through their Collaborative Action Designee (CAD) and through the Market Actions (D) Working Group. Since an investigation is a separate and distinct process from an examination, the existence of an investigation may not be reported to MATS, nor are the findings of an investigation always reported to RIRS.

- Some entities will request that a department of insurance enter into what may be referred to as a confidential settlement to resolve any violations found during an investigation. Confidential settlements are not allowed under many state public record laws. Fellow regulators expect NAIC databases to maintain accurate information. All violations and monetary payments should be reported to the appropriate NAIC databases unless prohibited by law.

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

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

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

C. Standards for Conducting a Field Investigation

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

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

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

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

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

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

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

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

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

D. Guidelines for Conducting an Interview

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Preparation of the Interview Form

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

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

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

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

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

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

F. Procedures for Closing a Market Regulation Investigation

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

- The allegations are unfounded or the investigator is unable to make a determination due to lack of information, etc.;
- All investigative efforts have been pursued to their logical conclusion without proving or disproving the allegations;
- All investigative efforts have been completed, subjects have been administratively, civilly or criminally charged and all aspects of the case have been resolved;

- All investigative activity has been completed, a complaint and/or warrant has been issued and all efforts to locate the subject(s) have been expended;

- The case is exceptionally cleared (i.e., subject dies, subject is arrested in another jurisdiction, entity goes out of business, etc.);

- Assistance is no longer required;

- Inactive status; and

- An entry should be made in the appropriate NAIC database(s).

G. Procedures for the Completion of Case Summary Reports

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

- The identity of the person or entity to be cited in the report. This section contains the name, business address and phone, residence address and home phone for the individual or entity to be cited and prior regulatory history, if any, of the entity;

- The investigator should indicate all current licensure of the person or entity to be cited;

- The investigator should provide a brief narrative description of the allegations, including the number of violations;

- The investigator should provide a brief and concise representation of the information obtained during the investigation, including what the respondent did, how the violation occurred, how often the violation occurred, what further action needs to be taken, an identification of consumers who are due restitution and a description of any special circumstances or mitigating or aggravating factors;

- Witness list; and

- Source of the complaint.

H. Guidelines for Conducting a Photographic Lineup

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

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

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

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

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

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

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

I. Forensic Examinations—Expert Witnesses

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

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

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

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

- Writings which are produced for the purposes of investigation (requested standards).

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

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

Some important general guidelines are as follows:

- The subject should never be allowed to see the questioned material;

- If possible, use a format similar to that of the questioned material (i.e., same amount of writing space horizontally and vertically, lined paper/unlined paper, similar type of writing instrument, etc.);

- Dictate, verbatim, the questioned material;

- After each repetition, remove it from view prior to execution of the next specimen;

- Obtain a sufficient sample of known source writing (i.e., 15 to 25 repetitions, full text);

- If there are multiple-question items, sporadically interchange them to further frustrate disguise;

- Ensure that the writer provides comparable writing (i.e., cursive or printing); and

- If available, submit collected specimens along with requested writing so as to demonstrate normal writing. Collected writings may be all that are available. In such instances, as many writings as possible should be obtained to maximize comparability.

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

- The original document;

- Photograph of the document;

- Photocopy of the document;

- Microfiche/microfilm; and

- Facsimile/carbon copy.

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

J. Form of Investigative Report

General

- Objectivity
  An investigative report should reflect, in its wording, the same objectivity that was used in the fact-finding and information-gathering process of the investigation. The report must be a factual recording of the findings. Use of words such as "some," "many," "several" and "few" must be minimized. The use of superlatives should be avoided in writing the report. The most important questions that must be answered in an investigative report are: who, what, when, where, why and how.

- Privacy
  The investigator should be aware that although investigative reports are privileged and confidential, they may, in fact, be used in administrative, civil and possibly criminal proceedings. Accordingly, steps should be taken, when possible, to protect the confidentiality of individual policyholders or consumers. For example, when listing Social Security numbers, the investigator may want to list only the last four digits of the number.

- Use of Jargon
  The needs of various individuals who will review and utilize the investigative report should be kept in mind during the preparation of the report. Whenever possible, the use of insurance industry jargon within the report should either be avoided or explained.

- Writing Style
  The writing style of an investigative report should tell the story of the investigation. The story is simple, direct and factual and should always be told in chronological sequence.

- Main Objectives of an Investigative Report
  An investigative report should inform the reader of the investigator's findings, including information and the source of information. The report should facilitate the understanding of the investigation and foreshadow the uncompleted portion of the investigation. The report should also fulfill the duties of the assignment.

Content of the Report

- Title Page
  - Type of investigation;
  - Subject and address of investigation. If the investigation location is different, include that address also;
  - Identifying numbers (e.g., agent number, Social Security number, etc.);
  - Dates of investigation;
  - Period covered by the investigation; and
  - List of jurisdictions and agencies participating.
- Table of Contents
- Case Summary Page (see Exhibit B in this chapter)
  The case summary report is designed to provide a brief overview of the specific information and documentation obtained during the investigation. These reports assist insurance department supervisors and legal counsel in expeditiously identifying the pertinent facts of a case so that an informative decision can be made regarding the final disposition of the case. The case summary page should contain the following:
  - Identity of person or entity—including any available addresses or phone numbers;
  - Current licenses—all license powers of the person or entity to be cited;
  - Allegations—brief description of the allegations, including number of violations; and
  - Summary of the case—brief, concise information obtained during investigation including:
    - What the respondent did;
    - How the violation occurred;
    - How often violations occurred;
    - What further action needs to be taken; and
    - Identifications of consumers due restitution.

- Detail of Report
    - Scope of the Investigation
        - Cite specific statutory authority for the investigation; and
        - Briefly outline the investigation purpose.
    - Body of the Report
        - Detail of the investigation;
        - Summary of interviews; and
        - Summary of documentary evidence.
    - Appendices
        - Copies of interviews;
        - Copies of documentary evidence;
        - Copies of sworn statements and affidavits;
        - Copies of all licensing records; and
        - Flow chart.

K. Indicators of Fraud

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

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

L. Investigative Priorities

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

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

- High priority (complete in 60 days or as supervisor designates): Multiple victims, elderly victims, high-dollar losses, felony convictions and high risk of continuing harm, publicity or media attention;

- Medium priority (complete in 120 days): Single or few victims, relatively lower dollar amounts involved, low risk of continuing harm; and

- Low priority (complete in 270 days): Little or no harm to consumers (e.g., advertising, rebating).

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

- A producer who has had three or more complaints filed against them in the previous two years;

- Three or more complaints involving marketing and sales or policyholder service in the previous five years; and

- Complaints where there are serious allegations of consumer harm, particularly harm to the elderly.

M. Exhibits

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

Exhibit A Sample Interviews

SAMPLE SUBJECT INTERVIEW

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

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

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

John Doe, Mary Doe and Fred Doe each paid by check and those checks were deposited into Crook's business account. Crook then wrote checks to Unlimited Risk Insurance Company to pay for their premium. Crook does know that some of his checks have been returned for insufficient funds at his bank but was not aware that his

check for insurance on John Doe, Mary Doe and Fred Doe had in fact been returned for insufficient funds. Crook was not aware that Unlimited Risk Insurance Company had no record of policies being issued for John Doe, Mary Doe and Fred Doe. Nor did the company have any record of any application being submitted on their behalf.

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

Investigation on John T. Crook at Anytown, USA

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

By Investigator George Goodguy and Investigator Fred Fearless

SAMPLE CUSTODIAN OF RECORDS INTERVIEW

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

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

Investigation on John T. Crook at Anytown, USA

File Number P-2003-12345JD Date of Interview August 7, 2003

By Investigator George Goodguy

SAMPLE INTERVIEW OF COOPERATIVE WITNESS

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

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

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

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

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

Investigation on John T. Crook at Anytown, USA

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

By Investigator Fred Fearless

SAMPLE VICTIM INTERVIEW

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

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

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

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

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

Investigation on John T. Crook at Anytown, USA

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

By Investigator George Goodguy

SAMPLE ARREST INTERVIEW

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

Investigation on John T. Crook at Anytown, USA

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

By Investigator George Goodguy

Exhibit B Case Summary Page

CASE SUMMARY PAGE

Identity

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Current Licenses

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Allegations

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Summary

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Chapter 4—Collaborative Actions

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

A. Collaborative Action Guidelines

1. Goal

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

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

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

2. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Assumptions

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

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

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

4. Determinations

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

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

a. Determining Need for Collaboration

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

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

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

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

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

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

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

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

5. Is this regulated entity already on the Market Actions (D) Working Group agenda?
   □ Yes □ No

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

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

b. Determining Level of Collaboration

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

1. Is the regulated entity nationally significant?
   □ Yes □ No

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

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

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

3. Has the regulated entity been chosen as part of the Market Actions (D) Working Group's National Analysis Project?
   □ Yes □ No

4. Does the issue involve a significant amount of consumer harm?
   □ Yes □ No

5. Does the issue lend itself to a multistate resolution?
   □ Yes □ No

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

B. Responsibilities of Key Players in a Collaborative Action

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

1. Managing Lead State (MLS) Responsibilities

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

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

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

2. Lead State Responsibilities

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

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

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

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

3. Replacement of a Lead State

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

4. Participating State Responsibilities

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

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

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

C. Market Actions (D) Working Group

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

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

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

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

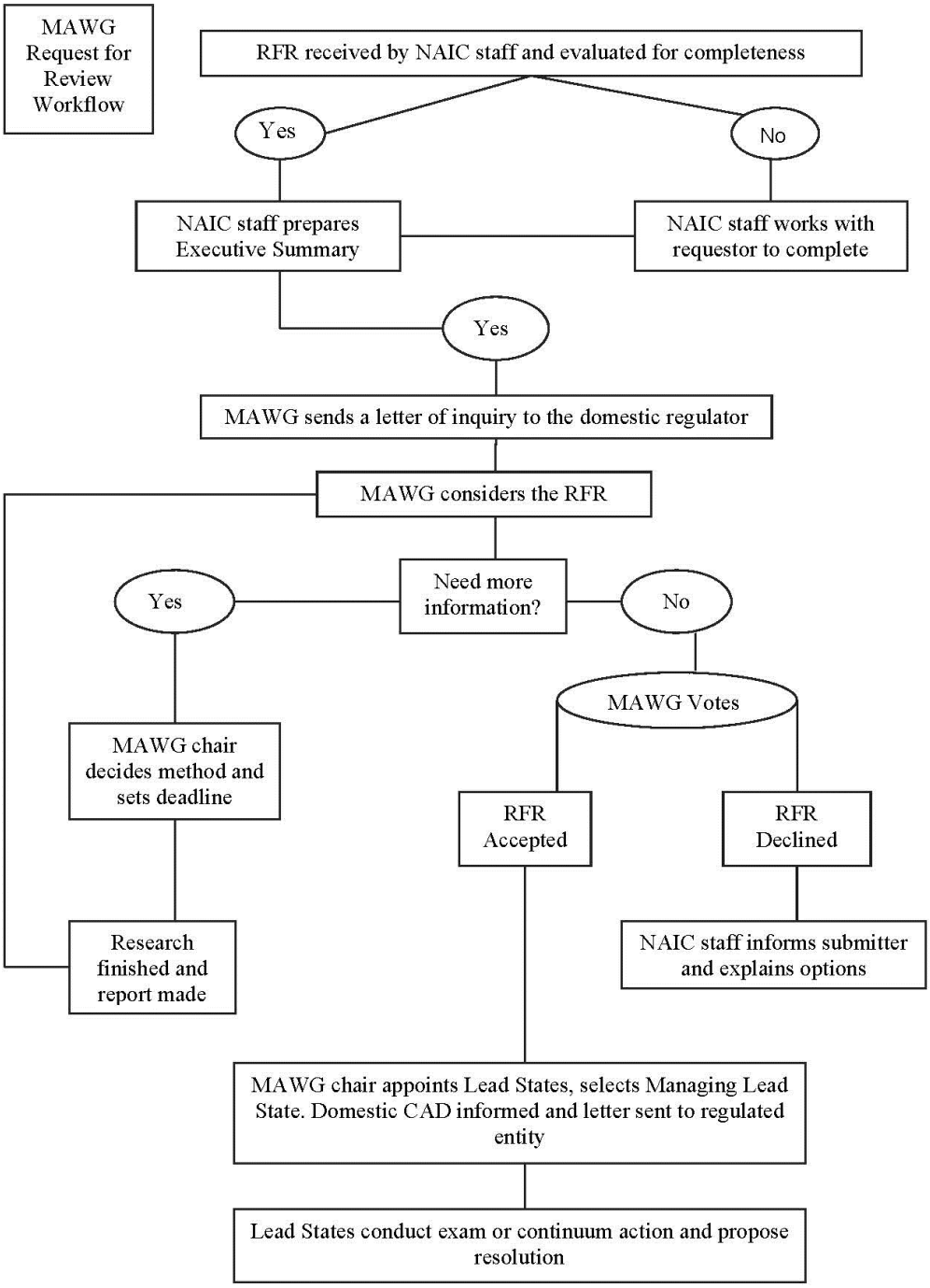
2. Request for Review (RFR)
When a Market Analysis Chief (MAC) discovers an issue that impacts multiple jurisdictions, the MAC should consult with their state Collaborative Action Designee (CAD). Working together and answering the questions in Subsection 4a and 4b of this chapter, the CAD and MAC may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

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

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

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

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



D. Multistate Examination Process

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

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

Steps:

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

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

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

Steps:

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

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

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

Steps:

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

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

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

Steps:

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

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

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

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

Steps:

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

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

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

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

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

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

Steps:

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

Deliverable:
Examination notification is sent to the company.

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

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

Steps:

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

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

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

Steps:

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

10. Finalize the Examination Report
Final Examination Report = Multistate Examination Summary + State Addendum
Each Participating State may issue an examination report or choose to adopt the Lead State report that consists of the multistate examination summary. Alternatively, each Participating State may issue an optional state addendum, taken from the EIC's report on findings related to state-specific issues.

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

Steps:

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

E. Conclusion of Collaborative Enforcement Actions

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

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

1. ***Best Practices for Multistate Settlement Agreements***

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

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

Chapter 5—Core Competencies

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

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

2. Market Analysis Core Competencies	
Data Collection	Ability to gather and evaluate data as demonstrated by: 1) utilization of the Market Analysis Review System; 2) collection of data as required by the Commissioner, Director or Superintendent; and 3) for participating Departments of Insurance, collection of data for the Market Conduct Annual Statement; 4) use of the standardized data requests when there is a need for the collection of relevant data prior to the initiation of an investigation of market regulatory action.
Analysis	Departments of Insurance shall gather information from data currently available to the Department of Insurance, as well as surveys and required reporting requirements, information collected by the NAIC and a variety of other sources in both the public and private sectors, and information from within and outside the insurance industry. The information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review regulated entities or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.
Market Analysis Chief	The Market Analysis Chief (MAC) is the principal liaison with the NAIC Market Analysis Division, the Market Analysis Procedures (D) Working Group and the Market Information Systems (D) Task Force. The MAC is responsible for all market analysis-related communications with other work units within the Department of Insurance. The MAC and CAD may be two individuals or the same person. The Department of Insurance should have the appropriate staff member assigned as the MAC to ensure an effective market analysis program.
Market Analyst	Market analysis is a process where data and information is collected and analyzed for an insurance market and particular companies to determine both what are standard practices and when companies or general market trends are outside of those standards. The purpose is to provide both general understanding and specific company identification for further analysis, audit, investigation or examination. The market analyst works under the supervision of the MAC to assure a systematic approach to market analysis. The market analysis process typically includes baseline analysis on the various lines of insurance utilizing a variety of standardized and state-based tools and data, as well as the Market Conduct Annual Statement (MCAS) submissions by companies. The market analyst combines the findings of baseline analysis and MCAS to identify outliers for Level 1 and Level 2 reviews. The market analysis process should include working closely with various program areas in their respective insurance department as well as other states' insurance departments and the NAIC. Working closely may also include providing regular or even formal reports to a variety of internal and external stakeholders, at the direction and supervision of the MAC or CAD.

3. Continuum Core Competencies	
The Continuum of Market Actions is a means of moving from market analysis to regulatory response. The continuum is a spectrum of regulatory tools to address actions necessary as a result of analysis of specific regulatory concerns regarding the conduct of a regulated entity. Specific examples of the continuum and recommended goals to consider when determining the nature of the regulatory response are discussed in the Continuum of Market Actions chapter of the *Market Regulation Handbook*. Each Department of Insurance should evaluate and document market problems using the continuum of market actions.	
Market Conduct Examinations	A Department of Insurance should have standards in place to determine when a market conduct exam is called. Departments of Insurance should adhere to the standards in the *Market Regulation Handbook*.
Investigations	Investigations should be conducted in accordance with investigation standards. When appropriate, investigations should be posted in the Market Action Tracking System (MATS) and upon completion, if regulatory action is taken, in RIRS.
Consumer Complaints	The Department of Insurance shall have standards in place to receive and handle complaints and inquiries in accordance with the guidelines developed by the Market Analysis Procedures (D) Working Group. The Department of Insurance records complaints in a database and submits closed complaint data to the NAIC CDS on a regular basis. The Department of Insurance shall have standards for investigating complaints, responding to the complainant, and referring law violations for administrative action and reporting complaint patterns and trends to the Market Analysis Chief.

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

Competency: Resources
SubSection: Regulatory Authority

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

The following standards apply to this competency:

Standard One. **The Department of Insurance has the necessary authority to implement the continuum of market actions.**

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

Standard Two. **The Department of Insurance has the necessary authority to take corrective action when necessary.**

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

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

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

Standard Four. **The Department of Insurance has statutory provisions to protect insurance consumers.**

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

Competency: Resources
SubSection: Staff and Training

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

The following standards apply to this competency:

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

Standard Two. **The Department of Insurance has minimum educational and experience requirements for all professional employees and contractual staff positions in the market regulation and market analysis area that are commensurate with the duties and responsibilities of the position.**

The Department of Insurance should have examiners with appropriate experience to perform necessary tasks. Accredited Insurance Examiner (AIE) or Certified Insurance Examiner (CIE) professional designations and a Market Conduct Management (MCM) professional designation from Insurance Regulatory Examiners Society (IRES) are presumed to meet the minimum standard of acceptable qualifications as the combination of designations not only indicate a depth of knowledge in a major line of authority, but an advanced level of technical proficiency in market regulation.

Individuals who hold an advanced professional designation from a nationally recognized credentialing organization are presumed to have a broad knowledge of insurance concepts in a particular major line of authority. Examples of this type of designation include: Chartered Property Casualty Underwriter (CPCU), Chartered Life Underwriter (CLU), Certified Insurance Counselor (CIC), Fellow Life Management Institute (FLMI), and Registered Health Underwriter (RHU); while individuals who have obtained the NAIC designations Associate Professional in Insurance Regulation (APIR), Professional in Insurance Regulation (PIR), Senior Professional in Insurance Regulation (SPIR) as well as the Associate in Regulation and Compliance (ARC) and the Associate, Insurance Regulatory Compliance (AIRC) designations from the Institutes and LOMA respectively, have demonstrated an appropriate level of competence in regulatory matters.

Other designations (usually characterized as at the associate level) may indicate proficiency in certain aspects of insurance operations: these include, but are not limited to Associate in Claims (AIC) for property and casualty claims, Associate in Insurance Accounting and Finance (AIAF) for insurance financial operations and Associate, Annuity Products and Administration (AAPA) for annuity operations.

The professional designations listed are not intended to be exhaustive nor is it intended that designations be requirements for qualification. Appropriate experience both within and without departments of insurance is highly desirable.

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

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

Competency: Resources
SubSection: Contract Examiner

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

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

The following standards apply to this competency:

Standard One. **The Department of Insurance shall have established procedures to select contractors in accordance with applicable state laws and policies.**
The Department of Insurance shall utilize the approved state method of selection of contractors, such as Requests for Proposal (RFP) and when possible, maintain or select from a national pool of contractors to ensure selection of examiners with market regulation expertise and knowledge of the relevant lines of insurance.

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

Strict observance to conflict of interest standards must be observed. Examiners should not be affiliated with the management of the regulated entity nor own a pecuniary interest in any company. Generally, contractors that conduct examinations should not also engage to do work for the regulated entity. Neither should they be engaged to provide evidence as an "expert witness" against or on behalf of the regulated entity unless such testimony is on behalf of the engaging regulator and in relationship to the applicable work plan. Regulators should identify potential conflict of interest matters during the selection process and also be mindful or potential issues during and after the examination. States may have specific conflict of interest provisions that apply.

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

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

The Department of Insurance shall have contract analysts and examiners with appropriate experience perform necessary tasks. Accredited Insurance Examiner (AIE) or Certified Insurance Examiner (CIE) professional designations and a Market Conduct Management (MCM) professional designation from Insurance Regulatory Examiners Society (IRES) are presumed to meet the minimum standard of acceptable qualifications as the combination of designations not only indicate a depth of knowledge in a major line of authority, but an advanced level of technical proficiency in market regulation.

Individuals who hold an advanced professional designation from a nationally recognized credentialing organization are presumed to have a broad knowledge of insurance concepts in a particular major line of authority. Examples of this type of designation include: Chartered Property Casualty Underwriter (CPCU), Chartered Life Underwriter (CLU), Certified Insurance Counselor (CIC), Fellow Life Management Institute (FLMI), and Registered Health Underwriter (RHU); while individuals who have obtained the NAIC designations Associate Professional in Insurance Regulation (APIR), Professional in Insurance Regulation (PIR), Senior Professional in Insurance Regulation (SPIR) as well as the Associate in Regulation and Compliance (ARC) and the Associate, Insurance Regulatory Compliance (AIRC) designations from the Institutes and LOMA respectively, have demonstrated an appropriate level of competence in regulatory matters.

Other designations (usually characterized as at the associate level) may indicate proficiency in certain aspects of insurance operations: these include, but are not limited to Associate in Claims (AIC) for property and casualty claims, Associate in Insurance Accounting and Finance (AIAF) for insurance financial operations and Associate, Annuity Products and Administration (AAPA) for annuity operations.

The professional designations listed are not intended to be exhaustive nor is it intended that designations be requirements for qualification. Appropriate experience both within and without departments of insurance is highly desirable.

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

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

The nature and scope of services, time frames, budget and hourly rates, hours of work, confidentiality provisions, contractor responsibilities and reporting mechanisms shall be documented prior to commencement of the examination. Emphasis should also be placed on expectations regarding examiner conduct, adherence to the work plan and conflict of interest guidelines.

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

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

Department of Insurance authorized staff shall monitor or oversee the pre-examination and exit conferences and appropriate department staff shall meet regularly with the contract examiners to ensure that the examination is being conducted in accordance with pre-exam agreements. Department staff shall review the contractors' preliminary findings and draft report before it is submitted to the insurer.

Monitoring the work performance and related activities of contractors is necessary. It can be accomplished through a number of ways. Communication with the contract examiners and regulated entity, use of periodic reporting or an interim review of examination work papers are useful. The Department of Insurance shall require contractors to provide status reports to state insurance regulators. Such a report shall include, at a minimum, the following:

a. A clear explanation of the examination's progress, broken down by phase/key activity;
b. A summary of time incurred by contract examiners, including budget, actual and time remaining to complete;
c. A summary of unusual problems, any significant issues identified throughout the examination and the examiner-in-charge's proposed resolution; and
d. Proposed changes to the approved budget.

The responsibility for requiring contract examiners to act on unusual problems or significant issues identified throughout the examination by broadening the scope of an examination or requiring additional date not germane to the original scope of an examination rests with the state insurance regulator. The issues disclosed in the status reports are preliminary in nature, and no action should be taken based solely on preliminary findings.

An on-site visit to the examination site may be appropriate in certain instances. When considering whether an on-site visit should be used, consider such factors as the known performance of the contractors, cost of travel to the job site, length of examination and feedback regarding progress of the examination.

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

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

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

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

Contracts or other written agreements between a Department of Insurance and contract examiners shall contain language that the contract examiner shall safeguard confidential information. These contracts shall also specify that contractors shall not share confidential information with other contractors within their organization unless they were specifically authorized by the state to work on its behalf. Contracts should also ensure that confidential information should not be shared with any contractors within their organization who have a conflict of interest. This includes protection of proprietary information received from the regulated entity under examination, information received from other state Departments of Insurance and data residing in NAIC databases.

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

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

Competency: Market Analysis
SubSection: Data Collection

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

The following standards apply to this competency:

Standard One. **The Department of Insurance fully participates in CDS, MATS, and RIRS.** "Full" participation means that CDS, MATS, and RIRS data in the Department of Insurance is submitted electronically to the appropriate NAIC databases in a frequent, current, accurate, and complete manner.

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

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

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

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

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

Competency: Market Analysis
SubSection: Analysis

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

The following standards apply to this competency:

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

Standard Two. **The Department of Insurance has appointed a Market Analysis Chief and promptly notifies the NAIC if the Market Analysis Chief changes.**

Each Department of Insurance needs a clearly identified person with whom all other Department of Insurance staff should share indicators of potential market regulation problems and who will also coordinate information sharing with other Departments of Insurance through the Market Analysis Procedures (D) Working Group and oversee the Department of Insurance's market analysis.

Standard Three. **The Department of Insurance has established a systematic procedure for interdivisional communication.**

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

Standard Four. **The Department of Insurance has identified core information that all staff should share with the Market Analysis Chief.**

In particular, all Department of Insurance staff should share any of these indicators with the Market Analysis Chief in accordance with established procedures.

- Participation with the Market Actions (D) Working Group to include, but not be limited to, participation in calls and surveys;
- Significant changes in the ratio of consumer complaints against the regulated entity or significant numbers of complaints in a relatively short period of time;
- Dramatic growth (> +33%) or decline (< -10%) in one or more lines of business;
- Significant changes in the regulated entity's book of business;
- Rapid expansion into new states and significant premium volume in new states;

- Significant concentrations of risk—geographically, by line of business or exposure—or significant changes in the concentrations of risk;
- Significant changes in expense levels (such as defense costs or commissions);
- Recent change of the state of domicile of a major writer in a group of regulated entities;
- Recent changes in ownership or senior management;
- A high degree of reliance on third parties, such as MGAs or TPAs, to perform regulated entity functions; or
- Significant problems with electronic data processing systems such that the integrity of data underlying claims, underwriting and financial systems is questionable.

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

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

- Specific complaints so critical that one complaint merits reporting (e.g., antitrust);
- Spikes in complaints against the same regulated entity on the same product/practice during a specific time interval (e.g., 10 new complaints in a week); and
- Any of the other indicators listed in Standard Four.

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

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

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

Every regulated entity—foreign as well as domestic—is required to file a State Page with each state in which it is licensed, to show changes in the regulated entity's business in the state. In most Departments of Insurance, a significant amount of staff resources at that time are devoted to review and analysis of the financial statements. While such financial analysis should be primary, at some point after the Blanks are available, the Market Analysis Chief should be aware of:

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

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

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

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

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

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

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

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

Standard Twelve. **The Department of Insurance has documented procedures.**

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

Competency: Market Analysis
SubSection: Market Analysis Chief

The Market Analysis Chief (MAC) is the principal liaison with the NAIC Market Analysis Division, and the Market Analysis Procedures (D) Working Group. The MAC is responsible for all market analysis-related communications with other work units within the Department of Insurance. The MAC and CAD may be two individuals or the same person. The Department of Insurance should have the appropriate staff member assigned as the MAC to ensure an effective market analysis program.

The following standards apply to this competency:

Standard One. **The Department of Insurance has appointed a Market Analysis Chief and promptly notifies the NAIC if the Market Analysis Chief changes.**

The MAC or the MAC's designee shall have the authority to represent the Department of Insurance in matters related to discussions regarding market analysis**.**

Standard Two. **The MAC or his or her designee is actively involved with the NAIC market analysis areas and working groups.**

The MAC will work with the NAIC to accomplish the goal that each state should "adopt uniform market analysis standards and procedures" and use its market analysis in other market regulatory functions, including market conduct and interstate collaboration. The MAC or, when unavailable, a designee assigned by the MAC, shall participate in all Market Analysis Procedures (D) Working Group meetings or conference calls.

If the MAC does not attend the NAIC national meetings, the MAC or designee shall participate in each Market Analysis Procedures (D) Working Group conference call.

Standard Three. **The Department of Insurance has procedures for the MAC to communicate with appropriate Department of Insurance staff.**

The MAC shall work with the appropriate staff in areas including consumer services, enforcement, legal, forms and filing, financial, market analysis and market conduct to ensure that there are documented procedures to notify the MAC of unusual activity that may be of interest for market analysis.

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

Standard Four. **The MAC participates in communication with other Departments of Insurance regarding market analysis.**

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

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

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

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

Competency: Market Analysis
SubSection: Market Analyst

Market analysis is a process where data and information is collected and analyzed for an insurance market and particular companies to determine both what are standard practices and when companies or general market trends are outside of those standards. The purpose is to provide both general understanding and specific company identification for further analysis, audit, investigation or examination. The market analyst works under the supervision of the MAC to assure a systematic approach to market analysis. The market analysis process typically includes baseline analysis on the various lines of insurance utilizing a variety of standardized and state-based tools and data, as well as the Market Conduct Annual Statement (MCAS) submissions by companies. The market analyst combines the findings of baseline analysis and MCAS to identify outliers for Level 1 and Level 2 reviews. The market analysis process should include working closely with various program areas in their respective insurance department as well as other states' insurance departments and the NAIC. Working closely may also include providing regular or even formal reports to a variety of internal and external stakeholders, at the direction and supervision of the MAC or CAD.

The following standards apply to this competency:

Standard One. **Analysts should possess skills and abilities necessary to access and navigate a variety of databases utilizing several formats (e.g., online, Access, CSV, Excel, etc.).**

Standard Two. **Analysts should have or be able to gain an understanding of insurance markets, products and coverages in at least one line of insurance, but preferably multiple lines.**

Standard Three. **Analysts must be capable of interpreting applicable laws, regulations and standards to ensure analyses are appropriately conducted.**

Standard Four. **Analysts should have the skill and aptitude to discuss complex compliance and regulatory issues with other regulators and company representatives.**

Standard Five. **Analysts should have the experience, training or aptitude to adequately review and understand financial statements with specific focus and understanding on how the information in those statements may impact company operations or result from company operations (e.g. claims, underwriting, rating, reinsurance, sales, marketing, etc.).**

Standard Six. **Analysts should have the skills and abilities necessary for the analysis of abstract data from a variety of resources (MAPT, MCAS, iSite+, state systems, Internet databases, etc.) in order to identify issues and companies for further analysis (baseline analysis) and then utilize that data, and additional data, in completion of appropriate company analyses (MARS Level 1 and Level 2 Analyses).**

Standard Seven. **Analysts should be competent in the writing of management reports (for inside the agency) and formal finding reports (to companies or for enforcement actions).**

Standard Eight. **Analysts should be skilled in working independently and with other regulators within their state, regionally and nationally.**

Standard Nine. **Analysts are encouraged to attend seminars or attain education that regularly supports and updates their knowledge of insurance and insurance regulatory and compliance areas (the NAIC/NIPR Insurance Summit, the IRES Career Development Seminar, the Association of Insurance Compliance Professionals National Conference, NAIC meetings, etc.) as well as encouraged to attain advanced education or certification in areas related to insurance and insurance compliance or regulations (CIE, SPIR, CPCU, FLMI, CFE, and other designations by major insurance organizations, etc.), as allowed or supported by the rules and regulations of each state.**

Competency: The Continuum

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

The following standards apply to this competency:

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

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

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

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

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

Competency: The Continuum
SubSection: Market Conduct Examinations

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

The following standards apply to this competency:

Standard Three. **Each Department of Insurance shall prioritize examinations.**
Each Department of Insurance shall establish criteria for calling a market conduct examination. Each Department of Insurance shall prepare a schedule of examinations and select a person responsible for developing and maintaining the schedule. Exceptions may be made when an examination is called as a "no-knock" examination.

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

Standard Four. **The Department of Insurance shall utilize the Market Action Tracking System (MATS).**
As soon as scheduled, each Department of Insurance shall enter the examination into the MATS, which is administered by the NAIC.

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

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

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

Standard Seven. Each Department of Insurance shall develop a standard planning process.

Many of the items reviewed may have been used in the examination priority process and may become the basis for the pre-examination planning.

- At the end of the planning process, the Department of Insurance shall determine the phases and/or standards of the examination that require more attention, the phases or standard that require average examination scrutiny or attention and those that require a reduced emphasis or may be waived.
- Each Department of Insurance shall prepare an examination work plan prior to the examination. The work plan or planning memorandum shall include:
    a. The scope of the examination;
    b. The justification for the examination;
    c. A time and cost estimate; and
    d. An identification of factors that will be included in the billing;

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

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

- The name and address of the regulated entity(ies) being examined;
- The name and contact information of the Examiner-in-Charge;
- The date the on-site examination is expected to begin;
- The statutory authority for the examination;
- The identification of items that will be billed to the regulated entity, if any;
- A request for the regulated entity to name its examination coordinator; and
- Additional information may be requested at a later date.

If the examination is to be led by a contract firm, the regulated entity shall be notified.

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

The preliminary information shall contain the following information:

- General instructions;
- The scope of the examination;
- The materials requested to perform the examination;
- Data requests;
- Requirements for accommodations and supplies including modem requirements;
- Time and cost estimates;
- Travel information;
- Specific instructions regarding sampling, communications with the regulated entity and other pertinent information;
- Location of on-site examination;
- Security arrangements;
- Billing procedures; and
- An outline of state insurance department policies and procedures for maintaining the confidentiality of documentation reviewed during an examination.

Standard Ten. **The Department of Insurance shall adopt the standardized data requests contained in the reference documents section of the *Market Regulation Handbook*.**

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

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

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

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

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

Standard Thirteen. **Each Department of Insurance shall develop a procedure for document handling, including the removal of original documents, where that is necessary, to a location other than the Department of Insurance.**
To address the issue of confidentiality, original work paper documents shall remain at the Department of Insurance, especially if the examiner is a contracted employee of the state Department of Insurance.

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

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

Standard Fifteen. **The Department of Insurance shall offer to conduct an exit conference at the end of an examination.**
The exit conference should offer the following:

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

Standard Sixteen. **The Department of Insurance shall utilize the standard report format found in the *Market Regulation Handbook*.**
Each report shall at a minimum include the following:

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

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

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

- The regulated entity has 30 days to accept the final report or request a hearing.

Standard Eighteen. **The Department of Insurance shall include the regulated entity's response in the final examination report where allowed by law.**
The response may be included as an appendix or in the text of the examination report. If it is not in the final report, the report should indicate that a response is available. The regulated entity is not obligated to submit a response. Individuals involved in the examination should not be named in either the report or the response except to acknowledge their involvement.

Standard Nineteen. **The Department of Insurance shall publish final reports as public documents where allowed by law.**
- Departments of Insurance should publish the final examination report on the Department of Insurance's website; and
- Department of Insurance shall develop a process for releasing final examination results to the public. A press release may be used.

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

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

Competency: The Continuum
SubSection: Investigations

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

The following standards apply to this competency:

Standard One. **The Department of Insurance has the necessary authority to conduct an investigation into entities.**
If the Department of Insurance has reason to believe an entity has violated or is violating any provision of the insurance code or upon complaint by any resident of its state, the Department of Insurance should have the necessary statutory authority to investigate. Such authority should include complete access to the accounts, records, documents and transactions of anyone engaging in the business of insurance.

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

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

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

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

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

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

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

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

Information should also be obtained from various NAIC databases including:

a. RIRS (Regulatory Information Retrieval System);
b. CDS (Complaints Database System);
c. MATS (Market Action Tracking System); and
d. SPLD (State Producer Licensing Database);

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

Initially, if the entity is one with a valid NAIC company code and the subject of a civil or administrative investigation, the matter should be entered into the MATS database. Should the investigation lead to an examination of a regulated entity, the status of the original MATS record should be changed to reflect this fact.

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

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

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

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

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

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

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

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

Standard Eight. **At the conclusion of any regulatory action, each Department of Insurance shall enter the appropriate information into the RIRS system.**
Each Department of Insurance shall enter the appropriate information into the RIRS database as well as update any previous information provided to MATS or other NAIC databases.

Competency: The Continuum
SubSection: Consumer Complaints

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

The following standards apply to this competency:

Standard One. **Each Department of Insurance shall have a unit or staff responsible for receiving consumer complaints and inquiries.**
The Department of Insurance shall have a separate unit or individuals whose duties are to receive consumer complaints and inquiries.
The unit or individuals have sufficient training and expertise to identify the elements of a complaint.

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

Standard Two. **Each Department of Insurance shall establish criteria defining complaints and inquiries, the method of receipt and the content required in order to accept the complaint.**
The Department of Insurance will use, at a minimum, the definition of a complaint developed by the Market Analysis Procedures (D) Working Group.

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

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

Standard Three. **The Department of Insurance shall have a process for acknowledging receipt of complaints, investigating the allegations and reporting the results of the investigation to the consumer.**
The Department of Insurance shall establish criteria for determining if the Department of Insurance has jurisdiction over a complaint and communicating that information to the consumer.

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

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

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

Standard Four. **The Department of Insurance shall have a process for identifying complaints involving violations and referring these complaints for administrative action.**
The Department of Insurance has procedures to identify complaints that require administrative action.

Standard Five. **Each Department of Insurance shall have a system for recording and tracking complaints in a database using a coding system to facilitate analysis and trending.**
The Department of Insurance shall record complaints on receipt using uniform definitions and standard coding protocols.

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

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

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

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

Standard Six. **Complaint analysts provide periodic reports to the Market Analysis Chief regarding complaint ratios, trends and significant individual complaints.**
The Department of Insurance has procedures in place and provides regular reports on complaint patterns, trends, unusual activity and significant individual complaints.

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

Competency: Interstate Collaboration

Interstate collaboration may be accomplished by the following:

- Participation with the Market Actions (D) Working Group to include, but not be limited to, participation in calls and surveys;
- Timely entry and participation in the NAIC databases;
- Notifying the Collaborative Action Designee or Market Analysis Chief of the domestic Department of Insurance when you realize you are considering one of the continuum of market actions;

- Verifying the Department of Insurance can ensure the confidentiality of materials and data as necessary; or
- Following the collaborative actions guidelines for recommendations to the Market Actions (D) Working Group.

The following standards apply to this competency:

Standard One. **The Market Analysis Chief or their designee is actively involved with the Market Analysis Procedures (D) Working Group and participates in the Working Group meetings.**

Standard Two. **The Market Analysis Chief or their designee must participate on the quarterly Market Analysis Procedures (D) Working Group/MAC conference calls**.

Standard Three. **The Collaborative Action Designee or their designee is actively involved with the Market Actions (D) Working Group.**

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

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

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

Standard Seven. **Referrals to the Market Actions (D) Working Group are made when appropriate and when material issues may impact other jurisdictions. Referrals should be made by the Collaborative Action Designee, Deputy Insurance Commissioner, Insurance Commissioner or other individual designated by the Commissioner.**

Standard Eight. **Department of Insurance referrals and accompanying materials to the Market Actions (D) Working Group are provided in the format developed and approved by the Working Group or the NAIC Market Regulation and Consumer Affairs (D) Committee, as appropriate.**

Standard Nine. **In instances where the Market Actions (D) Working Group refers an issue to the Department of Insurance, and the Department of Insurance accepts responsibility for following through with the recommendation, the Department of Insurance reviews the issue in a timely manner and responds timely and appropriately to the Market Actions (D) Working Group.**

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

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

Standard Twelve. **The Department of Insurance notifies the Market Actions (D) Working Group when a material issue has been detected and the regulated entity has offered to take corrective action in all impacted jurisdictions.**

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

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

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

Competency: Interstate Collaboration
SubSection: Collaborative Action Designee

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

The following standards apply to this competency:

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

Standard Two. **The CAD or his or her designee is actively involved with the Market Actions (D) Working Group.**
The CAD or when unavailable, a designee assigned by the CAD, shall participate in all Market Actions Working (D) Group meetings or conference calls that are opened to non-working group member regulators. If the state does not have a designee attending national meetings, the CAD or designee shall participate in each quarterly Market Actions (D) Working Group/CAD conference call.

Standard Three. **The Department of Insurance has procedures for the CAD to communicate with appropriate Department of Insurance staff regarding potential collaborative action issues and ongoing collaborative actions.**
The CAD shall advise the appropriate staff in areas including, but not limited to consumer services, enforcement, market analysis and market conduct of the role of the CAD and procedures to notify the CAD of compliance issues that may affect multiple jurisdictions.

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

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

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

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

Standard Five. **When authorized by the Department of Insurance Commissioner or Director, the CAD prepares referrals to the Market Actions (D) Working Group for potential collaborative actions affecting multiple jurisdictions.**
The CAD shall follow the procedures of the Collaborative Actions Guide in the *Market Regulation Handbook* or the Market Actions (D) Working Group Procedures/Participation Guidelines, as appropriate, to determine if the matter should be referred to the Market Actions (D) Working Group.

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

Standard Six. **The CAD shall follow-up on Market Actions (D) Working Group referrals and if requested, report to the Market Actions (D) Working Group.**
If the Market Actions (D) Working Group referral results in the Department of Insurance becoming a lead state in the collaborative action, the CAD shall coordinate the Department's handling of the matter and report as requested to the Market Actions (D) Working Group and other CADs.

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

Standard Eight. **If the Market Actions (D) Working Group refers a matter to the Department of Insurance, the CAD shall relay the referral to the appropriate Department staff in a timely manner and respond appropriately and timely to the Market Actions (D) Working Group regarding the referral.**

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

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

VOLUME II—FOREWORD
What is Market Analysis

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

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

Market analysis can enable a regulator to do the following:

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

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

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

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

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

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 was 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.

Updates to the *Market Regulation Handbook*

This handbook is updated and released on an annual basis. Instructions for accessing the updates on the NAIC website are located at the front of the most recently published *Market Regulation Handbook*.

Chapter 6—Basic Analytical Tools

A. Market Conduct Indicators and Priorities

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

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

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

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

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

Other factors for state regulators to consider when setting priorities include consumer complaint activity and the lines of insurance transacted. Some lines of insurance are more prone than others to particular types of market conduct problems. A more proactive market regulation program is generally better suited to personal lines than to commercial lines and generally better suited to small business markets than to other commercial lines markets. However, none of these criteria should be applied too rigidly. There is no foolproof way to predict which market issues will rise to the forefront, as demonstrated, for example, by the impact on the health care market of the problems many states have been experiencing with their medical malpractice insurance markets and by the broad-ranging consequences of the property insurance market's response to Sept. 11, 2001.

B. NAIC iSite+

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

iSite+ provides state insurance department regulators with access to applications used by regulators. Regulators may access iSite+ via the myNAIC link on the NAIC website. In order to log into myNAIC, regulators must have an active NAIC Oracle account and password login. Regulators who do not have myNAIC login credentials or do not remember their user ID and password should contact their insurance department IT Liaison.

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

C. Use of Complaint Data in Market Analysis

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

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

- Complaints are to some degree anecdotal and often are not documented in sufficient numbers to be statistically credible. Although this deficiency can be mitigated to some degree by using multistate data, inconsistencies between different state approaches raise other concerns;
- One reason for the small sample size is that not every problem gives rise to a documented complaint. States need to gauge how informed state consumers are about voicing concerns or complaints regarding insurance;
- Conversely, the customer might not always be right. The presence of a complaint points to the existence of a conflict, but not the nature or the cause. A complaint could be the result of an insurer failing to live up to its obligations or the result of a breakdown in communications, but it could also be the result of unrealistic expectations on the part of the consumer. To address this concern, "confirmed" complaints should be distinguished from other consumer complaints;
- There are some lines of insurance for which there are no useful complaint records, because the nature of the business makes it unlikely that consumers will file complaints or the insurance department does not have an active complaint resolution program. For example, violations of disclosure requirements might never generate complaints because, in the absence of disclosure, consumers do not know their rights have been violated. Similar problems also arise when premiums or benefits involve complex calculations because of the nature of the product; and
- Some markets are inherently more prone to complaints than others. For example, this is likely to be true for the high-risk sector within any line of insurance. Such differences must be taken into account before trying to compare the performance of different companies serving different markets. When problems appear with life insurance, they are less likely to become visible through the consumer complaint process. Similarly, complaints are more likely in lines of business where consumers have more frequent interactions with their insurer, such as health or personal auto, regardless of how serious the potential problems might be.

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

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

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

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

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

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

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

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

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

D. Use of Annual Statement Data in Market Analysis

Market Conduct Annual Statement

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

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

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

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

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

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

Currently, MCAS data is collected on individual life cash and non-cash value products, individual indexed fixed, individual other fixed, individual indexed variable, and individual other variable annuities, individual stand-alone and hybrid long-term care policies, private passenger automobile policies, homeowners policies, in-exchange and out-of-exchange health plans, disability income plans, lender placed home and automobile policies, private flood, travel and short-term limited duration plans. The line of business "Other Health" MCAS data will first be collected for the 2023 data year reported in 2024.

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

Additional information regarding the Market Conduct Annual Statement program may be found at *https://content.naic.org/mcas-2023.htm* or by contacting NAIC Market Regulation Department staff.

Financial Annual Statements

The most comprehensive source of data on the financial aspects of insurers' activity in the marketplace are the annual (and quarterly) financial statements, which an insurer is required to file with its state of domicile, the NAIC and, in most instances, all jurisdictions in which the insurer is authorized to transact business. These statements include specific schedules and interrogatories that provide detailed information, such as premium volume, losses and changes in business. The NAIC compiles a wide variety of reports from the filed financial statements and makes them available to state insurance departments at iSite+. Financial statement data has value for market analysis on several levels and sometimes will allow regulators to identify companies with an increased risk of future compliance problems, allowing regulators to respond proactively before serious problems occur.

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

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

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

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

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

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

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

Financial statement data also allows the calculation of "reverse market share" information—since companies report premium written by state, it is apparent how a state fits into the company's overall operations, what the rest of its market looks like and how that pattern compares to other companies doing business in a regulator's state marketplace.

For property/casualty companies, market share information is readily available on iSite+ in the NAIC's financial market share summary report titled, "Market Share—By Line of Business," which can be calculated for any line of business as reported on the annual statement Blank or for any combination of up to 10 lines of business. This report indicates the market share by company, by line of business, as well as relative loss ratio.[4] This report is based on three columns from the State Page: Direct Premiums Written, Direct Premiums Earned and Direct Losses Incurred. Market share for each company is calculated by dividing Direct Premiums Written for that company by total Direct Premiums Written. Data for Property and Health companies is included in this report.

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

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

The loss ratio information will help identify companies with greater contact with consumers through the claims settlement process and significant deviations from the norm could indicate financial stress if the loss ratio is too high—or the potential for concerns about claim handling or underwriting practices if the loss ratio is unusually low. It must be kept in mind, however, that what might be considered a "normal" loss ratio—consistent with profitable operations—may vary significantly, depending upon the line of business and (especially for "long-tail" lines of business) upon changes in general economic conditions.

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

The Insurance Regulatory Information System (IRIS) tool, based on financial statement data, should also be noted. Although the IRIS ratios were developed to assist solvency regulators, they also capture some information that can be useful to market analysts.

E. Issues Specific to Particular Types of Companies

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

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

Property/Casualty Insurance
Personal lines property/casualty coverage is another key focus of consumer assistance and complaint resolution programs. Because a high proportion of consumer concerns in these lines of business relate to claims and to policy termination; often the two go together. This is a dynamic market with many emerging issues, such as the use of credit scoring in underwriting and rating. Other issues include concerns raised by consumer advocates that some companies may be using underwriting guidelines that have the effect of limiting the availability or quality of insurance to certain groups. There are significant state-to-state variations in property/casualty lines of business. Many of the variations in the liability insurance markets reflect variations in the underlying substantive laws giving rise to the liability exposure. This is especially true for automobile insurance, where several states have modified the traditional tort law for automobile collisions with some form of "no-fault" coverage.

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

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

F. Other Useful Information

While complaint records and financial statements may be the most comprehensive and concentrated sources of data on market activity, there are many additional sources that should be reviewed in order to obtain the rest of the story. For example, a high proportion of the activity in the insurance marketplace involves licensed insurance producers. Records of disciplinary actions or appointment terminations may reveal patterns of questionable practices in certain market sectors or implicating certain companies. Even routine activities, such as increases or decreases in new licenses or appointments or changes in lines of authority, can be indicative of market trends which might warrant further inquiry to evaluate whether the effects are positive, negative or mixed. The information contained in this handbook provides additional resources for assisting with the analysis of a company. This handbook contains information about matched pair testing, rating territories and underwriting guidelines, which may be helpful if the initial analysis has indicated a potential area of concern.

Financial Reporting (Public and Private Sector)
Statutory annual and quarterly statements are the principal source of financial information on insurers, but they are not the only source. If the insurer is publicly traded, it will also be filing with the U.S. Securities and Exchange Commission (SEC). There are a variety of private-sector sources that compile and evaluate financial information, such as rating agencies, statistical and ratemaking advisory organizations, trade associations, securities analysts and academic and nonprofit research institutions. Some of these data compilations are directed towards specialized information, such as claims activity, that is also of particular interest to market regulators. Surveys and reports on particular topics by research institutions, consumer groups and trade organizations may also yield valuable data.

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

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

Communication Between Work Units
As mentioned above in the discussion of complaint information, anecdotal information of various kinds can also be valuable even when it cannot be measured and reduced to numbers. The rewards of quantitative analysis can bring with them the risk of "not seeing the forest for the trees." Thus, a continuous dialogue with regulators in other areas with a department of insurance is essential, as issues arising in other areas may be mirrored by related problems consumers are having with the same companies or markets. For lines of business that are subject to form or rate review or certification, incidents where a company has been observed using unapproved or improperly certified rates or forms should trigger further inquiry, since such incidents often are part of a wider pattern.

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

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

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

Self-Audits and "Best Practices" Reviews

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

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

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

In some states, self-evaluative privilege statutes provide specific guidance on the regulators' access rights and confidentiality obligations, whereas regulators in other states must consider a variety of issues related to the protection of proprietary information, attorney work product, trade secrets and other privileged information. Addressing these concerns and working with companies' voluntary review activities is important, because a full understanding of a company's market activities encompasses the company's policies and the practices that implement the company's policies. An active compliance program at a company often reflects a corporate culture that places a high value on compliance. Since "bottom-up" information on a company's market practices is more accessible to regulators, the "top-down" policy focus often found in insurer peer reviews can be a useful complement to the information that is otherwise available.

Consumer Dispute Resolution Processes

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

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

Matched Pair Testing

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

Rating Territories

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

Miscellaneous

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

Other information collected by some regulators, though not necessarily available in all states, includes underwriting guidelines, detailed geographic market performance data, surveys of market participants and marketplace testing. Detailed geographic data—such as ZIP code data by company and type coverage—has been used by some regulators to identify underserved markets and investigate redlining allegations. Surveys of market participants—including agents, realtors and consumers—are another source of real-time market performance information. Testing—sending people to purchase insurance who have similar risk characteristics but different races or other characteristics that may make them targets of unfair discrimination—adapts a tool that has long been used in the fields of housing, lending and employment to verify compliance with fair practices. In addition, a review of recent insurance-related lawsuits can provide insight into consumer perceptions of market abuses, and this information is publicly available.

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

Chapter 7—Putting It All Together: Market Analysis

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

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

A. Framework for Market Analysis

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

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

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

To accomplish its purposes, market analysis has an array of tools for states to use. The first of these is the Market Analysis Prioritization Tool (MAPT) available from the NAIC. This tool is designed to provide states a quick overall look at their marketplace for a particular line of business. The Market Analysis Prioritization Tool (MAPT), released in 2006, creates a weighting system to assist analysts in prioritizing companies. The Market Analysis Prioritization Tool will provide the analyst a high level comparison of companies for a particular line of business based on financial, complaint and regulatory activity information available from NAIC databases. States should use this tool to identify companies that need further, more detailed analysis and elevate these companies to a Level 1 Review. The information obtained from this tool is merely an indicator of a potential regulatory problem. Normally, additional research and investigation is required to draw a final conclusion about actual behaviors than what is available at this level of analysis.

The Level 1 Review is a second tool available to the states in their market analysis process. This tool involves looking at much of the same data in the Market Analysis Prioritization Tool (MAPT) but on a more detailed and thoughtful basis. Whereas the Market Analysis Prioritization Tool identifies companies based on certain formulas

and overall company performance, the Level 1 Review requires a more detailed and thoughtful analysis, where the analyst looks at company-specific information to determine if the anomalies can be explained. A Level 1 review is a more detailed review of certain information contained in NAIC databases, and is available to the analyst through the Market Analysis Review System (MARS). It is critical for the state to do this review to eliminate companies that do not warrant further analysis and to begin the process of identifying the cause of the anomaly for those that do warrant additional analysis.

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

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

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

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

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

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

B. Developing a Market Analysis Program

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

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

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

Step 2—Establish a Systematic Procedure for Interdivisional Communication
Market conduct problems do not occur in a vacuum. Complaint activity, legal issues, financial concerns or irregularities in rate and form filings often accompany them. At the same time, market conduct problems may be an early warning sign of other problems with a company, so it is essential for information to be shared and discussed between the MAC and other department staff. This should be done on a systematic basis, including, at a minimum, a quarterly questionnaire requesting other work areas within the department to report unusual activity that may be of interest to the MAC, such as patterns of adverse financial data, consumer complaints, policy termination activity, producer misconduct or use of noncompliant forms or rates.

Step 3—Identify Warning Signs that All Staff Should Share with the MAC
In particular, all insurance department staff should report any of these indicators to the MAC when the information is received in the department (e.g., annual statements, holding company reports, license transactions):

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

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

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

Step 4—Develop and Instruct Complaint Analysts in Key Indicators in Complaint Data
Complaint analysts in the insurance department should report the following types of information to the MAC at the time the insurance department receives this information:

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

Step 5—Identify Potential Problems from Complaint Ratios
Complaint ratios should be reviewed annually at a regular time and the MAC should use information generated on insurers with ratios outside of the norms, along with other information about those companies available in the department, to determine whether any further review is necessary. Through the use of complaint ratios, regulators are able to properly gauge not only long-term trends, but more importantly, to monitor frequent problems or developing areas of concern to determine whether an inquiry should be generated or if prompt regulatory action is required. After compiling complaint ratios for the individual insurers, the department can compare the ratios to determine which companies lie outside the average in a given year and to compare an individual insurer's ratio with the previous year. For example, an increase in the number of complaints can indicate a change in claims practices.

Step 6—Annual Statement State Page and Other Financial Indicators Should Routinely Be Shared with the MAC
Every insurer—foreign as well as domestic—is required to file a State Page with each state in which it is licensed, to show changes in the company's business in the state. In most insurance departments, a significant amount of staff resources are devoted to the review and analysis of financial statements. While such financial analysis should be primary, at some point after the Blanks are received, the MAC should be routinely advised of:

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

Step 7—Market Conduct Annual Statement
If a state participates in the Market Conduct Annual Statement (MCAS) project, that data should be reviewed as part of market analysis.

Step 8—Establish a Market Analysis Program on a Coordinated Schedule and Conduct Baseline Analysis
On a coordinated basis, states should conduct baseline analysis as outlined in the Framework for Market Analysis document, reproduced in Section A of this chapter. All states should analyze the various data elements and indicators within the same general time frame to assist in the coordination of possible collaborative actions. Results should be compiled and reviewed quarterly. If state Market Analysis Chiefs (MACs) find an issue with a particular company, they can share information with their state Collaborative Action Designees (CADs). CADs can then contact other state CADs to compare the most current information and determine if a collaborative action or a Request for Review (RFR) to the Market Actions (D) Working Group is in order.

Step 9—Conduct Level 1 Analysis via the Market Analysis Review System (MARS)
The Market Analysis Procedures (D) Working Group is responsible for the MARS Level 1 areas of review and questions. Level 1 Analysis questions have been reproduced in Chapter 10 of this handbook. Level 1 Analysis questions are subject to annual review by the Market Analysis Procedures (D) Working Group and state insurance regulators.

Step 10—Conduct Level 2 Analysis via the Market Analysis Review System (MARS)
A Level 2 Analysis allows market analysts to further investigate and review a company, without the need to contact the company. Unlike the initial analysis or Level 1 Analysis, a Level 2 Analysis requires the market analyst to seek input and gather information from sources outside of the NAIC databases and the company's financial and market conduct annual statements. By its very nature, a Level 2 Analysis is much more labor intensive than a Level 1 Analysis. To assist market analysts in completing a Level 2 Analysis of a company, the Level 2 Analysis Guide has been developed. The guide consists of six core areas of review and an additional 15 potential areas that the market analyst may review when performing a Level 2 Analysis. For each area of review, the guide includes information about the area to be reviewed and, where applicable, potential resources to aid in the review of that area. The guide also provides the user with specific items to consider during the review of a particular area. The Level 2 Analysis Guide is contained Chapter 11 of this handbook.

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

Step 11—Coordinate Regulatory Actions through the Market Actions (D) Working Group
Concerns resulting from market analysis that appear to focus on a small number of states should be brought to those states' attention by communication through state Collaborative Action Designees (CADs). Plans for regulatory actions, including examinations and investigations, that focus on companies of national significance should be referred by CADs to the Market Actions (D) Working Group through a Request for Review (RFR).

C. Identifying Markets and Companies for Analysis

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

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

Additional Uses for Market Share Information

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

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

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

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

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

D. Baseline Analysis

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

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

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

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

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

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

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

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

How to Conduct Baseline Analysis

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

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

After the reports are downloaded, an analyst may:

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

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

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

Other Methods Used to Conduct Baseline

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

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

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

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

E. How to Analyze Consumer Complaint Data

In order to conduct a systematic and focused analysis, it is necessary to develop meaningful numerical indicators which will allow regulators to make comparisons between companies and track the activities over time of each company and of market averages. Outliers—companies whose complaint activity significantly exceed industry norms, historical conditions or established best practice guidelines—can be singled out for individualized attention.[6]

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

Basic Complaint Ratio Analysis

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

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

[6] Of course, the identification of a company as an outlier may be the result of factors entirely unrelated to the company's actual performance in the market. For example, a report once identified a company as having a complaint index of 2,189,763.36730—that is, a complaint frequency more than two million times higher than "expected," based on the company's premium volume. However, this statistic was based on $1 in reported premium and a single consumer complaint.

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

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

Definition of "Confirmed Complaint"
The NAIC definition of a confirmed complaint, as adopted by NAIC membership, is:

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

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

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

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

Key revisions to CDS complaint coding and mapping included:

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

Implementation called for each state to convert to the new coding plan, with the assistance of NAIC staff, over a five-year conversion period (2011-2015). Following conversion, states reported complaints to CDS using the new coding plan. Prior to converting to the new coding plan, states reported complaints to CDS using the previous coding plan. The NAIC converted these complaints, upon receipt, to the new coding plan. As of December 13, 2010, all historical complaint data in CDS was converted to the new coding plan.

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

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

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

*Note: After a state implemented the new complaint coding plan, referenced above, the state no longer uses the above-referenced complaint disposition codes to determine if a complaint is confirmed; upon implementation of the new coding plan, states submit either a "Yes" or "No" confirmed status, indicating if a complaint is confirmed or not, based upon the state's analysis of the consumer complaint.

Complaint Ratios
A company's complaint ratio is defined as:

(number of confirmed complaints)
(gross premium written [in thousands of dollars])

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

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

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

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

Complaint Index
A complaint index is defined as:

(complaint ratio for the company)
(complaint ratio for the aggregate market)

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

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

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

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

The "complaint share" is defined in the same manner as a company's market share; i.e., by dividing the company's complaints by the aggregate number of complaints in the relevant market.[7] This is the format in which the NAIC CDS compilations are presented on iSite+.[8] When doing the actual numerical calculations, in order to minimize rounding errors, the relevant data should be input directly, so that the complaint ratio is calculated as:

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

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

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

670 confirmed complaints/$61 million in premium: 670/61000 = 0.011

This corresponds to complaint indices for the three insurers (rounded to two decimal places) of:[9]

Insurer A	0.010/0.011	0.91
Insurer B	0.015/0.011	1.37[10]
Insurer C	0.020/0.011	1.82

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

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

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

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

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

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

- Although complaint indices should be calculated by line of business if possible, their accuracy depends on the availability (and the use) of accurate confirmed complaint counts by line of business. Complaint ratios and complaint indices draw a misleading picture if the complaint count and the gross premium figure are based on different sets of policies;
- Premium volume may not be the best measure of market activity in many lines of business, particularly annuities and life insurance. States should give strong consideration to supplementing their basic complaint analysis with an alternative complaint index calculation based on policy count, when that information is available. For life insurers, the number of policies and group certificates in force is reported on the State Page, itemized by the type of coverage;
- Complaint indices can be misleading for companies with small market presence. In particular, it is not appropriate for published tables or rankings to include (at least without a conspicuous disclaimer) companies whose complaint indices would be significantly different with one or two more or fewer confirmed complaints;[11]
- Using more states and/or more years provides a larger sample size, but this will only give more accurate results if the information from other states or earlier years is comparable. Inaccuracies may result from changes in company behavior over time, different company practices or market conditions in other states or inconsistencies in the ways different states gather or report complaint data. For example, all other things being equal, if the average policy in a given state is half as expensive as in a neighboring state, then complaint ratios, calculated by premium volume, will be twice as high in that state as the same level of complaint activity would generate in a neighboring state; and
- A CDS Closed Complaint Summary Index Report can be run, using complaint information from one year and premium information from a different year, allowing multiple complaint years to be compared to a common baseline. This corrects for the effects of general economic conditions, such as inflation on premium growth, but will create other distortions when premium volume changes for other reasons.

Reports from the NAIC Complaints Database System

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

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

- **CDS Closed Complaint Summary Index Report**—Displays the 1) market share (total business line premiums for the company in a specified state or zone/total business line premiums for all CDS companies in the specified state or zone) and 2) complaint share (total CDS complaints for the company writing the designated line of business in a specified state or zone/total CDS complaints for all companies

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

writing that line of business in the selected state or zone) for the selected company based on specific lines of business. An index of 1.0 indicates that the company had a percentage of complaints equal to its percentage of premium written for the coverage type and state(s) selected. The report is available only for those firms that have both closed consumer complaints and premiums reported through submission of their annual financial data to the NAIC. Current complaint year data is available on July 1st of the current year.

- **CDS Summary Closed Complaint Counts by Code Report**—Displays the number of complaints selected for an entity based on various complaint codes (type, reason and disposition) based on the criteria selected.
- **CDS Summary Closed Complaint Counts by State Report**—Displays an alphabetical list of all NAIC member jurisdictions with a count of the number of complaint records in the database for an entity based on the criteria selected.
- **CDS Summary Closed Complaint Trend Report**—Displays the number and percent of change in closed complaints for an entity, based on the criteria selected. The information is displayed for the current year and the previous five years, as well as monthly detail for the past 36 months.
- **CDS Closed Complaint Participating State Report**—Lists by state/territory the number of closed complaints entered in CDS, the earliest record closed data, the most recent record closed date and the most recent entry date. This report is useful in determining which states/territories are actively participating in submitting complaint records to CDS.

The NAIC also publishes complaint index information for the general public through its Consumer Insurance Search (CIS). These reports calculate complaint indices on a nationwide basis, based only on confirmed complaints, and rebalanced so that a score of 1.00 represents the median company for a particular line of business[12]—half the companies in that line of business had better complaint ratios for that year, while the other half had worse, rather than the mean complaint ratio overall. To illustrate the difference, the median complaint index for group health insurers in 2002 was 1.28. This indicates that most companies in this line of business had complaint indices noticeably greater than 1.00—the most likely explanation for such a result is that those companies with high complaint indices tended to be smaller companies (or companies for which group health was not a major line of business), while the larger group health writers tended, on average, to have fewer complaints relative to premium volume.[13] This brings down the average, so that a company could have a better complaint record than most of its competitors, but still have a complaint index of 1.1.

Therefore, the CIS would report such a company's complaint score as 1.1/1.28 = 0.86, highlighting its performance relative to other companies rather than its proportionate share of the nationwide complaint total.[14]

F. Market Conduct Annual Statement Data

The Market Conduct Annual Statement (MCAS) is a uniform method for states to collect key data elements. Currently, MCAS data is collected on individual life cash and non-cash value products, individual indexed fixed, individual other fixed, individual indexed variable, and individual other variable annuities, individual stand-alone and hybrid long-term care policies, private passenger automobile policies, homeowners policies, in-exchange and out-of-exchange health plans, disability income plans, lender placed home and automobile policies, private flood, travel and short-term limited duration plans. The line of business "Other Health" MCAS data will first be collected for the 2023 data year reported in 2024.

[12] The CIS report refers to the rebalanced complaint index as a "complaint ratio," but that is different from the way that term is used in this guide.

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

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

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

G. How to Analyze State Page Data

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

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

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

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

Review Data for Significant Changes in Premium Volume

The list of licensed companies and changes in premium volume needs to be examined to find the companies with significant fluctuations in premium volume since the prior year. The initial analysis of premium volume should aim at focusing state insurance department resources on companies with the most significant changes. Every insurer's premium volume changes every year, so the analyst should be looking for dramatic growth (33 percent or more) or decline (10 percent or more) in one or more lines of business in the state. Since most changes are increases, the normal range for increases is broader than the normal range for decreases.[15] Schedule T, on all three types of statement blanks, provides a state-by-state breakdown of premium activity; and it may be useful to check this schedule to compare activity in other states and identify regional or national trends.

Market analysis of the State Page data when it is filed in March provides a good opportunity to double-check whether all state insurance department staff are aware of and are alerting the department's MAC of the warning signs noted above. The March annual statement filings should rarely be the first notice that the department receives if an insurer has had significant premium fluctuations or other unusual financial results in the prior year. Usually, some preliminary indication was already present in the quarterly reports or some other source of current information.

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

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

- Does the change correlate with complaints filed against the insurer?
- How many rate, rule and form filings has the company made? Does the number, compared to the change in the company's writings, suggest that the company is using a rate structure that is not filed or not approved, if required for that line of business?
- Is the increase in premium volume due largely to an increase in the number of risks assumed or due largely to rate increases?[16]
- If there are significant rate increases, do they reflect trends in the overall market or is the company an outlier?
- If the company's writings have changed, have the numbers of agents changed accordingly?
- How many agent appointments and terminations has the company made?
- For what lines are they licensed?
- If the company's writings have changed, have the number of adjusters changed? (If relevant to the line of business in question and the state requires a license for adjusters or this information is otherwise available.)

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

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

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

[16] In lines of business where rates are not filed, this will be more difficult to ascertain.

Review Data for Changes in Reserves

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

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

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

Review Loss Ratio Data

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

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

Review Data on Defense Costs

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

Chapter 8—Enhancing State Market Analysis

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

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

Below are some examples of possible approaches.

A. Improving Consumer Complaint Analysis

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

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

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

1. Key Elements of Best Practices

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

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

> A complaint is **"any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose."**[17]

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

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

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

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

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

- Insured;
- Service provider; and
- Other.

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

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

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

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

2. More Detailed Information on Complaints and Regulatory Actions

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

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

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

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

3. Calculating Complaint Ratios by Number of Policies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Confirmed Complaints
The definition of a confirmed complaint, as adopted by NAIC membership, is:

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

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

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

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

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

B. Use of myNAIC and iSite+ in Market Analysis

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

MyNAIC was created by the NAIC in June 2016 to serve two purposes: 1) it is a web page from which publicly available NAIC tools can be accessed, and 2) it serves as a web page which allows regulators to have a single page from which to access regulator-only NAIC/NIPR/Compact tools. Regulators may access myNAIC by clicking the myNAIC link on the Regulator tab at *www.naic.org*; then clicking on "Login" in the upper right corner of the myNAIC public applications web page. The applications on the myNAIC regulator-only web page are based upon the roles associated with a regulator's myNAIC password and user ID.

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

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

C. Use of IRIS Ratios in Market Analysis

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

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

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

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

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

- **Property/Casualty—Change In Net Premiums Written (P/C Overall Ratio 3)**
  Major increases or decreases in net premium written can indicate a lack of stability in the company's operations and/or management. A large increase in premium may signal an abrupt entry into new lines of business or new jurisdictions—this could have market conduct implications even if the new business is profitable financially. In addition, a company that is attempting to increase cash flow in order to make loss payments may do this by taking on risky or unprofitable business. A large decrease in premiums indicate the discontinuance of certain lines of business, scaled-back writings due to large losses in certain lines, loss of market share due to competition, or increased use of reinsurance.

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

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

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

- **Property/Casualty—Adjusted Liabilities to Liquid Assets (P/C Liquidity Ratio 9)**
  This ratio is a measure of the company's ability to meet the financial demands that may be placed upon it. If the company's ratio is out of the norm in this area, there may be problems with its ability to pay claims.

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

- **Life/Health—Net Change in Capital and Surplus (Life/A&H Overall Ratio 1)**
  This ratio compares the company's surplus in the current and immediately preceding years, adjusted to disregard capital and surplus paid-in to reflect the impact of operations on capital and surplus. It is considered the most general measure of improvement or deterioration in a company's financial condition during the year.

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

- **Life/Health—Gross Change in Capital and Surplus (Life/A&H Overall Ratio 2)**
  This ratio is similar to the Net Change in Capital and Surplus ratio, but it takes into account capital and surplus, including surplus notes, paid-in during the year.

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

- **Life/Health—Change in Premium (Life/A&H Change in Operations Ratio 9)**
  This ratio represents the percentage change in premium from the prior year to the current year. This ratio is not calculated for a newly formed company because of the lack of prior year data. The calculation is the change in total premiums, deposit-type contract fund considerations and other considerations from the prior year to the current year, divided by total premiums, deposit-type fund considerations and other considerations for the prior year.

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

- **Life/Health—Change in Product Mix (Life/A&H Change in Operations Ratio 10)**
  This ratio represents the average change in the percentage of total premium from each product line during the year. The calculation of this ratio begins by determining the percentage of premium from each product line for the current and prior years. Next, the change in the percentage of premium between the two years is determined for each product line and expressed as a positive number, whether it is an increase or a decrease. Finally, these differences are averaged by adding them (without regard to sign) and dividing by the number of product lines. Lines for which total premiums for either year are zero or negative are excluded.

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

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

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

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

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

D. The Use of Underwriting Guidelines in Market Analysis

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

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

Although underwriting judgment is at the heart of insurers' business practices in almost every area of insurance, there are a variety of reasons why underwriting practices differ for different lines of insurance. The more complex the risk insured, the more underwriting practices may differ from company to company and from risk to risk. The primary focus of this discussion is personal lines property/casualty coverage and, therefore, regulators must keep in mind that when considering other lines of insurance, not all of the concepts discussed here will apply. For

example, annuities typically are not underwritten at all; life insurance is often written as a whole life contract or as a term contract with guaranteed renewal at a set rate for an extended period of time; and many health insurance markets are subject to laws requiring guaranteed issue, guaranteed renewal and limits on rate variation.

1. The Significance of Underwriting Guidelines

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

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

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

2. Reviewing Underwriting Guidelines

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

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

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

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

3. Use of Information Obtained from Underwriting Guidelines

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

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

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

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

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

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

Example of Compilation of Underwriting Guidelines for Private Passenger Auto

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

Conclusion

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

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

E. Modes of Analysis

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

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

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

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

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

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

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

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

Identify underserved and noncompetitive markets: Markets are typically defined by line and by geographic location, perhaps the state or perhaps a more local unit. It is important to recognize that market operation can also be impacted by demographic factors, such as level of urbanization and income. For example, automobile insurance costs are significantly higher in high-density, low-income areas, especially when these factors are

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

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

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

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

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

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

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

Chapter 9—iSite+ Reports

The NAIC systems contain a variety of data related to companies and individuals operating in the insurance industry. Insurance department personnel and NAIC staff may receive access to the NAIC databases through iSite+. The reports in this chapter are confidential, for regulator use only. Several reports may require a role assignment to the regulator user's ID or specific permissions enabled in order to view and/or add report content.

In many of the reports described in this chapter, regulators can inquire about a company or individual and readily identify which applications contain information about that entity. The NAIC also provides many sources of market analysis information to state regulators. In particular, summary reports provide a variety of financial and market conduct information. Most of these reports provide information related to a group of entities with similar attributes (e.g., companies that write business in a particular state), rather than individual entities.

The following is not a list of all reports currently available on iSite+. A current, comprehensive listing of all available iSite+ reports, their descriptions and how they can be used by regulators is available in the Index of Help Topics on iSite+. To obtain a history of iSite+ updates, click on Documentation on the Welcome tab in iSite+.

Market-related reports can be categorized as follows:

1. Market applications;
2. Market analysis summary reports; and
3. Other NAIC resources.

1. Market Applications

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.

Complaints Database System (CDS)

The Complaints Database System contains information about closed consumer complaints filed against insurance entities and producers. The information contained in this database may be submitted by states at varying times and should be used only as an indicator. There are four closed consumer complaint reports available for selected entities and National Producer Numbers: closed complaint counts by code, closed complaint counts by state, closed complaint trend report and closed complaint index.

Market Action Tracking System (MATS)

The Market Action Tracking System 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).

Market Analysis Prioritization Tool (MAPT)

The Market Analysis Prioritization Tool, released in 2006, expands upon the Company Listings by creating a scoring system so companies can more easily be prioritized. MAPT utilizes key market and financial components, from state and national sources, to generate weighted ratios on which the prioritization is based. Key market regulation components used in MAPT vary by line of business. They include, but are not limited to: losses, expenses and premiums, enrollments, regulatory actions, complaints, examinations and demographics.

Market Analysis Review System (MARS)

MARS is available to regulators for the purposes of tracking, recording and reviewing Level 1 Analysis and Level 2 Analysis done by other states, as defined by the Market Analysis Procedures (D) Working Group. In order to submit data into MARS, a role assignment must be granted to the user's Oracle ID.

Regulatory Information Retrieval System (RIRS)

The Regulatory Information Retrieval System contains records of regulatory actions taken by participating departments of insurance against insurance producers, companies and other entities engaged in the business of insurance.

Special Activity Archive PDF

The Special Activity Archive PDF consists of SAD records—other than 1033 waivers and denials and FINRA actions—which were migrated from the Special Activities Database (SAD) as it existed on December 1, 2016, and which were less than 7 years old based upon the SAD entry date. SAD had contained information related to market activities and legal actions involving entities engaged in the business of insurance. Not all states actively participated in SAD. SAD was no longer functional as of December 2, 2016.

1033 waivers and denials which were previously located in SAD were migrated to the 1033 State Decision Repository on December 1, 2016. FINRA actions that were in SAD are available through FINRA's Broker Check public website.

NAIC staff will, on a yearly basis, remove SAD records that are more than 7 years' old and create and post an updated Special Activity Archive PDF on iSite+. Regulators are able to perform searches of the data in the Special Activity Archive PDF. The absence of data in the Special Activity Archive PDF is not conclusive information that no market activities are or have been under investigation or that no legal actions have been taken against an entity.

2. Market Analysis Summary Reports

CDS Closed Complaint Summary Index Report

The Closed Complaint Summary Index report gives the user the option to choose a grouping of U.S.-domiciled insurers filing an annual financial statement with the NAIC, with a designated line of business for a specific state(s), premium year and complaint year. Users may also choose a comparison grouping of states, if desired.

Life Policy Locator Report

The Life Policy Locator report lists details concerning consumer requests to locate and identify individual life insurance policies and annuity contracts of a deceased family member. This report is useful in determining the number of consumer requests, the number of found policies and the insurer associated with the policy.

Market Action Tracking System (MATS) Detailed Report

The Market Action Tracking System (MATS) Detailed report allows regulators to review a list of examinations and other market actions based on business practices reviewed. The report allows for searching by domiciliary state, action type, entered date, status of action, and nature of violations. The report also displays the company name, NAIC company code and line of business.

Market Analysis Market Share Report

The Market Analysis Market Share report lists the market share and premiums for the past three years for companies matching the line of business and state grouping criteria selected.

Market Analysis Profile (MAP) Demographics

The Market Analysis (MAP) demographic information is composed of data received from the various market regulation applications. This data is submitted to the NAIC with updates and when a regulatory action or closed consumer complaint is submitted. Market analysis demographics include the firm name, federal employer identification number (FEIN) and the NAIC entity number.

Market Analysis Profile (MAP) Reports

The following reports pull data from other areas within iSite+ in order to create comprehensive reports, without the regulator having to manually retrieve the data from multiple locations:

- State-Specific Premium Volume Written—5 Years: This report is a summary of the data on the Schedule T report for a five-year period for those companies filing a property, life, health, fraternal or title annual statement. This differs from the Schedule T report under "Financial Company Search," as those reports are national in scope and each report is for a single specified year;

- Modified Financial Summary Profile—5 Years: This report is similar to the profile reports available under "Financial Company Search" for the state of the user requesting the report. It is limited to those companies filing a property, life, health, fraternal or title annual statement;

- Confirmed Complaints Index Report—5 Years: This reports lists the index, complaint share, complaint count, U.S. market share and premiums written for the specified company for a five-year period. The complaint index report allows the user to select policy types, instead of including all policy types;

- Regulatory Actions Report—5 Years: The Regulatory Information Retrieval System (RIRS) contains regulatory actions taken by participating departments of insurance. A summary of the RIRS information appears below the identifying demographic information. The actions are listed in reverse chronological order from the "Action Date;"

- Closed Complaints Report—5 Years: The closed complaints report displays the number of complaints selected for an entity or National Producer Number based on various complaint codes (e.g., type, reason and disposition). The report also displays percentages of the number of complaint records considered justified (confirmed) for the policy types and the reasons. There are percentages of the total number of complaints that each disposition type represents;

- Closed Complaint Code Summary—5 Years: The closed complaint code summary report displays the number of complaints selected for an entity or national producer number based on various complaint codes (type, reason and disposition). The report also displays percentages of the number of complaint records considered justified (confirmed) for the policy types and the reasons. There are percentages of the total number of complaints that each disposition type represents;

- Market Action Exam Summary—5 Years: The Market Action Exam summary report displays a history of examinations called through the Market Action Tracking system (MATS) for the stated company over a 5-year span;

- Defense Costs Against Reserves—5 Years: The defense costs against reserves report is available for property and casualty companies. It contains data from financial statements related to defense costs incurred by the company over a five-year span;

- Resisted Claims Against Reserves—5 Years: The resisted claims against reserves report is available for life companies. The data comes from Exhibit 8, the Life Insurance Exhibit and Schedule F. It contains a summarized table for each of the five years, as well as the percentage change from the previous year;

- Unpaid Claims to Incurred Claims—5 Years: The unpaid claims to incurred claims report is available for health companies. It contains data from the financial statements related to incurred and paid claims by the company over a five-year span. The data for health companies comes from the claims unpaid and claims incurred schedules on the health financial statements; and

- Market Action Initiatives Summary—5 years: This report provides regulators with a listing of actions where the action types were "Focused Inquiry" and "Non-Exam Regulatory Intervention" associated with the company and includes:
    - Action name;
    - Managing lead state;
    - Participating state(s);
    - Line(s) of business;
    - Trigger(s);
    - Conclusion; and
    - Action type(s).

Market Analysis Review System (MARS) Reports

The Market Analysis Review System (MARS) provides four reports to assist regulators in viewing and managing data related to market analysis reviews: the Completed Reviews report, the Market Analyst Reviews report, Reviews Automatically Deleted report and Companies with No Reviews report.

Market Analysis Tracking System (MATS) Participating States Report

The Market Analysis Tracking System (MATS) Participating States report lists by state/territory the number of open and closed actions, the most recent entry date and the total number of actions. This report is useful in determining which states/territories are actively using MATS to alert NAIC members of action calls.

Market Conduct Annual Statement (MCAS) Filing Status Report

The Market Conduct Annual Statement (MCAS) Filing Status report provides the latest status for each company's Market Conduct Annual Statement filing by state and line of business. The companies listed on this report are those doing enough business in a given state to likely meet the threshold requirements for filing.

Market Conduct Annual Statement (MCAS) Market Analysis Prioritization Tool (MAPT) Report

The Market Conduct Annual Statement (MCAS) Market Analysis Prioritization Tool (MAPT) report utilizes MCAS data and financial premium information to generate a report of company ratios and rankings. The report contains current year data values for each of the MCAS elements and ratios as well as rankings for the last three years.

Market Conduct Annual Statement (MCAS) Ratio Summary Report

The Market Conduct Annual Statement (MCAS) Ratio Summary report shows ratios at the state level for each state selected, at each of the relevant NAIC zone levels, and at the national level as well as the percentage of change between the base year and the year prior to the base year. By displaying up to three years of ratios derived from Market Conduct Annual Statement data, this report provides a way to examine trends at the various geographic levels.

Market Conduct Annual Statement (MCAS) State Ratio Distribution Report

The Market Conduct Annual Statement (MCAS) State Ratio Distribution report uses data from the Market Conduct Annual Statement to provide state ratios for each line of business. This report provides regulators with 1) a distribution of the number of companies that fall into each of twelve ranges based upon their individual ratio values; and 2) the state value that is calculated for each ratio using all the data from companies reporting in that state. The aggregated company totals are entered into the ratio formulas resulting in the state ratio value.

Market Conduct Annual Statement (MCAS) Validation Exception Summary Report

The Market Conduct Annual Statement (MCAS) Validation Exception Summary report provides a matrix of errors by company found in the Market Conduct Annual Statement filing for the selected criteria.

Market Systems Participation Report

The Market Systems Participation report displays information regarding each state's frequency, completeness and accuracy of data submissions to the NAIC's Market Systems. The report reflects information by year, for a 5 year period. A report of the number of Market Analysis Level 1 Reviews (MARS) by line of business for the current year is also included.

Regulatory Information Retrieval System (RIRS) Summary—Firms and Individuals Report

The Regulatory Information Retrieval System (RIRS) Summary—Firms and Individuals report provides a listing of entities and National Producer Numbers that have common regulatory action elements, such as the same action state, a common penalty amount range or a common date range. Separate reports for firms and individuals are available.

3. Other NAIC Resources

Personalized Information Capture System (PICS)

The Personalized Information Capture System (PICS) allows regulators to set up a customized notification system for changes to the NAIC databases. When information changes within the scope of the profile a subscriber has created, an email alert is sent. Events for which alerts are available include company name change, group code change, company status change, financial filings available, company scoring, IRIS results summary, key financial data change and Analyst Team level assignment. There are also specific events designed for market conduct, including producer loss of resident license, regulatory action for producers licensed in a state and six various events for tracking the status of examinations. Also available is an alert to notify a state when a producer has applied for and been granted a resident license, when an active resident license is already reflected in the State Producer Licensing Database (SPLD).

State Producer Licensing Database (SPLD)

The State Producer Licensing Database (SPLD) is a database of state licensing and regulatory information designed to aid states with the producer licensing process. The SPLD is a facet of the National Insurance Producer Registry (NIPR), which is an affiliate of the NAIC that creates and maintains applications specific to the producer licensing process. SPLD is a regulator-only database accessible through iSite+, and is not subject to the Fair Credit Reporting Act (FCRA).

Uniform Certificate of Authority Application (UCAA) Summary Report

The Uniform Certificate of Authority Application (UCAA) Summary report lists UCAA applications that have been submitted for either licensure expansion or corporate amendments. The UCAA process is designed to allow insurers to file copies of the same application for admission in numerous states.

Specific Issuer—Schedule D Securities Summary Report

The Specific Issuer—Schedule D Securities Summary report provides a listing of all companies licensed in a specified state that own a particular security.

Statistical Reports

The NAIC produces several statistical reports that summarize many types of insurance industry data for use by regulators, educators, financial analysts, insurance industry members, lawyers and statisticians. Regulators can view a list of all statistical reports published by the NAIC and download these reports for free from StateNet. Non-regulators can view a listing of all NAIC publications, including statistical reports, available to non-regulators at *https://content.naic.org/publications*. Some NAIC publications are available for free. Others are available for purchase at *https://content.naic.org/account_manager.htm*.

Chapter 10—Market Analysis Level 1 Questions

The following are the questions that are included in Level 1 Analysis in the NAIC Market Analysis Review System (MARS). Level 1 Analysis questions are subject to annual review by state insurance regulators.

Operations

1. Has there been a significant change in the contacts for the financial annual statement, officers, directors or trustees of the company as reported in the financial annual statements over the last three years?

2. Are you aware of any changes in the company's organization, management or operations that might change the way the company operates in the marketplace?

3. Has the insurer reported in its financial annual statements over the last three years that it has:
    a. Been involved in or a party to a merger or consolidation, or;
    b. Had any certificates of authority, licenses, or registrations (including corporate registrations, if applicable) suspended or revoked by any governmental entity, or;
    c. Changed its state of domicile?

Financial Ratios

4. Review the company's risk-based capital (RBC) ratios and Financial Analysis Solvency Tools (FAST) scores for the last five year period to determine whether financial results may have the potential to have an adverse impact on the market conduct activities of the company.
    a. Review RBC ratios for the last five-year period. Has the company's RBC ratio triggered any action level events or has the RBC ratio significantly declined during the period reviewed?
    b. Review total FAST scores for the last five year period. Are there any concerns related to the total FAST score or individual scores?

Regulatory Actions

5. Review the Regulatory Actions Report—5 Years, the Substantive Regulatory Actions report and the summary information of these reports. Are there any regulatory actions reported of concern or are there concerns with any patterns in the origins of action, reasons for action, disposition etc., of the actions listed in the Regulatory Actions Report—5 Years?

Market Action Examinations

6. Review the Market Actions Summary—5 Years report and the summary information of the report.
    a. Have there been more than three examinations entered in the last 12 months?
    b. Identify and describe any examinations reported of substantive concern or concerns in the exam triggers, types, areas, status, etc., of the examinations listed in the Market Action Exam Summary—5 Years report?

Market Action Initiatives

7. Review the Market Action Initiative Summary—5 Years report and the summary information of the report. Identify and describe any initiatives reported of substantive concern or any concerns with patterns in the lines of business, triggers, action types, conclusions, etc., of the initiatives listed in the Market Action Initiative Summary—5 Years report.

Premiums

P&C Statement Blank

8. Review the company's direct written premium reported on a national and state basis.
    a. Has the company's direct written premium in any one jurisdiction increased or decreased by more than 33% in any single year during the last five years?
    b. For the state under review, has the company's direct written premium for any of the top five lines of business increased or decreased by more than 33% in any single year during the last five years?
    c. For the state under review, has the company's direct written premium for the line(s) of business under review increased or decreased by more than 33% in any single year during the last five years?

Life, Accident & Health Statement Blank (*when performing a Level 1 Analysis on companies writing long-term care, review earned premium*)

8. Review the company's direct business reported on a national and state basis.
    a. Has the company's direct business for any line of business in any one jurisdiction increased or decreased by more than 33% in any single year during the last five years?
    b. For the state under review, have the company's direct premiums and/or annuity considerations for any of the top five lines of business increased or decreased by more than 33% in any single year during the last five years?
    c. For the state under review, have the company's direct premiums and/or annuity considerations for the line(s) of business under review increased or decreased by more than 33% in any single year during the last five years?

Health Blank

8. Review the company's direct business reported on a national and state basis.
    a. Has the company's direct business for any line of business in any one jurisdiction increased or decreased by more than 33% in any single year during the last five years?
    b. For the state under review, have the company's premiums written for any of the top five lines of business increased or decreased by more than 33% in any single year during the last five years?
    c. For the state under review, have the company's premiums written for the line(s) of business under review increased or decreased by more than 33% in any single year during the last five years?

U.S. Market Share

9. Review the company's U.S. market share information for the state under review over the last five years. Has there been a significant change in the company's U.S. market share for the line(s) of business under review over the last five years?

Loss and Expense Ratios

P&C Statement Blank

10. Review the company's loss and expense ratio information on a national and state-specific basis for the line(s) of business under review for the last five years.
    a. For the line(s) of business under review in all jurisdictions, are the loss and expense ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's loss ratios?
    b. For the state and line(s) of business under review, are the loss and expense ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's loss ratios?

Life, Accident & Health Statement Blank

10. For individual and group accident and health, review the company's loss and expense ratio information on a national and state-specific basis for the last five years.
    a. For the line(s) of business under review in all jurisdictions, are the loss and expense ratios for the company unusually high or low as compared to the industry trends averages or are there any unusual trends in the company's loss ratios?
    b. For the state and line(s) of business under review, are the loss and expense ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's loss ratios?

Health Blank

10. Review the company's loss, administrative expense and combined ratio information on a national and state-specific basis for the last five years.
    a. For all jurisdictions, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?
    b. For the state under review, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?
    c. For the line(s) of business under review, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?
    d. For the state and line(s) of business under review, are the loss, administrative expense and combined ratios for the company unusually high or low as compared to the industry averages or are there any unusual trends in the company's ratios?

Resisted or Unpaid Claims

P&C Statement Blank

11. Review the premium written, direct defense and cost containment expenses paid, direct losses incurred and industry averages for the last five years on a national and state-specific basis.
    a. On a national basis, are the direct defense and cost containment expenses paid unusually high when measured against premium volume and industry averages or are there any unusual patterns with the direct defense and cost containment expenses paid and direct losses incurred?
    b. On a state-specific basis, are the direct defense and cost containment expenses paid unusually high when measured against premium volume and industry averages, or are there any unusual patterns with the direct defense and cost containment expenses paid and direct losses incurred?

Life, Accident & Health Statement Blank

11. Review the summary information related to resisted claims for the last five years.
    a. On a national basis, are there any unusual patterns in the amount of resisted claims compared to the total claims for either the entire book of business or an individual line(s) of business?
    b. For those claims disposed of or resisted during the current year, are there any unusual patterns in the state of residence of the claimant?
    c. For those claims disposed of or resisted during the current year, are there any unusual patterns regarding the reason claims were compromised or resisted?

Health Blank

11. Review the unpaid claims information for the company over the last five years. Are there any significant changes in the average number of days of unpaid claims, claims unpaid, claims incurred or the unpaid claims to incurred claims expense ratio over the last five years?

Complaints

12. Review the company's complaint data:
    a. Has there been a significant change in the CONFIRMED complaint index for the current year plus four years?
    b. Has there been a significant change in the COMPLETE complaint index for the current year plus four years?
    c. Review the Closed Complaint By Code—5 Year report and the Summary of the Closed Complaint By Code—5 Year report. Are there any areas of concern noted in these reports?

Market Conduct Annual Statement

13. Does your state participate in the Market Conduct Annual Statement?
    If yes, did the company file a Market Conduct Annual Statement for the data year under review?
    a. Review the ratio and rank results at the state level for the state being reviewed. According to this review, does the company have any areas of concern?
        If yes, in what areas are the ratios and/or rankings of concern?
    b. Review the ratio and rank results at the national level. According to this review, does the company have any areas of concern?
        If yes, in what areas are the ratios and/or rankings of concern?
    c. Review the company ratio results by coverage type and compare them with the state ratio results by coverage type. Are there any coverage types that show particular concern?
        If yes, what are the coverage types of concern?
    d. Does any of the company data indicate a trend that causes concern?
    e. Was the company identified as an "outlier" through analysis of the Market Conduct Annual Statement data?
        If yes, in which line(s) of business is the company considered an outlier?

Conclusion

14. What is your recommended next step?
    - Incomplete review
    - Direct contact with the company is scheduled
    - Investigation is scheduled
    - Examination is scheduled
    - Enforcement action is scheduled
    - We will contact the Collaborative Action Designee (CAD) of other states with similar concerns regarding possible collaborative activity
    - We will proceed with another option on the continuum of market actions (if known, please explain the option to be used along with the rationale description)
    - No further analysis is necessary
    - No further analysis this year, but review again next year
    - Level 2 Analysis is scheduled

Chapter 11—Level 2 Analysis Guide

The Level 2 Analysis Guide is a guide to assist market analysts in performing a Level 2 Analysis of a specific company. The Guide consists of 2 sections, Core Areas of Review and Additional Areas of Review. The core areas of review are required for every Level 2 Analysis of a company unless there is a valid reason not to review a particular area. The number and specific additional areas reviewed during a Level 2 Analysis of a company will be dependent on many different factors, such as the line of business under review, the areas of concern identified during earlier analysis, the rules and regulations of the jurisdiction performing the analysis and the company itself.

Prior to beginning any additional areas of review, the analyst should identify which of the additional areas of the Level 2 Analysis Guide should be completed based on the specific situation of the company under review and the areas of concern identified via other levels of review. Identification of these key areas prior to starting the review of any additional areas will help the analyst focus on the areas of concern and assist in obtaining and reviewing the information necessary to complete a Level 2 Analysis.

During the course of completing a Level 2 Analysis of a company, the analyst may find information that requires the review of one or more areas not initially selected for review. If this happens, the analyst should expand the scope of the Level 2 Analysis to include those areas of review not previously identified. The analyst may also want to do a Level 2 Analysis on related companies (companies under the same management or ownership) if the areas of concern for the company under review have the potential to be present in the related company.

Note: It is important for the analyst to be familiar with the line of business under review and the marketplace within the analyst's state. The analyst should also be familiar with the rules/regulations applicable to the line of business under review, including any recent legislative changes that might affect the company's operations. The analyst may want to review the applicable rules/regulations and general marketplace information for the line of business under review before beginning a Level 2 Analysis.

In 2006, the Level 2 Analysis Ad Hoc Technical Group recommended automation of the Level 2 Analysis process. The automation of Level 2 Analysis was placed into production in the MARS system in December of 2008.

Core Areas of Review

Six core areas should be reviewed for each Level 2 Analysis done on a company unless there is a valid reason why a review of the area is not warranted. The six core areas of review are:

1. Consumer complaints;
2. Continuum activity;
3. Examinations;
4. Interdepartmental communications;
5. Market analysis; and
6. Regulatory actions.

For each core area of review, the following provides the analyst with information about the area to be reviewed, where applicable potential resources to aid in the review of the area and specific items to consider during the review of the area.

Area of Review:	Consumer Complaints

Suggested Review

A detailed analysis of actual complaints filed with the insurance department by consumers against a company can provide valuable information about the company and its business practices. It can also help pinpoint specific areas of concern that may be having an adverse impact on consumers.

The analyst should review summary information about consumer complaints against the company for the line of business under review for both the analyst's state and other states. In addition, the analyst should also review the complaint file itself for the complaints filed in the analyst's state for line of business under review.

In cases where the complaint volume is significant, internal system reports can assist in identifying specific complaint reasons that appear to be problematic. This should help the analyst to focus on reviewing only those complaints that appear to stem from areas of concern.

For example, if a company received 1,000 complaints over the last year for the line of business under review, it may not be possible to review all of the complaints. If a review of an internal system report summarizing the complaint reasons indicates that the most material area of concern is claim delays, the analyst may want to focus specifically on those complaints that involve allegations of claim delays.

If it is not practical to review all of the complaints against the company for the line of business under review even after narrowing the scope of complaints, the analyst may review a random sample of the complaints filed against the company, or a random sample of the specific type of complaint.

Note: Not all states currently produce summary reports that will allow the analyst to complete some of the suggested review items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing summary information regarding consumer complaints that involve the company for the line of business under review, the following items should be considered:

1. Are there trends in particular areas of noncompliance, number of complaints, the origin of the complaints or areas of consumer concern? For example, are there any patterns in who is complaining, the geographic origin (zip code/county) of the complaints, the reasons for the complaints, whom the complaints are about, or the outcome of the complaints?
2. Does the data on iSite+ for other states indicate similar patterns of noncompliance, number of complaints or areas of consumer concern?
3. How long has any pattern or trend been occurring?
4. Are there any regulatory actions or market conduct examination findings in the analyst's or other states related to similar complaint patterns? If yes, has the company been advised to correct the situation and has it reportedly done so?
5. Do the complaint patterns align with the industry norms for the line of business under review? For example, if 30% of the complaints received by the insurance department for the line of business under review are usually claims related, one would expect that the company's ratio would be similar to the rest of the industry.

In reviewing specific complaints that involve the company regarding the line of business under review, the following items should be considered:

1. Are there complaints of a specific nature related to a growing area of concern in the market (i.e. credit; mold; underground storage tanks) even if the company is compliant with the laws?
2. Are there problems with specific vendors, adjusters, other company personnel, producers, providers, networks or business segments?

3. How quickly and completely does the company respond to a complaint?
4. Are there complaints that involve a specific business practice of the company that may be technically compliant with the laws but a questionable business practice?
5. Are there consumer complaints that involve a previously identified issue that the company has been ordered to or agreed to correct? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Area of Review:	**Continuum Activity**

Suggested Review

Insurance regulators have a broad continuum of market actions available to them when determining the appropriate regulatory response to an identified issue or concern. The continuum of market actions includes such initiatives as office-based information gathering, interview with the company, correspondence, policy and procedure reviews, interrogatories, desk audits, on-site audits, investigations, enforcement actions, company self-audits and voluntary compliance programs.

The NAIC Market Action Tracking System (MATS) database is used to track both market conduct examinations and other significant market conduct actions not tracked in the Regulatory Information Retrieval System (RIRS). A review of the non-examination initiatives (focused inquiries and other non-examination regulatory intervention) related to the company contained in MATS may provide the analyst with useful information about the company.

The analyst may also find it helpful to contact the originating state of a MATS initiative related to the company to discuss the initiative in detail. However, the decision to contact a state directly to discuss a specific initiative is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing a summary of non-examination initiatives involving the company, the following items should be considered:

1. Are there a high number of MATS actions involving the company? If yes, are the majority of the initiatives originating from just a few states, or are the initiatives spread across the states in which the company does business?
2. Have the number of market actions increased, decreased or remained the same over the last 5 years?
3. How old are the majority of the initiatives? Have the initiatives been concluded within the past 3 years?
4. Are the reasons for the initiatives similar? Are there any patterns of concern in the reason for the initiatives?
5. Are the dispositions of the initiatives similar? Are there any patterns of concern in the dispositions of the initiatives?

In reviewing an individual initiative involving the company (whether the initiative has been finalized or is pending), the following items should be considered:

1. How old is the specific initiative? Was it concluded within the past 3 years?
2. Are the functional areas and/or line(s) of business currently under review covered under the subject of the initiative?
3. Does the initiative identify issues that are similar to the areas of concern currently under review?
4. Could the issues related to the initiative also manifest themselves in the analyst's state and/or the line of business or functional areas currently under review?
5. To what extent would the issues contained in the initiative have an affect on the consumers in the analyst's state (consider statutes, codes, Unfair Trade Practices Act, Unfair Claims Settlement Practices Act, etc.)?
6. Are the issues contained in the initiative considered "repeat" issues in either the analyst's state or other states (i.e., was the company cited previously for violations related to the issues)?

7. Are the issues involved with the initiative isolated occurrences, or systemic in nature and likely to affect an entire class of business and/or consumers in the analyst's state?
8. Are there any regulatory actions or market conduct examination findings in the analyst's or other states similar to the issues involved with the initiative? If yes, has the company been advised to correct the situation and has it reportedly done so?
9. Was the company required to implement a remedial action plan or take other corrective measures as a result of the initiative that might address issues that have a potential impact on consumers in the analyst's state? If so, has the company reportedly implemented the action plan or reportedly taken the necessary corrective measures?
10. Was the company required to refund restitution and/or interest because of the initiative? If yes, is the amount a concern?
11. For issues that may have a direct impact on consumers in the analyst's state, does the company response appear to adequately address the areas of concern?
12. Has the analyst's state received consumer complaints regarding the subject of the initiative? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Area of Review:	**Examinations**

Suggested Review

Examination reports that include a market conduct component and the company response to the examination reports can be valuable sources of information about a company. By reviewing the reports and the company's response, the analyst may be able to identify specific issues found during an examination that have the potential to have an adverse impact on the consumers in the analyst's state. The analyst may also discover that a situation has already been corrected by the company as a result of the examination and therefore may not present an issue in the analyst's state that requires further investigation.

Review the history of the examinations called on the company over the last five years. When readily available, review the most recent examination reports of the company and any company response to the report for examinations done by:

1. Analyst's insurance department; and
2. Other state insurance departments.

In addition to reviewing recent examination reports, it may also be helpful to contact the market conduct area of the insurance department that conducted the examination should a review of an examination report raise concern regarding the company's operations in the analyst's state.

The analyst should also review information about examinations that are pending within the insurance department. It may also be helpful for the analyst to contact other states with pending examinations to discuss the examinations.

Information about examinations called on the company is available via the NAIC Market Action Tracking System (MATS) accessible on iSite+. The MATS Detailed Report provides a history of examinations called through MATS for the company under review over a five-year period. It is important to note that MATS is an essential resource for market regulators and states should ensure its high quality by taking care to accurately record all examinations. Analysts however, should not rely solely on the MATS reports, as the potential exists that all examinations and any related actions might not be recorded in MATS for a variety of reasons. The analyst may find it helpful to:

1. Cross check the MATS Detailed Report with the RIRS Action Report; and/or
2. Check individual state insurance department websites for recent examinations.

Examination reports and any company response may be posted on iSite+, available on the website of the examining state insurance department or in the company files of the analyst's insurance department. If an examination report is not readily available, the analyst may be able to obtain a copy of the examination report by contacting the state that did the examination. However, the decision to contact a state directly to obtain or discuss a specific examination report is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing a summary of examinations that involve the company, the following items should be considered:

1. Are there a high number of market examinations? If yes, are the majority of the examinations originating from just a few states? Or are the examinations spread across the states in which the company does business?
2. Have the number of examinations increased, decreased or remained the same over the last 5 years?
3. How many of the examinations were conducted within the past 3 years?
4. Are the examination triggers (statutory, complaints, market share analysis, etc.) similar? Are there any patterns of concern in the examination triggers?
5. Are the lines of business covered by the examinations the same or different?
6. Are the types of examinations (comprehensive, targeted, etc.) similar?
7. How many of the market examinations are currently open? How many are closed? How many were closed with an order? How many were closed with an order and fine?

In reviewing an individual examination report and the company response or a pending examination, the following items should be considered where applicable:

1. How old is the examination/report? Was the examination conducted within the past 3 years?
2. Are the functional areas and line(s) of business under review covered in the examination/report?
3. Could the findings of the examination also manifest themselves in the analyst's state and/or the line of business or functional areas under review?
4. To what extent would the violations contained in the examination report have an affect on the consumers in the analyst's state (consider statutes, codes, Unfair Trade Practices Act, Unfair Claims Settlement Practices Act, etc.)?
5. Are the violations contained in the examination report considered to be "repeat" violations in either the analyst's state or another state (i.e., was the company cited previously for the violations)?
6. Are the violations isolated occurrences, or systemic in nature and likely to affect an entire class of business? Could the cause of the violations have implications that would affect consumers in the analyst's state?
7. Did the examination report include discussion of any non-violation business practices of concern?
8. Does the examination require the company to implement a remedial action plan or take other corrective measures that might address issues that have a potential impact on consumers in the analyst's state? If yes, has the company reportedly implemented the action plan or taken the necessary corrective measures addressed?
9. Was a monetary penalty imposed on the company as a result of the examination? If yes, is the size of the penalty a concern?
10. For issues that may have a direct impact on consumers in the analyst's state, does the company response appear to adequately address the cited violations and/or areas of concern?
11. Was the company required to refund restitution and/or interest as a result of the examination? If yes, is the amount a concern?
12. Has the analyst's state received consumer complaints related to the findings of the examination? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Area of Review:	Interdepartmental Communications

Suggested Review

One of the 3 basic mechanisms for gathering information described within the *Market Regulation Handbook* is the analysis of existing information that insurance departments already collect. The best way of doing this is to survey and communicate with other units through a "Systematic Interdepartmental Communication Program" as outlined in the *Market Regulation Handbook*. This should be a process of formalizing and improving the communication between the analyst and other work units within the insurance department.

A discussion of the companies selected for a Level 2 Analysis should be included during intradepartmental meetings. However, because the timing of regularly scheduled interdepartmental meetings may not be conducive to the timely completion of a Level 2 Analysis, the analyst may want to the contact other insurance departments individually in between the regularly scheduled meetings regarding a specific company.

Establishing a 'best practice' to notify other areas of companies selected for a Level 2 Analysis is highly recommended. States may find it helpful to notify all other units about companies selected for Level 2 Analysis and solicit information and documentation from these other units. In addition, other work units should be encouraged to initiate communication regularly about any other companies or issues they may have about a company as the issues/concerns arise.

Note: A substantial amount of information will already be gathered by other areas of review for the Level 2 Analysis. The intent of this section is to capture information that is not already being collected in other areas of review.

Examples of sources of interdepartmental information not specifically outlined in other areas of the guide include, but are not limited to:

1. Meetings with companies: Other sections of the insurance department may have meetings with companies that the analyst may not be aware of. These meetings may be related to the introduction of a new product, withdrawal from a line of business or geographical area within the analyst's state, a systems problem, or other possible noncompliant areas;
2. Correspondence from companies: Other sections of the insurance department may periodically receive correspondence from companies informing them of new products, marketing changes, discovery of noncompliance in a certain area, etc.;
3. Outreach program(s): Some insurance departments have specific outreach employees who meet with other government agencies (e.g., SHIP) regarding insurance matters or attend consumer outreach programs. These individuals may include staff from the consumer services area or the public information office. Because of their interaction with other agencies and consumers, these individuals may be a valuable source of information about the general market and specific companies; and
4. Other types of consumer requests: Certain inquiries and/or grievances may not be handled by the area that handles consumer complaints (e.g., health care appeals or prompt-pay/provider grievances). Information regarding these areas may need to be gathered from other work units.

Specific Items to Look For

In reviewing the interdepartmental communication section, the following items should be considered:

1. Meetings with companies: Has the section met with the company? If so, was the meeting requested by the company or the section? What was the purpose for and outcome of the meeting?
2. Correspondence from companies: Has the section received correspondence from the company notifying it of substantial changes that may have potential impact on the consumers in the analyst's state? If so, what markets are affected and how will these markets be affected?

3. Outreach program(s):
    a. Have the "outreach" program employees met with any other governmental agencies regarding insurance matters? If so, what was the nature of the meeting? What companies or market(s) are affected?
    b. Have the "outreach" program employees met with any insurance consumer groups? If so, what was the nature of the meeting? What companies or market(s) were affected?
    c. Have the "outreach" program employees received a high volume of calls related to a particular insurance company or issue? If so, what was the nature and outcome of the calls?
4. Other types of consumer requests:
    a. Have there been a high number of provider grievances or prompt-pay complaints received against this company? If so, what was the resolution of the grievances?
    b. Have there been any health care appeals received against this company? Of the health care appeals received, 1) how many were upheld in favor of the insurance company, 2) how many were overturned in favor of the consumer, or 3) how many remain pending?

Area of Review:	**Market Analysis**

Suggested Review

Companies doing business in multiple states may have similar issues arise in those states. As such, the analyst may not be the first analyst to identify potential issues with a company. Reviewing any recent Level 1 Analysis completed by the analyst's insurance department and/or another state for the company under review may provide the analyst with additional information and/or insight related to the analyst's Level 2 Analysis.

An analyst may find it useful to review the Baseline Analysis results (available since summer 2006) for the line of business under review before reviewing any Level 1 or Level 2 Analysis of the company. A review of the Baseline Analysis results may allow the analyst to gain an understanding of how the various measures contained in this prioritization tool for the company compare to the other companies writing business in the state.

When a state similar to the analyst's own has not performed a recent Level 1 Analysis of the company, the analyst may find it useful to conduct a Level 1 Analysis of the company using the company's data for that state.

In addition, the analyst may find it helpful to contact a particular state regarding a recently completed Level 1 Analysis and/or Level 2 Analysis recently completed for the company. However, the decision to contact another state directly to discuss a specific analysis is at the discretion of the state performing the Level 2 Analysis.

Note: Level 1 Analyses completed on specific companies are available in the Market Analysis Review System (MARS), which can be accessed on iSite+. Access to MARS is restricted to those people authorized by the individual insurance departments. If the analyst does not currently have access to MARS, the analyst must follow his/her insurance department's internal procedures for obtaining proper authority to access MARS.

Specific Items to Look For

In reviewing the Level 1 Analysis completed by the analyst's insurance department, another state, the analyst's own Level 1 Analysis of the company's data for a similar state, or a Level 2 Analysis completed by another state, the following items should be considered:

1. Does the analysis cover the same line of business of currently under review?
2. Does the analysis identify any significant issues that could have implications in the analyst's state? If yes, consider referring to the Market Actions (D) Working Group.
3. Does the analysis identify issues that are similar to the areas of concern currently under review?

Area of Review:	Regulatory Actions

Suggested Review

Regulatory actions taken against a company can provide a great deal of information about a company. It is important to note, that a prior regulatory action in and of itself does not necessarily mean that the company is currently doing anything wrong. However, reviewing information about specific actions taken against the company, may allow the analyst to identify specific issues that may have the potential to have an adverse impact on the consumers in the analyst's state. The analyst could also discover that the company as a result of the action in another state may have already addressed an area of concern identified by his/her analysis.

Review the history of the regulatory actions taken against the company over the last five years. When readily available, review the details of recent regulatory actions taken against the company by:

1. The analyst's insurance department; and
2. Other state departments.

In addition to reviewing the regulatory actions, it may also be helpful to contact the enforcement area of the department that took the action should a review of an action raise concern regarding the company's operations in the analyst's state.

The analyst should also review information about enforcement actions that are pending within the insurance department and are therefore, not yet recorded in RIRS.

Information about finalized regulatory actions is available via the NAIC Regulatory Information Retrieval System (RIRS) accessible on iSite+. RIRS tracks adjudicated regulatory actions against companies, producers and agencies reported to the NAIC by the state that took the action. RIRS provides a 5-year history of information on regulatory actions against companies including the origin, reason, and disposition of the regulatory action.

It is important to note that RIRS is an essential resource for market regulators and states should ensure its high quality by taking care to accurately report all actions. Analysts however, should not rely solely on the RIRS reports, as the potential exists that all adjudicated actions may not be recorded in RIRS for variety of reasons. The analyst may find it helpful to:

1. Cross check the RIRS Action Report with the MATS Detailed Report; and/or
2. Check individual state insurance department websites for recent actions.

More detailed information about each regulatory action, such as a copy of the order issued by the state, may also be available on the website of the state insurance department that took the action or in the company files of the analyst's insurance department. If information about a regulatory action is not readily available, the analyst may be able to obtain information about the action by contacting the state that took the action. However, the decision to contact a state directly to obtain or discuss a specific regulatory action is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing the 5-year summary report of regulatory actions against the company, the following items should be considered:

1. Are there a high number of RIRS actions against the company? If yes, are the majority of the actions originating from just a few states? Or are the actions spread across the states in which the company does business?
2. Have the number of regulatory actions increased, decreased or remained the same over the last 5 years?
3. How old are the majority of the regulatory actions? Have a higher percentage of the regulatory actions been concluded within the past 3 years?

4. Are the origins of the regulatory actions similar? Are there any patterns of concern in the origins of the actions?
5. Are the reasons for the actions similar? Are there any patterns of concern in the reason for the actions?

In reviewing an individual regulatory action against the company (whether the action has been finalized or is pending), the following items should be considered:

1. How old is the specific regulatory action? Was it concluded within the past 3 years?
2. Are the functional areas and/or line(s) of business under review covered under the subject of the regulatory action?
3. Could the findings of the regulatory action also manifest themselves in the analyst's state and/or the line of business or functional areas being researched?
4. To what extent would the violations contained in the regulatory action have an affect on the consumers in the analyst's state (consider statutes, codes, Unfair Trade Practices Act, Unfair Claims Settlement Practices Act, etc)?
5. Are the violations contained in the regulatory action considered to be "repeat" violations in either the analyst's state or other states (i.e., was the company cited previously for the violations)?
6. Are the violations isolated occurrences, or systemic in nature and likely to affect an entire class of business? Could the cause of the violations have implications that would affect consumers in the analyst's state?
7. Does the regulatory action require the company to implement a remedial action plan or take other corrective measures that might address issues that have a potential impact on consumers in the analyst's state? If yes, has the company reportedly implemented the action plan or reportedly taken the necessary corrective measures?
8. Was a monetary penalty imposed on the company as a result of the regulatory action? If yes, is the amount of penalty a concern?
9. Was the company required to refund restitution and/or interest as a result of the regulatory action? If yes, is the amount a concern?
10. For issues that may have a direct impact on consumers in the analyst's state, does the company response appear to adequately address the cited violations and/or areas of concern?
11. Has the analyst's state received consumer complaints regarding the subject of the regulatory action? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?

Additional Areas for Review

For a Level 2 Analysis, any areas of additional review done by the analyst of a specific company will be dependent on many different factors, such as the line of business under review, the areas of concern identified during earlier analysis, the rules and regulations of the jurisdiction performing the analysis and the company itself.

The additional areas of review are:

1. Insurance Department Filings (Rates, Rules, Policy Forms, and/or Underwriting Manuals);
2. Dispute Resolution Activity;
3. Financial Analysis;
4. Financial Rating Agencies;
5. Geographic Analysis;
6. Human Resource Department;
7. Internet/World Wide Web;
8. Legal Information;
9. NAIC Bulletin Boards;
10. Other Governmental and Quasi-Governmental Agencies;
11. Producer Licensing;

12. State-Mandated Items (Reports, Data Requests, Surveys and Exhibits);
13. Trade Publications and Other Media Sources; and
14. Voluntary Accreditation/Certification Programs

For each additional area of review, the following provides the analyst with information about the area to be reviewed, where applicable potential resources to aid in the review of the area and specific items to consider during the review of the area.

Area of Review:	**Insurance Department Filings (Rates, Rules, Policy Forms, and/or Underwriting Manuals)**

Suggested Review

Many states require companies to file and sometimes receive prior approval of rates, rules, underwriting manuals and/or policy forms before the company can use these items. For those states that have such filing requirements, a review of the information on file with the insurance department can provide valuable information about the company and its marketing strategies.

It is important for the analyst to know the filing requirements that apply to the rates, rules, underwriting guidelines and/or policy forms (e.g., file & use; prior approval, etc.) for the line of business under review before beginning the review of this area. In addition, the analyst should be familiar with any laws specific to the line of business under review that would affect the company's filings.

For those states that have filing requirements, the analyst may need to review the various filings on file with the insurance department. For those states that have prior approval requirements, the analyst should talk with the rate/form analysts involved regarding any concerns he/she may have about the company and/or its filings.

Note: Not all states currently produce summary reports that will allow the analyst to complete some of the suggested review items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing information about the filing activity for the company, the following items should be considered:

1. Has there been a significant change in the number and/or types of filings being made by the company over the last 3 years? A change in the volume or types of filings may indicate a change in the marketing focus of the company.
2. Has the company made any filings within the past 3 years that would indicate a substantial change in marketing practice/focus of the company?
3. Are there an unusually high number of filings rejected and/or questioned by the rate/form analysts? A high number of rejected/questioned filings may be an indication of the company's attitude toward compliance and how well it keeps up to date on compliance issues.
4. Is there a lack of filing activity by the company over the last 3 years where the marketplace for the line of business under review is currently experiencing change? A lack of filing activity may be an indication that the company is not keeping its filings up-to-date or keeping up with changes in the marketplace.
5. Are there filings currently under review for this line or with the company overall? If yes, does the rate/form analyst or analysts reviewing the filings have any specific concerns about the pending filings?
6. Are there any pending filings related to a growing area of concern in the market (e.g., use of credit in underwriting/rating, coverage for mold, etc.)?
7. Are there consumer complaints related to the filings (specifically any evidence that the company is not complying with filed rates, forms or utilizing appropriate guidelines to cancel or nonrenew coverage, etc.)?
8. Are there any regulatory actions or market conduct examination findings of concern, in the analyst's or other states related to the company's filings?

9. Are any areas of concern identified through Level 1 Analysis problematic in the company's filings?
    a. Rates: Do any of the recent filings by the company contain rate increases or decreases that are not in line with the industry average or current norms for the line of business under review? Is the company requesting rate increases or decreases for a specific territory or block of business that could be a source of concern for the line of business under review?
    b. Underwriting manuals: Do the procedures/provisions of the company's underwriting manual comply with the laws applicable to the line of business under review?
    c. Policy forms: Has the company made any recent filings that introduce new or unusual policy language (including any language that may be unusually restrictive) that could be a source of concern for the line of business under review?

Area of Review:	**Dispute Resolution Activity**

Suggested Review

Many states have formal dispute resolution processes (such as external reviews by independent review organizations or IROs) available to its consumers to assist in resolving insurance issues. These formal dispute resolution processes are those processes in addition to any complaint resolution process available to the consumer via the insurance department. A review of the information related to the use of these formal resolution processes by consumers of the analyst's state that involve the company can provide valuable information about the company's business practices.

Note: Not all states currently produce summary reports that will allow the analyst to complete some of the suggested review items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing information about the activity of the company in any dispute resolution process available within the analyst's state, the following items should be considered:

1. Has there been a sharp increase or decrease in the number of cases filed against the company?
2. Are there any trends of concern in the nature of the appeals involving the company going through the dispute resolution processes?
3. How does the number of cases against the company compare to the industry averages or with the number of cases against companies of similar premium volume, lives insured and/or market segment?
4. Are resolutions available and if so, does the company have a high number of adverse decisions compared to the industry average or with the number of adverse decision for companies of similar premium volume, lives insured and/or market segment?
5. For managed care plans where the company is required to file a grievance report with the state, do the patterns in the number of reviews requested move in the same direction as the number of grievances received?

Area of Review:	**Financial Analysis**

Suggested Review

There may be a correlation between significant financial risk for a company and a firm's market behavior. Currently, the relationship between financial indicators and market behavior has not been studied in any rigorous or scientific way. Analysts should therefore exercise caution when interpreting financial ratios. Analysts should seek the counsel of a financial analyst in those instances where summary ratios indicate financial stress, to determine what, if any, implications for market behavior might be indicated.

Numerous summary financial ratios and other financial information are available on iSite+. This information includes:

1. Analyst Team Summary Report;
2. Handbook Summary (last annual and most recent quarterly summary);
3. Financial Analysis Solvency Tools (FAST);
    a. Annual/Quarterly Scoring System–Summary Totals Report;
    b. Company Profile Report; and
    c. Insurance Regulatory Information System (IRIS) Ratios
4. Information Systems Questionnaire (ISQ);
5. Analyst Team Summary Report; and
6. Company Summary Report (if further detailed information is required).

Analysts not trained in financial analysis should not attempt to formulate conclusions about the financial state of a company on their own. After reviewing the summary indicators and ratios, an expert within an insurance department's financial division should be consulted. If it appears that a company is financially stressed, the analyst should formulate specific and explicit conclusions about how a specific form of financial impairment might impact market behavior. When formulating such conclusions, the financial data should be interpreted within the context of all other available market -related information.

Analysts should, however, have some familiarity with the basic financial surveillance tools. The following resources for the appropriate line of business are available from the NAIC website (StateNet/NAIC Publications Online/Financial Analysis and Receivership):

1. *Financial Analysis Handbook*;
2. *NAIC Scoring System*; and
3. *Using the Insurance Regulatory Information System*.

Specific Items to Look For

In reviewing financial information for the company, the following items should be considered:

1. Analyst team summary report: Has the company been designated Level A (highest priority) or B (elevated priority)?
2. Handbook summary: Did the handbook summary report return a high number of "yes" responses for any one area, or in total? If so, what areas of possible concern were identified (categories are those of the *Financial Analysis Handbook* checklists)?
3. Annual/Quarterly scoring system summary: Did the annual or quarterly summary report ratios indicate areas of financial stress? If so, which ones (for P&C, for example, RBC, Profitability, Leverage, Asset & Liquidity (A&L) or Misc.)?
4. ISQ: Did the ISQ reveal any vulnerabilities or systemic IS problems that might have implications for policyholders or claimants? If yes, what areas of possible concern were identified?
5. IRIS ratios: Are areas of financial stress indicated by IRIS ratio outliers? If yes, what areas (e.g., P&C—Overall, Profitability, Liquidity and Reserves)?
6. Is there a pattern demonstrated by the financial data that would raise concern for market behavior? If so, in what way? Document overall conclusion.

Area of Review:	**Financial Rating Agencies**

Suggested Review

It is common for a company's compliance and/or marketing strategies to change when there is a change in the company's rating by one or more of the five principal rating agencies. The analyst should review the company's financial rating from one or more of the main financial rating agencies to determine if there is a possible correlation between the company's rating and market regulatory practices.

Review rating history for the last five years and the most current analysis of the company provided by one or more of the following financial rating agencies:

1. **A.M. Best Company**: The A.M. Best Company has been rating insurance companies since 1900. The objective of A.M. Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Ratings are available at *www.ambest.com*;
2. **Fitch Ratings**: Fitch Ratings was founded as the Fitch Publishing Company in 1913. Fitch's rating evaluations are qualitative and quantitative and provide two basic types of ratings—insurer financial strength ratings and issuer and fixed income security ratings. Fitch Ratings are available at *www.fitchratings.com*;
3. **Moody's Investors Service**: Moody's Investors Service was founded in 1900. Moody's insurance financial strength ratings reflect its opinion as to an insurer's ability to discharge senior policyholder claims and obligations. Ratings are available at *www.moodys.com*;
4. **Standard & Poor's**: Standard & Poor's has been rating bonds since 1923 and insurance companies' claims-paying ability since 1983. Standard & Poor's claims-paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policyholder obligations in accordance with its terms. Ratings are available at *www.standardandpoors.com*; and
5. **Weiss Ratings, LLC** (formerly TheStreet.com): In 2006, Weiss Group sold Weiss Ratings to TheStreet.com. In 2010, TheStreet.com sold the insurance and bank ratings back to the Weiss Group. Weiss' financial strength rating indicates its opinion regarding an insurer's ability to meet its commitments to its policyholders under current economic conditions Ratings are available at *www.weissratings.com*.

Note: The amount of information available free of charge varies with each rating agency. It is recommended that the analyst check with other areas within his/her insurance department to determine if the information is currently being maintained elsewhere in the agency. For example, the financial area of many states may already be subscribing to one or more of the services.

Information about rating changes for individual companies can also be found in news articles of the various trade publications that may currently be available within the analyst's state insurance department. In addition, information regarding company ratings from A.M. Best may be available through the NAIC library.

Specific Items to Look For

In reviewing the rating history and any additional information about the company available from a rating agency, the following items should be considered:

1. Has the company's rating changed in the last 5 years? If the company rating has changed, is there anything of concern in the rationale behind the rating change?
2. Is there anything of concern in the most recent rating rational provided by the rating agency?
3. Is there anything of concern in the operations areas of any additional information about the company provided by the rating agency?
4. Is the company currently on a watch list for potential change in its rating? If so, why was it placed on the watch list?

Note: Ratings from each agency should be reviewed independently. Each rating agency uses its own rating methodology to rate a company. Therefore a cross comparison of the ratings between agencies would not be appropriate.

Area of Review:	Geographic Analysis

Suggested Review

Some states collect personal lines data by ZIP code, county, or other sub-state level of geography. This data may be put to good use for market analysis. Additional analytical value can be realized by merging insurance with census data, vehicle registration data obtained from states' DMVs, and a DOI's own internal data, including complaints and agent appointments.

ZIP code data can be aggregated into larger geographic units, such as metropolitan statistical areas (MSAs), or areas with common demographic features. For example, the analyst might want to examine all poorer urban areas. In some instances, the use of larger geographic units is necessary to ensure that results are credible.

Areas of potential review for a geographic analysis include, but are not limited to:

1. Underserved areas: Analysts should review the *Market Regulation Handbook* (Chapter 8—Enhancing State Market Analysis) for information on how to identify underserved or non-competitive areas, and evaluating geographic based rating variables (such as automobile insurance rating territories). Whether or not a formal and comprehensive analysis is produced, the analyst should have a good working knowledge of which areas of the state exhibit affordability and availability problems.

Useful indicators include market penetration ratios, residual market share, average premium relativities, agent location, complaint rates, and other indicators of market structure and performance. Markets in geographic areas that score highly on a multitude of these indicators might be candidates for a designation of "underserved":

1. Spatial business patterns: Assess a company's market share across different areas of the state, including underserved areas. Examine such patterns through time;
2. Underwriting and rating variables: Identify any likely relationships between spatial patterns and underwriting and rating variables employed by a company. Rating territories bear the most obvious and direct relationship to geographic patterns, but there may well be non-geographic variables that possess geographic implications;
3. Agents per capita: Calculate the number of agents per 10,000 residents (or homes or autos). Select a geographic unit of analysis that is large enough to support credible inferences. ZIP codes are unlikely to be sufficient for this purpose; and
4. Complaint rates: Identify areas where complaint rates (e.g. complaints per 10,000 insureds) are unusually high. Complaints may be interpreted as an indicator of the level of service and adherence to obligations by a company. Again, ZIP codes are probably too small to support credible inferences based on a single company's complaints.

Note: Geographic or statistical patterns by themselves do not indicate anything untoward about a company's business practices. Rather, such patterns, when interpreted within the context of an analyst's total knowledge about a company's market conduct, may merit additional scrutiny. Analysts should be able to formulate explicit and logical connections between particular business practices and a market outcome prior to initiating any heightened regulatory scrutiny.

Census data can be downloaded from the website of the Bureau of the Census (*www.census.gov*) or purchased on other storage media. In some instances, this data can be obtained in a form that is relatively ready for use. If not, the raw summary file data can be downloaded and the necessary information extracted at the appropriate geographic level, from census block to ZIP code to county, etc. A good introduction to data available from the 2020 census can be found at: *https://www.census.gov/programs-surveys/decennial-census/decade.2020.html*.

Vehicle registration data should also be obtained from the state DMV where possible.

Specific Items to Look For

In reviewing geographic data, emphasis should be placed on overall patterns across a variety of indicators and the following items should be considered:

1. Underserved areas: are there areas of the state that score highly on a variety of indictors? For example, do some areas exhibit elevated premiums, high rates of uninsured vehicles or homes, few available agents, high complaint rates, and so forth?
2. Market share: Are there dramatic market share differences for the company in different areas of the state? Have there been any significant increases or decreases over time in some areas, compared to the statewide market share?
3. Agent location: Do geographic patterns of agent location suggest anything about the company's business strategies?
4. Complaint rates: Are there geographic areas where complaint rates are unusually elevated? If so, what appears to be the cause of such complaints?
5. Rating territories: Are there any identifiable geographic patterns in territorial rating factors? Do loss ratios across territories indicate that premiums are commensurate with losses?
6. Underwriting and rating variables: Can underwriting or rating variables account for observed patterns? If so, does a company employ atypical variables or factors that are not well understood or actuarially supported? Might such variables be applied in an arbitrary and capricious manner? If so, such variables may warrant additional scrutiny.
7. Loss ratio: Loss ratios, or losses expressed as a percent of premium, are an indicator of whether the price of coverage is commensurate with risk. Analysts should identify whether there are patterned variations in loss ratios across geographic areas, and determine whether such patterns might indicate a problem with a company's rating structure or a lack of market competition. Loss ratios that are consistently and significantly lower than the statewide average in a geographic area may indicate that an area is comparatively over-charged (policyholders receive less "return" per premium dollar than average). Conversely, consistently high loss ratios indicate that an area is systematically under-charged. In the event that either trend is found, an analyst should try to determine whether cross-subsidies exist, whereby an over-charged area in effect subsidizes an under-priced area.

Depending on the line of business or the presence of unpredictable or catastrophic losses, loss ratios may be subject to significant random fluctuations from year to year. Analysts should therefore assess trends over a period of several years. An examination of loss ratios over 3, 5 or even 10 years may be appropriate.

Analysts should try to determine whether patterns have an identifiable systemic origin, such as territorial rating structures, other aspects of rating plans, catastrophe loadings in rates, underwriting criteria, or other business or marketing practices.

Area of Review:	**Human Resource Department**

Suggested Review

When possible the analyst may also want to check with the Human Resource Department for his/her insurance department as it may have useful information regarding a company. For example, the Human Resource Department may have noticed a large number of applications to the insurance department from employees of a specific company. An influx of resumes or applicants from a single company could be a sign of stress and/or change at the company.

Specific Items to Look For

In checking with the Human Resource Department about the company, the following item should be considered:

1. Has there been an influx in the number of resumes or applications to the insurance department from employees of the company? If yes, are the resumes or applications being submitted coming from a specific functional or geographic area?

Area of Review:	**Internet/World Wide Web**

Suggested Review

The Internet/World Wide Web (the web) makes a lot of information available on virtually any topic imaginable. It can be a very useful tool and the analyst can learn a great deal about a specific insurance company. However, the amount of information can itself be a problem. It can be overwhelming, especially to those that are not proficient in navigating the web successfully. Nevertheless, finding relevant information about a specific insurance company can be easy if the analyst is able to search the web in an effective and efficient manner.

It is important to note that much of the information gathered for other areas of review for the Level 2 Analysis will be collected via the web. However, the information collected in this section relates to items not covered in the other areas of review. For example, the web contains a large variety of information about legal activity. Information found on the web regarding legal activity that involves the insurance company under review should be considered in the Legal Information area of review, not this section.

Information located on the web related to the company not covered in other areas includes items such as:

1. Company's website;
2. Agent websites; and
3. Other independent websites.

The company's website may contain a wealth of information related to the company itself and its history. It is common for a company to post information about the company's mission, its core business and its affiliates. Many companies also post items such as its annual report, news releases and employment opportunities with the company. Reviewing the company website may also give the analyst insight on the company's marketing strategies, distribution system, business territories and product mix.

A review of agent websites may also provide a great deal of information about the company under review. Reviewing a sample of agent websites may help the analyst determine what types of business the company is marketing, the extent of the company's agency system and the territories in which the company is operating.

Independent sites that contain information about the company may include quoting services or anti-company sites. Anti-company sites are those sites that attack the company, perhaps set up by an aggrieved employee or consumer. A review of these sites may provide the analyst with additional information about the company that may not find elsewhere and it may help the analyst identify potential areas of regulatory concern.

As noted above, the web can be overwhelming and the analyst can easily spend hours "surfing" the web for information only to turn up little or no relevant information about a company. As such, it is important to develop skills that allow the analyst to quickly locate information about the target company.

It is also important that the analyst develop skills on how to evaluate the information that is found. Because so much information is available, and because anyone can write a re, information of the widest range of quality, written by authors of the widest range of authority, is available. Excellent relevant sources of information exist right along side the most suspect so it is important that in addition to reviewing the information the analyst evaluate the source.

The University of California – Berkeley has a very good online tutorial program about the web that provides general information about the web itself, how to perform effective efficient searches and how to evaluate the information presented.

This tutorial is found at *http://www.lib.berkeley.edu/TeachingLib/Guides/Internet/FindInfo.html*.

Specific Items to Look For

In reviewing information available about the company via the web, the following items should be considered:

Company Website

1. Are there any recent (within the last 2 years) new releases by the company regarding the insurance company itself and/or the line of business under review that are noteworthy? If so, explain.
2. Does the Annual Report highlight any area of concern for the company? If so, in what area and what is the concern?
3. Are there any proposed or recent changes in company structure, management, mergers or acquisitions, change in product offerings, etc. that are of concern? If so, in what area and what is the concern?
4. Does the company provide links to individual agent websites? If yes, do these agents maintain information regarding the specific insurance under review on his or her website?
5. Are there consumer complaints against the company regarding the company's website?
6. Does the company allow an individual to get quotes or apply for insurance online? If yes:
    a. What sort of information is requested from the consumer?
    b. Is any of the information collected considered to be personally identifiable information covered by the applicable privacy rules and regulations?
    c. Does the information presented comply with the applicable advertising rules and regulations?
7. Does the website contain a privacy statement or privacy policy?
8. Does the company post current job openings on the website? If yes, are there an unusual number of openings for a specific functional area or in a particular location?

Agent Websites

1. Do individual agents maintain information regarding the specific insurance under review on his or her website? If yes:
    a. What sort of information is presented?
    b. Does the information presented comply with the applicable advertising rules and regulations?
    c. If the information provided appears to target a particularly vulnerable group of consumers, such as senior citizens, does the information appear to conform to suitability standards (set forth in either statute or regulation, or commonly enforced suitability provisions) for marketing to these consumers?
    d. Is the agent representing just the company under review? Or does he/she represent additional unrelated companies and is information about these other companies also contained on the agent's website?
2. Are there any consumer complaints against the company that involve an agent's website and the company?

Other Independent Websites—Quote Sites

1. Does the company allow third-party quoting services to provide a quote for the line of business under review? If yes,
    a. What sort of information is requested from the consumer?
    b. Is any of the information collected considered to be personally identifiable information covered by the applicable privacy rules and regulations?
    c. Does the information presented comply with the applicable advertising rules and regulations?

Other Independent Websites—Anti-Company Websites

1. Did the analyst find any anti-company websites? If yes,
    a. Is the subject matter on the website related to the line of business under review?
    b. Are there consumer complaints against the company regarding the issues noted on the website?
    c. Do the allegations seem credible and warrant further investigation?
    d. Is there any reason to suspect that a competitor might be sponsoring or assisting the website?

Area of Review:	**Legal Information**

Suggested Review

Pending legal activity that a company is involved in may be an indication of potential issues with a company that may have an adverse impact on consumers in the analyst's state. Investigating the legal activity involving a company may alert the analyst to litigation that may adversely affect the company's financial situation and may eventually have an adverse impact on the consumers of the analyst's state.

Check to see if there is any legal activity of concern involving the company under review using some or all of the following resources:

1. Insurance department staff responsible for this area;
2. State-specific court system accessible via the Internet; and
3. Miscellaneous Internet sites that collect/maintain information about litigation, such as:
    a. *https://www.lawyersandsettlements.com/*;
    b. *https://www.ama-assn.org/litigation-center*;
    c. LexisNexis (*https://www.lexisnexis.com/en-us/gateway.page*)—provides access to legal, news, public records and business information; including tax and regulatory publications in online, print or CD-ROM formats; and
    d. Westlaw (*https://legal.thomsonreuters.com/en*)—a legal research service that provides access to a collection of statutes, case law materials, public records, and other legal resources, along with current news articles and business information.

Note: LexisNexis and Westlaw are fee-based services. It is recommended that the analyst check with other areas within his/her agency to determine if access to either service is available elsewhere in the agency. For example, the legal department in many states may already be subscribing to one of these services and depending on the terms of the contract between the state insurance department and the service, it may be possible for the analyst to obtain access to the service at little or no additional cost to the agency.

Specific Items to Look For

In reviewing information regarding legal activity involving the company, the following items should be considered:

1. Is the company involved in any significant litigation that could affect its financial condition?
2. Was the litigation noted in the management discussion or in other areas of the financial statement?
3. Is the subject of the litigation related to the line of business under review?
4. Does the subject of the litigation have potential impact on the policyholders in the analyst's state?
5. Is the litigation a class action suit and if so is it at the state or federal level? Has the class been certified?
6. What state, county court or federal district court is involved?
7. Are there consumer complaints against the company regarding the subject of the litigation?
8. Is the conduct alleged in the litigation an area for which the company has been fined or cited on market conduct exams in the analyst's or other states?
9. If known, is the company attempting to settle the litigation or defending the suit?

Area of Review:	NAIC Bulletin Boards

Suggested Review

The NAIC maintains market-related electronic bulletin boards to which members of the boards may post and receive messages regarding specific companies and/or issues. The two market regulation-related bulletin boards are the Market Regulation Bulletin Board and the Market Analysis Bulletin Board; both bulletin boards are available on iSite+ and on StateNet.

The Market Regulation Bulletin Board is an electronic forum designed for state market conduct regulators to communicate global issues, concerns and information about entities engaged in the business of insurance or the specific rules/laws that help to govern the industry.

The Market Analysis Bulletin Board is an electronic forum designed for state analysts to communicate issues, questions, concerns and information about the market analysis process.

A review of these bulletin boards for postings regarding the company under review may provide useful information about the company that the analyst may not otherwise discover. Postings regarding individual companies may be found by logging on to the desired bulletin board and using the search function to query for postings related to a specific company.

Caution: There is no uniform method used by the members of the boards for identifying a specific company by name. As a result, a single company could appear on the boards in multiple postings each with a slightly different name. This can make it very difficult to search for postings for a specific company.

To ensure that as many references as possible to the company are found, the analyst may want to try several different versions of the specific company name when querying the boards. The analyst may also want to use a shortened version of the company name or the generic group name for the company in his/her query. While this method will produce more false hits, it will help ensure that all possible postings related to a company are unearthed.

To help reduce the problems associated with inconsistent use of company names, individuals posting to the bulletin boards are strongly encouraged to include the 5-digit NAIC company code in a posting when ever possible.

Note: To access either bulletin board, a regulator must be a registered member of the board which the regulator wishes to access.

Specific Items to Look For

In reviewing postings about the company from either bulletin board, the following items should be considered:

1. Are there any recent (within the last 2 years) postings regarding the insurance company that are noteworthy? If yes,
    a. Are the functional areas and/or line(s) of business under review covered under the subject of the posting?
    b. Does the posting identify any significant issues that could have implications in the analyst's state? Could the issue(s) presented in the posting manifest itself in the analyst's state? If so, to what extent would the issues contained in the posting have an affect on the consumers of the analyst's state?
    c. Are there areas of concern or need for further review identified in Level 1 Analysis that are the subject of a posting?
    d. Has the analyst's state received any consumer complaints regarding the issue raised in the posting?

Area of Review:	Other Governmental and Quasi-Governmental Agencies

Suggested Review

The review of information collected by other governmental agencies and quasi-governmental agencies may provide the analyst with information about a company and related activity involving the company not found elsewhere.

Other governmental and quasi-governmental agencies that may have relevant information about a company, include, but are not limited to:

1. **U.S. Securities and Exchange Commission (SEC)**;
   U.S. Securities and Exchange Commission (SEC): The SEC oversees the key participants in the securities world, including securities exchanges, securities brokers and dealers, investment advisors and mutual funds. The SEC is concerned primarily with promoting the disclosure of important market-related information, maintaining fair dealing and protecting against fraud. The SEC website (*www.sec.gov*) provides information on publicly held companies, as well as on entities licensed to sell securities products. The SEC's Electronic Data Gathering, Analysis and Retrieval (EDGAR) database provides free public access to corporate information, allowing the user to research a company's financial information and operations by reviewing registration statements, prospectuses and periodic reports filed on Forms 10-K and 10-Q.

   Documents that may be helpful to the analyst regarding a particular company include:
   a. Annual and quarterly filings (Forms 10-K and 10-Q), which can provide additional information about the company's structure, management, products and distribution, and a detailed management discussion of the financial condition and operating results; and
   b. The 8-K report, which contains information if a company has undergone a major change such as change in control or bankruptcy.

   These reports can be lengthy and some information may have already been reviewed in a Level 1 Analysis. The analyst may wish to only review these records if the Level 1 Analysis of financial information and/or the Management Discussion and Analysis page of the company's NAIC Annual Financial Statement identifies areas of concern or need for further review.

2. **U.S. Centers for Medicare & Medicaid Services (CMS)**;
   The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established minimum federal standards regarding access to and the portability and renewability of private health insurance, including provisions that assist individuals who change or lose their jobs in maintaining health coverage. Congress has also enacted a number of amendments to HIPAA, which provided additional federal standards that addressed private health insurance coverage of mental health, maternity and newborn and post-mastectomy reconstructive surgical benefits.

   In states that have standards that substantially conform to or exceed these federal standards, or in states that otherwise enforce the federal standards, state insurance regulators have primary enforcement authority for companies. For those states that do not have such standards, CMS enforces HIPAA and the related amendments.

   In states in which CMS is responsible for enforcement, CMS has assumed many of the responsibilities undertaken by state insurance regulators, such as responding to consumers' inquiries and complaints, reviewing company policy forms and business practices, performing market conduct examinations, and imposing civil money penalties, if necessary, for violations of HIPAA and the amendments.

3. **Financial Industry Regulatory Authority (FINRA)**;
FINRA is the largest non-governmental regulatory organization for all securities firms doing business in the United States. FINRA was created through the consolidation of NASD and the member regulation, enforcement and arbitration operations of the New York Stock Exchange. The consolidation, which was announced on Nov. 28, 2006, and approved by the Securities and Exchange Commission on July 26, 2007, became effective July 30, 2007.

FINRA's chief role is to protect investors by maintaining the fairness of the U.S. capital markets. FINRA is responsible for rule writing, firm examination, enforcement and arbitration and mediation functions, along with all functions that were previously overseen solely by NASD, including market regulation under contract for NASDAQ, the American Stock Exchange, the International Securities Exchange and the Chicago Climate Exchange.

FINRA is involved in registering and educating industry participants to examining securities firms; writing rules; enforcing those rules and the federal securities laws; informing and educating the investing public; providing trade reporting and other industry utilities; and administering the largest dispute resolution forum for investors and registered firms.

FINRA takes disciplinary actions against firms and individuals for violations of NASD rules; federal securities laws, rules and regulations; and the rules of the Municipal Securities Rulemaking Board. Information about disciplinary actions taken by FINRA is available via FINRA's BrokerCheck at *www.finra.org/BrokerCheck*.

4. **Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)**;
The Joint Commission is a not-for-profit organization that sets the standards by which health care quality is measured and evaluates the quality and safety of care for health care organizations. The Joint Commission maintains an accreditation program under which health care organizations are reviewed at least once every 3 years to determine if it meets or exceeds the Joint Commission's standards and quality expectations. A list of Joint Commission accredited organizations and survey results are posted in the Quality Check section of the Joint Commission website at *www.jointcommission.org*.

5. **Better Business Bureau (BBB)**; and
The BBB is a voluntary system of regional BBBs. The BBB collects information about companies who are members or nonmembers of the BBB and makes Reliability Reports on companies (complaint information filed by consumers with the BBB) available to the public on its website (*www.bbb.org*).

Complaint information on companies is generally national without state-specific data. The number of complaints received by the BBB on a given company tends to drive the detail in the report. For larger companies with more complaints, information is broken out by nature of complaint (service, sales, refunds, contracts, billing) and type of resolution (resolved, company made good faith effort to resolve, unresolved, no response, etc.). In some cases, government action information, such as multistate resolution of national problems is indicated.

Note: It is important to note that a "clean" BBB report does not necessarily indicate that there are no problems, only that complaints were not processed by this voluntary system.

6. **Other State Agencies/Departments/Divisions**.
    a. Securities;
    b. Banking;
    c. Consumer Affairs/Protection;
    d. Labor; and
    e. Attorney general.

Other state insurance departments not primarily engaged in regulating insurance, that may share joint regulation of certain activities of a company may provide additional information to the analyst. These may include departments regulating financial institutions and securities, the state insurance departments for consumer affairs/protection, the state attorney general and the state department of labor.

Specific Items to Look For

In reviewing SEC filings that involve the company, the following items should be considered:

1. Does the annual filing highlight an area of concern for the company? If so, in what area and what is the concern?
2. Are there any proposed or recent changes in company structure, management, mergers or acquisitions, etc. that are of concern? If so, in what area and what is the concern?
3. Are there any significant changes in the marketing of the line of business under review for this company? Is the company expanding or limiting marketing?
4. Has the company changed product offerings and if so, will this change impact the line of business under review?
5. Are there any 8-K filings for the company and if so, what change is indicated and is this of concern?
6. Are there any significant lawsuits discussed in the 10-K filing that have not been previously noted by the analyst? If so, are the lawsuits in areas of concern to the analyst's state?
7. Is there a pattern demonstrated in the management discussion information and financial data that would raise concern for market behavior? If so, in what way?

In reviewing enforcement actions taken against the company by CMS or market conduct examinations of the company done by CMS, the following items should be considered:

1. Are there any recent (within the last 2 years) CMS enforcement actions against the company that are noteworthy? If yes,
    a. Are the functional areas and/or line(s) of business under review covered under the subject of the CMS enforcement action?
    b. Does the CMS enforcement action identify any significant issues that could have implications in the analyst's state?
    c. Does the CMS enforcement action involve issues that are similar to the areas of concern currently under review?
    d. Does the CMS enforcement action highlight an area of concern for the company? If so, in what area?
    e. Has the analyst's state received any consumer complaints regarding the issue(s) raised in the CMS enforcement action?

2. Are there any recent (within the last 2 years) CMS market conduct examinations of the company? If yes,
    a. Are the functional areas and/or line(s) of business under review covered under the CMS examination report?
    b. Does the CMS examination report identify any significant issues that could have implications in the analyst's state?
    c. Does the CMS examination report involve issues that are similar to the areas of concern currently under review?
    d. Does the CMS examination report highlight an area of concern for the company? If so, in what area?
    e. Has the analyst's state received any consumer complaints regarding the issue(s) raised in the CMS examination report?

In reviewing disciplinary actions taken against the company by FINRA, the following items should be considered:

1. Are there any recent (within the last 2 years) FINRA disciplinary actions against the company that are noteworthy? If yes,
    a. Are the functional areas and/or line(s) of business under review covered under the subject of the FINRA disciplinary action?
    b. Does the FINRA disciplinary action identify any significant issues that could have implications in the analyst's state?
    c. Does the FINRA disciplinary action involve issues that are similar to the areas of concern currently under review?
    d. Does the FINRA disciplinary action highlight an area of concern for the company? If so, in what area?
    e. Has the analyst's state received any consumer complaints regarding the issue(s) raised in the FINRA disciplinary action?

In reviewing information about health care organizations used by the company's PPO or HMO network(s), the following item should be considered:

1. Does the network use health care organizations accredited by the Joint Commission? If yes,
    a. What percentage of the network's health care organizations is accredited?
    b. Is there a wide variety in the types of health care organizations accredited?
    c. Are the major health care organizations in the network accredited?

In reviewing information from the BBB about the company, the following items should be considered:

1. Does the information highlight an area of concern for the company or the product line under review? If so, in what area?
2. Are areas of concern or need for further review identified in Level 1 Analysis the subject of information available? If so, what are the areas of concern?
3. Are there complaints about the company and/or the line of business under review reported to BBB? Does a review of iSite+ and state-specific complaint information show similar areas of concern?

In reviewing information for the company from a non-insurance regulatory or quasi-regulatory entity, the following items should be considered:

1. Does the information highlight an area of concern for the company or the product line under review? Is so, in what area?
2. Are areas of concern or need for further review identified in Level 1 Analysis the subject of information available from the entity? If so, what are the areas of concern?
3. Are there complaints about the company and/or the line of business under review reported to entity? Does a review of iSite+ and state-specific complaint information show similar areas of concern?
4. Has the entity taken any sort of administrative action against the company? If so, what was it for and does it affect the consumers in the analyst's state?

Area of Review:	**Producer Licensing**

Suggested Review

A review of the state's producer licensing data for a company over the last 3 years could provide valuable insight about the company's producer licensing activity and its marketing focus. By reviewing the state's producer licensing data, the analyst may be able to identify trends that may signal changes in the company's marketing strategies or focus that have the potential to have an adverse impact on the consumers of the analyst's state.

For example, a large increase in the number of new producers appointed to represent the company in the last year may be an indication that the company is preparing for a major marketing campaign to increase sales within the analyst's state. On the other hand, a large increase in the number of producers being terminated by the company may signal a significant reduction in the amount of business the company plans to write in the analyst's state or a total withdrawal from a particular market.

A change in the types of appointments being made by the company could also be of importance. For example, if a company has recently begun appointing producers for a specific line of business it historically has not had producers for, this may indicate that the company is gearing up to start writing a line of business that it has not written in the past.

Note: Not all states require that a company appoint specific producers to represent the company. In addition, those states that do require an appointment may not require the company to appoint a producer for a specific line of business. Finally, those states that do require an appointment may not capture the appointment/termination information in such a manner that will allow the analyst to complete some of the suggested items. However, the analyst should review these items when the summary reports are available.

Specific Items to Look For

In reviewing information about the producer licensing activity for the company, the following items should be considered:

1. What type of agency relationship does the company have (e.g., direct writer, independent agents, exclusive agents)?
2. Has the company appointed or terminated an unusual number of producers in the last two to three years? If yes, are the appointments and/or terminations for a particular line of business?
3. Are there any producers representing the company that are the subject of consumer complaints, whether closed or pending?
4. Are there any producers representing the company that are the subject of regulatory actions, whether finalized or pending?
5. Has the company terminated producers for cause?

Area of Review:	**State-Mandated Items (Reports, Data Requests, Surveys and Exhibits)**

Suggested Review

Many states require companies to file various reports, data requests, surveys and exhibits with the insurance department. A review of the information provided in the mandated items related to the line of business under review can provide valuable information about a company. Items covered under this area would include, but not be limited to:

1. Grievance reports;
2. Market Conduct Annual Statement (MCAS);
3. Prompt-pay reports;
4. ZIP code reports; and
5. Premium comparison surveys.

Specific Items to Look For

It is important for the analyst to identify all of the specific mandated items applicable to the line of business under review. Once the applicable items to review have been identified, the following should be considered in the review of mandated items:

1. Did the company's response or data deviate from the norm? Did it deviate from prior years' data? If so, in what way?
2. Was there follow-up with the company on any specific areas of concern? If so, what was the outcome?
3. Have any issues been identified that the company has been advised to correct? If yes, has the company reportedly corrected the issues?
4. Are there any regulatory actions or market conduct examination findings of concern related to the mandated item in the analyst's or other states?
5. Are there any consumer complaints related to a specific issue previously identified through a mandated filing and reported corrected by the company? If yes, does the complaint stem from an incident that occurred after the company reportedly implemented the correction?
6. Grievance reports: When the company is required to file a grievance report, do the patterns in the number of complaints received move in the same direction as the number of grievances reported over the last 3 years?
7. Market Conduct Annual Statement: If the company must file the MCAS in other states, are there similar areas where the company data is outside the norm? Was there follow-up with the company by that state on any specific areas of concern? If so, what areas and what was the outcome?

Area of Review:	**Trade Publications & Other Media Sources**

Suggested Review

Trade publications and media sources inform regulators about emerging issues and other regulatory concerns. Reviewing articles and information from other readily available media sources may alert the analyst to potential issues that could adversely impact consumers in the analyst's state.

Review trade publications and other media sources for pertinent information related to the company. The various media sources may include, but not be limited to:

1. Agent/Company newsletters;
2. Local/National media:
    a. Newspaper articles (*Wall Street Journal*, *Business Insurance*, *National Underwriter*, *A.M. Best*, *American Banker*, *Kiplinger's Personal Finance,* etc.);
    b. Print advertisements (Magazines, direct mail, billboards, buses, etc.); and
    c. Television (News, "Dateline," "60 Minutes," etc.);
3. News wire on myNAIC—accessible to regulators with a myNAIC login ID and password;
4. KPMG—KPMG provides audit, tax and advisory services:
    a. *KPMG Institutes*, a network dedicated to helping organizations and their stakeholders identify and understand emerging trends and risks. To access, go to *https://institutes.kpmg.us/*; and
    b. *KPMG Global M&A Insurance Newletters*, an electronic monthly newsletter focused on transaction activity and trends specific to the global insurance industry including news and analysis about the trends behind the headlines. To view global mergers and acquisitions insurance news, go to *https://home.kpmg/xx/en/home/industries/financial-services/insurance/insurance-deal-advisory.html;*
5. *www.findarticles.com;*
6. *www.insure.com;*
7. Internal clipping folders—some states maintain internal folders for companies that contain press clippings and other media-related information;

8. LexisNexis (*https://www.lexisnexis.com/en-us/gateway.page*)—provides access to legal, news, public records and business information; including tax and regulatory publications in online, print or CD-ROM formats; and
9. Westlaw (*https://legal.thomsonreuters.com/en*)—a legal research service that provides access to a collection of statutes, case law materials, public records, and other legal resources, along with current news articles and business information.

Note: LexisNexis and Thomson Reuters Westlaw are fee-based services. It is recommended that the analyst check with other areas within his/her agency to determine if access to either of these services is available elsewhere in the agency. For example, the legal department in many states may already be subscribing to one of these services and depending on the terms of the contract between the state department and the service, it may be possible for the analyst to obtain access to the service at little or no additional cost to the insurance department.

Specific Items to Look For

In reviewing information from trade publications and other media sources regarding the company, the following items should be considered:

1. Are there any recent (within the last 2 years) publications regarding the company and/or the line of business under review that are noteworthy? Is so, explain.
2. Does the publication/report highlight an area of concern for the company? If so, in what area?
3. Are areas of concern or need for further review identified in Level 1 Analysis the subject of recent publications?
4. Are there any proposed or recent changes in company structure, management, mergers or acquisitions, change in product offerings, etc. that are highlighted in any publications?
5. If the company contracts with independent agents, do any producer trade publications make reference the company in a way that if of concern or would require further review?
6. If an article references alleged misconduct is the conduct alleged an area for which the company has been fined, been the subject of prior regulatory action or cited on market conduct exams in the analyst's or other states?

Area of Review:	**Voluntary Accreditation/Certification Programs**

Suggested Review

The growing use of voluntary accreditation/certification programs has the potential of providing regulators with important information about a company. Many of these organizations require companies to actively monitor their compliance practices and take appropriate corrective actions when necessary. This information may provide the analyst with insight regarding a company's commitment to establishing and maintaining a culture of compliance designed to continually improve its market conduct and compliance practices. It can be considered as one relevant indicator of compliance with related state statutes and regulations.

Where applicable for the line of business under review, check the website of any applicable voluntary accreditation/certification program to see if the company participates in a voluntary accreditation/certification program. Voluntary accreditation/certification programs include, but may not be limited to the National Council on Quality Assurance (https://www.ncqa.org/) and the Utilization Review Accreditation Commission (*www.urac.org*).

Note: Any self assessment/review done by the company to meet the certification/accreditation standards of these organizations must be obtained directly from the individual company under review. While the document may contain useful information, the decision to contact the company directly to obtain the document is at the discretion of the state performing the Level 2 Analysis.

Specific Items to Look For

In reviewing information regarding the participation of the company in a voluntary accreditation/certification program, the following items should be considered:

1. Does the company participate in a voluntary accreditation/certification program? If yes,
    a. How long has the company participated and when was it last accredited or certified?
    b. Does the company use the accreditation/certification in its marketing materials (letterhead, advertisements, brochures, website, etc.)? If so, is the use of it in its marketing materials appropriate?

Note: Access to the NAIC systems noted above (regulator-only myNAIC, iSite+, StateNet, MATS, RIRS, MARS, etc.) is restricted to those people authorized by the individual insurance departments. If the analyst does not currently have access to any of the systems, the analyst must follow his/her insurance department's internal procedures for obtaining proper authority to access the needed system.

VOLUME III—FOREWORD
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 was 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.

Updates to the *Market Regulation Handbook*

This handbook is updated and released on an annual basis. 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 run by jurisdiction and by line and the development of a complaint index by the use of market share and complaint share.

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

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

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

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

B. Scope

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

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

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

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

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

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

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

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

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

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

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

C. Overview of Examination Methods

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

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

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

The *Insurance Department Resources Report-Volume One,* (IDRR) 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 2021 data, published in December 2022, revealed that more than 65% of all jurisdictions perform market conduct reviews or examinations. Market conduct examiners are utilized by more than half of the jurisdictions. Jurisdictions may also use financial examiners, contract examiners or part-time market conduct examiners, who often also perform other functions as part of that insurance department's internal staff. Due to various forms of resource limitations, permanent full-time market conduct personnel are not always utilized.

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

The use of computers enhances an examiner's ability to perform sampling, record examination findings, produce a report of the findings and expedite 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 procedural manuals, marketing materials, underwriting guidelines, internal audits, self-evaluations, compliance plans, best practices organizations membership programs etc.); and
- Documents or other records created, produced, obtained by or disclosed to examiners and exchanges of information between state insurance department personnel, including department attorneys and examiners regarding the review of a regulated entity. This type of communications may include communication with representatives of other state insurance departments.

What Makes Data Confidential?
The type of data under review by an examiner may be considered confidential under federal and/or state law. Many jurisdictions have either promulgated the *Model Law on Examinations* (#390) or created a substantially similar statute or law, which sets forth confidentiality provisions of documents, including work papers, created, produced or obtained by or disclosed to an insurance commissioner or any other person in the course of any market conduct actions. Although the report, once adopted and with the passage of the required time period, becomes public, under the Model, the underlying work papers remain confidential. The *Market Conduct 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 lock, or at a minimum, locking file cabinets to store confidential information;
- Limiting unauthorized access to confidential data includes limiting access to all forms of electronic, verbal and written confidential information stored and disseminated via hard drives, laptops, personal computers, electronic mail, the Internet, network servers, telephone communications (both land line and cellular), facsimile machines, photocopiers, scanning devices, digital images and videography, and electronic equipment, such as peripheral media read/write storage devices (CDs, diskettes, flash drives, memory sticks, thumb drives, etc.);
- Examiners should assume that no storage or transmission of confidential or sensitive data via any of the above methods is considered secure; instead, adequate encryption of data is required and secure access passwords should be established for all confidential documents and changed on a regular basis. Password-protected screensavers should also be employed and used;
- During an examination, and upon the conclusion of an examination, all written confidential material which will no longer be used should be handled in accordance with state record retention laws. If permitted by state law, documents to be destroyed should be disposed of in accordance with the document destruction procedures established by the state; and
- When an examination is completed and the information required to be retained under the particular state's retention laws has been properly saved and secured, all electronic hardware used in the course of the examination, including hard drives, laptops, personal computers, voice messaging systems, facsimile machines, photocopiers, scanning devices, digital cameras and audio/visual recording devices and peripheral read/write storage media (CDs, diskettes, flash drives, memory sticks, thumb drives, etc.) should be sanitized so that recovery of confidential information is not feasible.

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

Some privileges which may be asserted include:

- Attorney-client privilege: Protects the actual communications between the client and lawyer and only extends to information given for the purpose of obtaining legal advice or representation. The information is generally not protected if it is available from another source and must be claimed and not waived by the client;
- Attorney work product privilege: "Tangible and intangible material which reflects an attorney's efforts at investigating and preparing a case, assembling of information, determination of the relevant facts, preparation of legal theories, planning of strategy, and recording of mental impressions." 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:

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

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

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

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

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

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

C. Minimum Qualifications of Multistate Examiners

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

D. Conflict of Interest for all Examiner Classifications

No examiner shall either directly or indirectly have a conflict of interest or be affiliated with the management of or own a pecuniary interest in any company subject to examination. This statement should not be construed to preclude an examiner from being a policyholder or claimant under an insurance policy; a grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity, if done under customary terms and in the ordinary course of business; an investment owner in shares of regulated diversified investment companies; or a settler or beneficiary of a blind trust into which any otherwise 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 at the time the examination is initiated and terminating upon completion of the examination or the examiner's active participation therein and to include actual travel time. If air travel is used, only one day's travel time will be authorized. If a motor vehicle is used, travel time allowed shall be computed at the rate of not less than 400 miles per day. To determine travel time for an examiner who uses a motor vehicle, divide actual mileage by a minimum of 400 miles, which results in the number of travel days.

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

If the examiner is assigned to an exam and available for work on any day that the company has closed for business, it is recommended that salary shall be allowed for that 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; and
    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 (SDRs) 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 SDRs that all states can use for uniform examinations. The SDR layouts and the fields contained within are subject matter and/or line of business specific. They include a brief description of the data the SDR intends to gather and a list of possible uses for the data submitted. The type and scope of examination will determine which SDRs and data fields should be requested.

The following parameters were taken into consideration during the development of SDRs:

- 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 SDRs. 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.

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

A. SDRs

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 An 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 SDRs Found?

Regulators may access NAIC SDRs adopted by the NAIC Executive (EX) Committee and Plenary via myNAIC. On the StateNet home page, click on the Market Regulation Handbook, Handbook Updates and Reference Documents link. Then click on the Market Regulation Handbook Reference Documents (Includes Standardized Data Requests) link. The SDRs are in the Standardized Data Requests section of the Reference Documents web page. Non-regulators may access SDRs adopted by the NAIC Executive (EX) Committee and Plenary via Account Manager 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. 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 SDRs (which replaced the combined NAIC Producer, Commission and Complaint SDR 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 1) new stand-alone life claims, life declinations, life in force and life replacement SDRs, which were adopted by the NAIC Executive (EX) Committee and Plenary in 2017, and by 2) new stand-alone annuity claims, annuity new business declinations, annuity in force, annuity payment, withdrawal and surrender, annuity plan code and annuity replacement SDRs, which were adopted by the NAIC Executive (EX) Committee and Plenary in 2018.

The combined Property and Casualty Personal Lines SDR adopted in 2006 was replaced by new stand-alone private passenger auto in force, private passenger auto claims, homeowners in force, homeowners claims and personal lines declinations SDRs, all of which were adopted by the NAIC Executive (EX) Committee and Plenary in 2019.

New Inland Marine in force, Inland Marine claims, Farmowners in force, Farmowners claims, and Workers' Compensation in force SDRs were adopted by the NAIC Executive (EX) Committee and Plenary in 2020 and new Long-Term Care in force and Long-Term Care claims SDRs were adopted by the NAIC Executive (EX) Committee and Plenary in 2021.

A new Title in force SDR and a new Title Claims SDR were adopted by the NAIC Executive (EX) Committee and Plenary in 2022. These two SDRs replace the Title Insurance SDR adopted by the Market Regulation Handbook (D) Working Group in 2008.

At the time of publication of the 2023 edition of the *Market Regulation Handbook,* there are 32 SDRs adopted by the NAIC:

1. Producer Data Request;
2. Marketing and Sales Data Request;
3. Commission Data Request;
4. Complaint Data Request;
5. Private Passenger Automobile In Force Data Request;
6. Private Passenger Automobile Claims Data Request;
7. Homeowners In Force Data Request;
8. Homeowners Claims Data Request;
9. Personal Lines Declinations Data Request;
10. Life Claims Data Request;
11.. Life Declinations Data Request;
12. Life In Force Data Request;
13. Life Replacement Data Request;
14. Long-Term Care In Force Data Request;
15. Long-Term Care Claims Data Request;
16. Annuity Claims Data Request;
17. Annuity New Business Declinations Data Request;
18. Annuity In Force Data Request;
19. Annuity Payment, Withdrawal and Surrender Data Request;
20. Annuity Plan Code Data Request;
21. Annuity Replacement Data Request;
22. Workers' Compensation In Force Data Request;
23. Farmowners In Force Data Request;
24. Farmowners Claims Data Request;
25. Inland Marine In Force Data Request;
26. Inland Marine Claims Data Request;
27. Property and Casualty Commercial Data Request;
28. Health, Long-Term Care and Medicare Supplement Data Request;
29. Credit Life and Accident and Health Data Request;
30. Title In Force Data Request and Sample Letter;
31. Title Claims Data Request and
32. Health Reform-Related Data Request and Definitions.

The NAIC updates SDRs periodically. When SDRs are adopted by the Market Regulation and Consumer Affairs (D) Committee, they are made available to regulators as an interim update to the *Market Regulation Handbook* in the Handbook Updates section at the link Market Regulation Handbook, Handbook Updates and Reference Documents on the StateNet home page. Non-regulators may access interim updated SDRs via the online subscription service (OSS) for paying customers.

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

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

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

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

G. Notice of Examination Reported to MATS

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

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

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

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

    b. Content of Notice—The notification letter should advise the company of the following information and arrangements. (Some states may include this in the form of an examination coordinator's handbook or pre-examination packet):
        1. The scope, intent and period to be covered by the examination and estimated start and end date. The duration of the examination may be adjusted based upon on-site conditions. If it becomes necessary to change the starting date, the company should be notified of the change;
        2. The legal basis for examination and cost and billing procedures;
        3. Arrangements for receiving copies of relevant company procedural guidelines, manuals, policy forms with notice of approval, advertising materials, producers' records, renewal material, methods used to solicit business, any required consumer complaint register and any other pertinent data;
        4. Requests for data that require lead time to develop—e.g., claims runs, loss and expense ratios (acquisition, administrative and claim cost), policy runs, licensed producers runs—or any alternate and/or appropriate methods of isolating records, if necessary;
        5. Office space, supplies and equipment required to conduct the examination;
        6. A request that the company respond to the notification letter and furnish the name of its examination coordinator;
        7. The parameters of 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's office, it may not be necessary to obtain such information at the company office.

2. Pre-Examination Visit or Telephone Call

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

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

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

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

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

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

f. Review materials requested in the notice; and

g. Discuss working hours and travel arrangements.

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

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

M. Data/Files

Data Requests Are Provided to the Company
Detailed instructions for data requests should be provided in the pre-examination packet or examination coordinator's handbook. States should utilize the uniform data requests or inform the company that they will be supplying alternative data requests. The request should clearly state the file type, format and medium. Examples of data requests are policy types by policy number and issue date; claim types by claim number and date received; commissions paid by name, date and amount; producer contracts by name and effective date; and policy forms by type and 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 field work. It may be included in the pre-examination packet/examination coordinator's handbook or mailed to the company at the conclusion of the examination. A sample post-examination questionnaire is included at the end of this chapter.

R. Market Conduct Uniform Examination Outline

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

    b. States shall utilize the NAIC Market Action Tracking System (MATS).
        1. As soon as scheduled, each state shall enter the examination into MATS, which is administered by the NAIC;
        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—A company may change its product mix, resulting in a significant change in its operations. If a company has not adequately managed for such a change, it may not have the expertise to properly and fairly treat its consumers. An examination may address problems before such problems become widespread.

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

9. Information from Statistics—States may maintain several databases. For example, Missouri law requires the reporting of certain information, such as financial statements, premium volume and amounts of claims paid categorized by ZIP code, malpractice claims, etc. Statistical tests evaluate aberrations that may necessitate further discovery by means of an examination. Many states participate in the Market Conduct Annual Statement (MCAS). General information and additional detail regarding MCAS may be found on the NAIC website *https://content.naic.org/mcas-2023.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 a judgment. Time and resources spent investigating the coin can be further reduced by reducing the sample size, or number of coin tosses, from 100 to 50. After 50 tosses the probability of 30 percent heads is .87 percent, and one can still be highly confident that the coin is unfair given the result.

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

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

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

[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 statute/complies with statute."

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

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

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

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

The most common calculations necessary to make inferences are included in various tables in this chapter. In addition, computer programs are available which can randomly select files, compute statistical formulas, develop probabilities, make complex computations and even make a sample selection. One such program, 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 instances. A stratified sample is obtained by performing a separate and independent random sample on each subpopulation of interest. The results are then combined into a single sample. For example, if a regulator is concerned about the impact of a specific processing center on overall claims settlement practices in a state, a random sample may be drawn from the center of interest, and a separate sample drawn from the remainder of claims in a state. The items in the resulting sample must be *weighted* to reflect the proportion of each subpopulation in the general or overall population before inferences can be made about the statewide claims processes.

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

D. Standards

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

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

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

   A famous example of pre-selection resulting in significant statistical bias in a sample is the 1936 *Literary Digest* poll of voting intentions. The *Literary Digest* predicted a large victory for challenger Alfred Landon over incumbent Franklin Roosevelt, a result 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 reviews of the data. For example, some insurance departments collect ZIP code data, which can be used to assess whether the pull list contains the entire population of interest. All states have access to 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, the level of confidence is associated with a numeric interval within which, with a probability equal to the confidence level, the true value is likely to lie.

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

   For the first-stage acceptance sample, a minimum confidence level of 95 percent should be selected. For the second-stage sample, the regulator should use discretion in selecting an appropriate confidence level, although it should 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 sampling error rate relative to such laws represents the probable number of violations within the total population rather than a benchmark for evaluating whether or not a violation has occurred. While it is not strictly necessary to use the 7 percent and 10 percent tolerance levels in these circumstances, states are still encouraged to do so when calculating appropriate sample sizes for consistency in both application and presentation. For this reason, all calculations in this chapter utilize the 7 percent and 10 percent tolerance levels.

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

[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, losses 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 repaired. The new population to be sampled then becomes all claims in a state, except those processed at the center producing the corrupt data. The subsequent sample indicates that 13 percent of claim files contain errors (+/– 'x' percent). The only valid generalization from this sample is that 13 percent of the claims from the centers sampled, not 13 percent of all claims in the state, contain errors. Nothing can be meaningfully said, based on the sample, of the processing center that was excluded from the initial population.

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

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

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

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

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

G. Sample Sizes

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

The term confidence, in the statistical sense, is always related to a specified level of precision (or margin of error) of an estimate calculated from a sample. Confidence and precision are inversely related: other things being equal, less confidence is associated with more precise estimates. For example, in many popular presentations of sample results, an estimate is presented with a confidence of 'x' percent and a margin of error (or confidence interval) of ±'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.

[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.

[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.

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 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

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.

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").

However, Type I risk is significantly greater than risks associated with larger samples. For claims, the Type I risk for each population size exceeds 71 percent for processes that have an actual error rate of only 3 percent, which is well below the 7 percent critical threshold. Similarly, the Type I risk for non-claims processes is more than 83 percent for processes with a 6 percent error rate. Large Type I risks are inherent in small samples due to a large margin of error.

This method is not recommended for general use, since it does not finely discriminate between compliant and noncompliant processes, except when the true error rate is well below 3 percent.[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 form similar to the AST table shown previously in this chapter. The cumulative probability column displays the percentage of samples (if taken over time) that would contain the corresponding number of errors *or fewer*, *if the population error rate equaled the tolerable error, or 5 percent.* For example, six or fewer errors 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 95 percent, and the upper error limit for claims or non-claims processes (7 percent or 10 percent). Since the AST was initially constructed using a 4.5 percent margin of error for claims, the "expected error rate" for ACL is 2.5 percent (upper error limit—margin of error) = (7% – 4.5%) = 2.5%. ACL's sample size will not exactly duplicate those listed in the AST, since the sample sizes in the AST were adjusted for Type I risks.

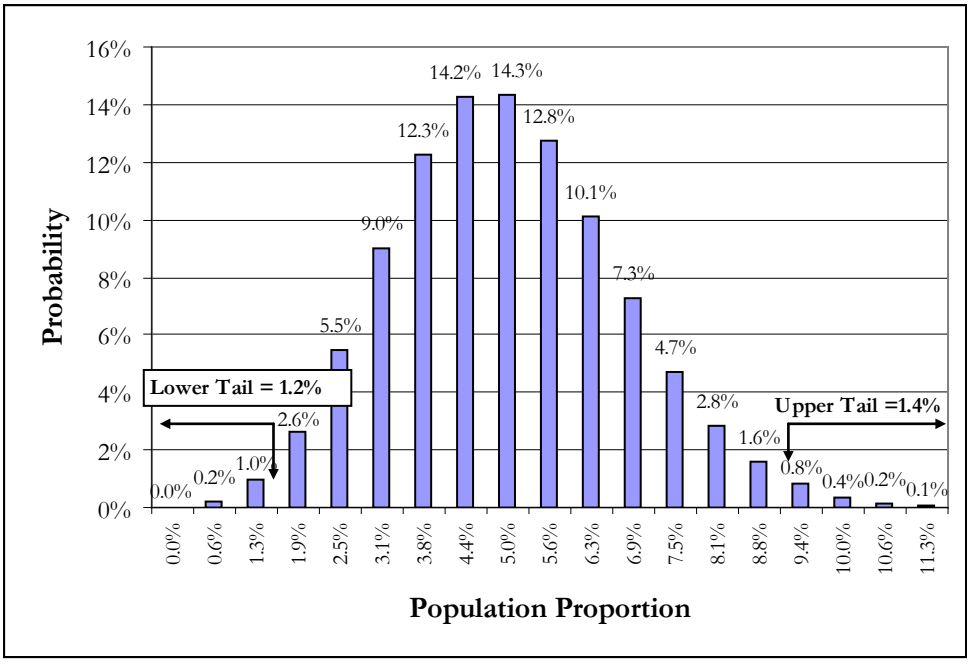
Because the ACL routine is a one-tailed test appropriate for acceptance sampling, confidence limits must be modified for the second stage sample, which generally employs a two-tailed test. That is, during the second-stage sampling, the concern is generally not whether the population proportion exceeds 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%

Probability Distribution if Population Proportion is 5%				
Population	Sample	Errors	% Errors	Probability
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 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 30 percent, the confidence limits will be significantly wider than initially anticipated. Confidence limits, therefore, must be calculated after the analysis of the sample is 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 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. 34

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

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

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 inquiries made of multiple market participants), and other non-examination regulatory interventions. MATS also provides notification of new and updated action information via the Personalized Information Capture System (PICS).

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

b. Complaints Database System (CDS)
   CDS has been operational since 1991 and is only available to regulators. Complaint information is recorded identifying the type, reason and ultimate disposition. Reports readily provide the number of complaints and are 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 is not subject to the Fair Credit Reporting Act (FCRA).

To search for producers via iSite+:

- Log into the regulator-only portion of myNAIC and select iSite+ from the login categories;
- 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 Analytics®

ACL Analytics, formerly known as ACL for Windows®, is the NAIC-recommended software to assist with the audit and evaluation of electronic data during an examination.

ACL Analytics 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 Analytics 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 Analytics 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 Analytics for a particular purpose. The examiner must be able to distinguish between useful and non-useful data.

ACL Analytics 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 Analytics, while others will not. A regulator may find the following examples of Analytics applications useful. These are "theoretical" examples that have not been tested in the field. Regulators are asked to share ideas regarding the use of Analytics with fellow examiners. The current schedule of NAIC-sponsored ACL Analytics 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.

In 2023, NAIC is transitioning to TeamMate+, a cloud-based version of the audit software. Since the existing Teammate AM version has a projected end of life of 2026, the Electronic Workpaper (E) Working Group decided to allow states to comfortably transition to TeamMate+, to continue to allow coordination and uniformity for users. There are TeamMate+ resources available in the regulator-only NAIC TeamMate+ portal at *https://www.naic-campus.org/d2l/login*. State insurance regulators may obtain access to the portal by contacting the NAIC Technical Training department at *ttrainin@naic.org*.

To assist in the states' utilization of TeamMate for market conduct purposes, the NAIC developed Market Regulation TeamStores. The NAIC Market Regulation TeamStores were developed to provide state insurance regulators with uniform procedures which 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 Analytics, Introduction to ACL Analytics—Market Conduct and Advanced ACL Analytics. 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 called 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 (Compact) is a valuable resource for market regulators in compacting states when they are working with Compact-approved products. The Compact website, *www.insurancecompact.org*, contains pertinent information about Compact law, uniform standards and reviewer checklists. Market regulators can visit the website to learn more about the Compact processes and procedures, including the mix-and-match process that allows a Compact-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. Compact 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 Compact. Contact information for the Compact office can be found on the Compact's website. Compacting states have one or more designated representatives that actively participate in Compact meetings and activities and may also be a good resource to provide guidance on working with Compact-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, 2018 through Dec. 31, 2018. The files will be used on a PC, so please provide the information on a CD. The files should contain fixed length records in the layouts shown. The file format requested, in the order of preference, is delimited (comma or tab) text 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, 2018 through Dec. 31, 2018. 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-related portion of the combined Producer, Commission and Complaint standardized 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	20	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 Analytics, 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 Analytics, duplicates of the file will be made when the files are saved in the corresponding software package's format. ACL will only make duplicates of ASCII files.

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

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

Example:
"987654321","JONES, THOMAS P","21","19850505","","00000000"
"876543210","MILLER, BEVRA K","21","19960814","","00000000"
"765432109","NOBEL, RICHARD C","21","19890906","","00000000"
"654321098","PRICE, MARLENE","21","19940428","","00000000"
"543210987","RICE, WILLIAM P","21","19860102","","00000000"
"432109876","SMITH, BRIAN K","21","19900424","C","19961204"
"321098765","TAYLOR, CARL R","21","19870407","","00000000"
"210987654","WILLIAMS, CLIFFORD","22","19890605","","00000000"

ASCII Fixed Length—Every record is a predefined or 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·····1819909060·00000000
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 Analytics.

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 Analytics, 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 Analytics, 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 Analytics: 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 Analytics
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 Analytics 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-related portion of the combined Producer, Commission and Complaint standardized 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	5	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-related portion of the combined Producer, Commission and Complaint standardized 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 Analytics 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-related portion of the combined Producer, Commission and Complaint standardized 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-related portion of the combined Producer, Commission and Complaint standardized 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	D	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).

   Please note that an updated stand-alone Private Passenger Auto In Force Standardized Data Request (SDR) was adopted by the NAIC in 2019. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Private Passenger Auto In Force SDR replaces the Private Passenger Auto in force-related portion of the combined P&C Personal Lines standardized data request dated 2006. Non-regulators may access the updated Private Passenger Auto In Force SDR at *https://www.naic.org/account_manager.htm*. Some field names from the updated Private Passenger Auto In Force SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
CoCode	1	5	A	NAIC company code
PolPre	6	3	A	Policy prefix (**Blank if NONE**)
PolNo	9	20	A	Policy number
PolSuf	29	3	A	Policy suffix (**Blank if NONE**)
PolStTyp	32	3	A	Policy status type for the record (i.e., new or renewal) **Please provide a list to explain any codes used**
PolTyp	35	25	A	Type of policy, if any (i.e., standard, preferred, nonstandard) **Please provide a list to explain any codes used**
PolForm	60	10	A	Policy form as filed with the insurance department
PrCode	70	9	A	Company internal producer, CSR, or business entity producer identification code **Please provide a list to explain any codes used**
NPN	79	6	A	National producer number
GarAddr	85	25	A	Vehicle garaging address
GarCity	110	20	A	Vehicle garaging city
GarSt	130	2	A	Vehicle garaging state
GarZip	132	9	A	Vehicle garaging ZIP code
RateTerr	141	5	A	Code specifying rating territory **Provide a list of codes along with their meanings**
BILmtPP	146	3	N	Bodily injury limit per person (in thousands)
BILmtPA	149	3	N	Bodily injury limit per accident (in thousands)
UMBIPP	152	11	N	Uninsured motorist bodily injury limit per person (in thousands)
UMBIPA	163	3	N	Uninsured motorist bodily injury limit per accident (in thousands)

* 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-related portion of the combined Producer, Commission and Complaint standardized 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
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	100	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 on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Marketing and Sales SDR replaces the marketing and sales-related 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*.

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

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

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

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

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

b. Secondary Usage

States have discovered that the 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.optum.com.

J. Policyholder Service

1. Policyholder Service Practices

a. Calculation of Nonforfeiture Benefits

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

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

Test:
Use ACL Analytics 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 created using ACL Analytics, 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.

Please note that an updated stand-alone Homeowners In Force Standardized Data Request (SDR) was adopted by the NAIC in 2019. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Homeowners In Force SDR replaces the Homeowners in force-related portion of the combined P&C Personal Lines standardized data request dated 2006. Non-regulators may access the updated Homeowners In Force SDR at *https://www.naic.org/account_manager.htm*. Some field names from the updated Homeowners In Force SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
PolNo	1	9	A	Policy number
InsCity	10	20	A	Insured city (location)
InsZip	30	5	A	Insured ZIP code (location)
ProtCl	35	3	A	Protection class (if protection class is utilized)

* 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 Analytics. 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.

Please note that an updated stand-alone Homeowners In Force Standardized Data Request (SDR) was adopted by the NAIC in 2019. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Homeowners In Force SDR replaces the Homeowners in force-related portion of the combined P&C Personal Lines standardized data request dated 2006. Non-regulators may access the updated Homeowners In Force SDR at *https://www.naic.org/account_manager.htm*. Some field names from the updated Homeowners In Force SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
PolNo	1	20	A	Policy number
PolTyp	30	5	A	Type of policy (i.e., HO-1, HO-2, etc.) **Please provide a list to explain any codes used**
StrYr	35	4	A	Year the structure was built
InsZip	39	5	A	Insured ZIP code (location)
InceptDt	44	10	D	Inception date of the policy [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.

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 Analytics, 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, Rescissions, Terminations)

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

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

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

h. Coverage Analysis

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

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

Please note that an updated stand-alone Private Passenger Auto In Force Standardized Data Request (SDR) was adopted by the NAIC in 2019. Regulators can access the SDR on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Private Passenger Auto In Force SDR replaces the Private Passenger Auto in force-related portion of the combined P&C Personal Lines standardized data request dated 2006. Non-regulators may access the updated Private Passenger Auto In Force SDR at *https://www.naic.org/account_manager.htm*. Some field names from the updated Private Passenger Auto In Force SDR are provided below:

FIELD NAME	START*	LENGTH*	TYPE**	DESCRIPTION
CoCode	1	5	A	NAIC company code
PolPre	6	3	A	Policy prefix (**Blank if NONE**)
PolNo	9	20	A	Policy number
PolTyp	29	25	A	Type of policy, if any (i.e., standard, preferred, nonstandard) **Please provide a list to explain any codes used**
InceptDt	54	10	D	Inception date of the policy [MM/DD/YYYY]
NPN	64	6	A	National producer number
GarAddr	70	25	A	Vehicle garaging address
GarCity	95	20	A	Vehicle garaging city
GarSt	115	2	A	Vehicle garaging state
GarZip	117	5	A	Vehicle garaging ZIP code
RateTerr	122	5	A	Code specifying rating territory **Provide a list of codes along with their meanings**
BILmtPP	127	3	N	Bodily injury limit per person (in thousands
BILmtPA	130	3	N	Bodily injury limit per accident (in thousands)
UMBIPP	133	11	N	Uninsured motorist bodily injury limit per person (in thousands)
UMBIPA	144	3	N	Uninsured motorist bodily injury limit per accident (in thousands)

* 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.

Please note that an updated stand-alone Private Passenger Auto Claims Standardized Data Request (SDR) and an updated stand-alone Homeowners Claims SDR was adopted by the NAIC in 2019. Regulators can access the SDRs on the Market Regulation Handbook Reference Documents web page on StateNet. The updated Private Passenger Auto Claims SDR and Homeowners Claims SDR replace the Private Passenger Auto claims-related and Homeowners claims-related portions of the combined P&C Personal Lines standardized data request dated 2006. Non-regulators may access the updated Private Passenger Auto Claims SDR and Homeowners Claims SDRs at *https://www.naic.org/account_manager.htm*.

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 Analytics 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 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 (EICs) for each jurisdiction participating. If the EIC wishes, a brief acknowledgment of the courtesy and cooperation of the officers and employees of the company may be included; and

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

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.

VOLUME IV—FOREWORD
Review/Examination Criteria for Specific Types of Insurance and Regulated Entities

There are three types of market conduct examination standards in the *Market Regulation Handbook*: 1) general examination standards, which apply to all lines of business; 2) line of business-specific or product-specific examination standards; and 3) examination standards which pertain to specific types of regulated entities.

Within each chapter, examination standards are further broken down into categories corresponding to the business area being reviewed by examiners. The examination of the insurance operations of a regulated entity may involve reviewing one or more of the following business areas:

- Operations/Management;
- Complaint Handling;
- Marketing and Sales;
- Producer Licensing;
- Policyholder Service;
- Underwriting and Rating; and
- Claims.

The business areas in each of the following chapters vary, depending upon the line of business, type of insurance product, or type of regulated entity. The examination standards in each business area may suggest other areas of review that may be appropriate on an individual state basis.

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 was 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.

Updates to the *Market Regulation Handbook*

This handbook is updated and released on an annual basis. Instructions for accessing the updates on the NAIC website are located at the front of the most recently published *Market Regulation Handbook*.

Chapter 20—General Examination Standards

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

The examination of the insurance operations of a regulated entity may involve reviewing one or more of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the regulated entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. Many states have executed an agreement to share complaint information with one or more of these federal or state agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal or state agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

This chapter contains examination standards that are relevant to nearly all types of examinations. Chapters 21 through 32 contain standards that are specific to various product lines and specialized entities.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the regulated entity is and how it operates. It is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate a financial examination review, but is important in providing the market conduct examiner with an understanding of the examinee. Many troubled companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. The areas to be considered in this kind of review include:

a. History;
b. Profile;
c. Subcontractor oversight;
d. Internal audits;
e. Antifraud initiatives;
f. Certificates of authority;

g. Disaster recovery plan;
h. Computer systems;
i. Minutes from all meetings attended by the board of directors; and
j. Privacy.

2. Techniques

Typically, the items to be reviewed here can be prepared by the regulated entity and provided at the pre-examination conference. Supplemental information, including history and profile may be available in the insurance department files. Other items suggest an active review of regulated entity files relating to managing general agent (MGA) or subcontractor oversight, internal audits, procedure manuals, record management, computer systems controls and antifraud plans. The latter category of items should have substantial supporting documentation.

The absence of subcontractor oversight, internal audit functions, written procedures or an antifraud plan should be specifically noted when preparing the examination report.

a. History

The examiner should prepare for the examination report a very brief history of the regulated entity, including its formation; its type; its structure, including the parent corporation and other members of the group; and any major changes that are relevant to the current examination.

b. Profile

The profile includes an overview of the regulated entity's operations, including management structure, type of carrier, states where the regulated entity is licensed and the entity's major line(s) of business. A total change in the management team may generate the need to review the regulated entity on an abbreviated time cycle.

The examiner should review Market Action Tracking System (MATS) findings from prior examinations, Regulatory Information Retrieval System (RIRS) results, complaint index reports and reports from other NAIC applications and databases to determine if other regulators have expressed concerns that may require additional attention during the examination. RIRS and MATS information should not be included in the examination report.

The total written premiums for the major lines of business should be compared to the total writing in a given state to determine the market share. The loss, expense and combined ratios can be obtained from the expense exhibit attached to the annual statement or the NAIC Financial Analyst Workbench (FAW) system and may be calculated for the specific jurisdiction. Review IRIS ratios, which can be an indicator of market conduct problems. The surplus ratio should also be examined and noted for the period under review. Substantial shifts in the geographical area of operation and kinds of business written and volume should be noted, questioned and described.

c. Subcontractor Oversight

The jurisdiction's statutes on MGAs and other subcontractors are sources of tests for this oversight. The aim is to ensure that a regulated entity using subcontractors engages in a realistic level of oversight. Contracts should be reviewed to ensure compliance with the MGA statutes governing contract content and oversight features. The focus is on the oversight impacting records and actions considered in a market conduct examination such as, but not limited to, trade practices, claims practices, policy selection and issuance, rating, complaint handling, etc. Examiners should pay particular attention to a subcontractor's dealings with policyholders and claimants.

d. Internal Audits

A regulated entity that has no internal audit function lacks the ready means to detect structural problems until after problems have occurred. Any questionable findings about the internal audit function should be referred to the Examiner-in-Charge.

e. Antifraud Plans

The regulated entity should have antifraud plans which are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. In addition, insurers may be required by law to establish antifraud plans, and examiners should be aware of any state-specific legal requirements pertaining to antifraud measures.

The guidelines set forth in the *Antifraud Plan Guideline* (#1690), adopted by the NAIC in March 2011, are intended to provide a road map for state fraud bureaus, insurers' Special Investigative Units (SIU)s or contracted SIU vendors for preparation of an antifraud plan.

Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meet state compliance standards. The *Antifraud Plan Guideline* does not preempt other state laws or preempt or amend any guidance previously published by the NAIC Antifraud (D) Task Force or in the *Fraud Prevention Model Act* (#680).

f. Certificates of Authority

The examiner should determine if the regulated entity's operations conform with the regulated entity's certificates of authority.

g. Disaster Recovery Plan

It is essential that the regulated entity has a formalized disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster. The examiners should determine if the regulated entity maintains separate backups of all records and facilities to continue operations.

h. Computer Systems

The examiners should determine the types of controls, safeguards and procedures for protecting the integrity of the computer information. The focus in this case is on those records subject to a market conduct examination that are maintained in electronic format, such as, but not limited to, underwriting files, claim files, rate and form filings, complaint files, statistical data used to support rates, etc.

The regulated entity should identify the location(s) of all websites maintained by or for and authorized by the regulated entity and all approved producer sites.

In addition, an Internet search using the regulated entity's name should be conducted using a search engine such as Yahoo, Google or a metasearch (aggregator) search engine such as WebCrawler. If any additional sites are located that the regulated entity did not identify, it should be specifically noted when preparing the examination report. The examiner should be mindful that some searches may produce a large volume of "hits." In such a situation, the examiner should employ sampling techniques to determine the regulated entity's general practices on the Internet.

i. Minutes from All Meetings Attended by the Board of Directors

A review of the minutes of meetings with the board of directors should be conducted to ensure the board has proper oversight of the company's operations and activities. Note: When a credit company is the subject of an examination, examiners should be aware that there may be statutes, rules, and regulations with specific requirements regarding the organization and structure of credit organizations.

j. Privacy

The NAIC has adopted several sets of privacy requirements, and examiners will need to determine which requirement(s) the state imposes to conduct an examination. The first is the *NAIC Insurance Information and Privacy Protection Model Act* (#670) (hereinafter, the 1982 Model Act). The second NAIC approach was the *Health Information Privacy Model Act* (#55), which, according to NAIC records, as of April 2015 had not been adopted by any state, although a few states have related laws.

The NAIC then adopted a model titled *Privacy of Consumer Financial and Health Information Regulation* (#672) (hereinafter, the 2000 Model Privacy Regulation) to assist states with promulgation of regulations to comply with certain requirements of Title V of the federal Gramm-Leach-Bliley Act (GLBA) (PL 102-106), enacted by Congress in 1999. And, in 2002, the *Standards for Safeguarding Customer Information Model Regulation* (#673) (hereinafter, the 2002 Model Information Security Regulation) was adopted to assist states in establishing standards for development and implementation of safeguards by insurers to protect customer information, also required by Title V of GLBA.

In some cases, a state may have one or more of these measures, or a combination thereof, in force. NAIC records indicate that as of April 2015, 39 states plus the District of Columbia and Puerto Rico have enacted regulations/laws based on the 2000 Model Privacy Regulation.

1982 Model Act (#670)
The 1982 Model Act is focused primarily on the insurance application process, underwriting, policy issuance and related transactions. It requires various disclosures to applicants regarding the insurer's practices (e.g., that an investigative consumer report may be obtained and that information may be disclosed to insurance support organizations which, in turn, may retain and later re-disclose the information to others) and the applicant's rights (e.g., that the applicant has a right to obtain a copy of any investigative consumer report and that the applicant has the rights of access to and correction of information about him/her).

Notices providing these disclosures may be required at application and whenever there is a "change of status"—e.g., at renewal or reinstatement—if new or additional information is to be collected from a source other than the applicant. There is no requirement for annual notices. If an insurer intends to disclose information for the marketing of a product or service, the customer must be given an opportunity to opt out. Operations/Management Examination Standards #10 and #11 in this chapter are applicable only for those states that have enacted the 1982 Model Act or substantially similar privacy requirements.

2000 Model Privacy Regulation (#672)
The 2000 Model Privacy Regulation was adopted to implement certain privacy provisions of the Gramm-Leach-Bliley Act. Title V of GLBA addressed the confidentiality of information about customers of "financial institutions," a term that includes insurance companies, banks and depository institutions, broker-dealers, investment companies, registered investment advisors and a variety of other kinds of businesses. Title V, as further implemented by the 2000 Model Privacy Regulation, requires that financial institutions establish and implement a privacy policy and

provide notices to customers describing such policies and the customer's rights to opt out of disclosures other than those allowed by the exceptions in Sections 14 through 16 (Section 17B of the 2000 Model Privacy Regulation sets forth exceptions for the customer authorization requirement for certain health information disclosures). The adoption of regulations and guidelines was delegated to the functional regulators of the various financial institutions.

The federal functional regulators (including, among others, the Securities and Exchange Commission, the Office of the Comptroller of Currency and the Federal Trade Commission) and the NAIC have taken substantially similar positions in their regulations regarding the disclosure of customer personal information and notices. The federal regulations are nearly identical to each other, with very minor differences to reflect the different financial products and services involved and related business practices. The 2000 Model Privacy Regulation is very similar to the federal regulations with respect to the treatment of financial information, with appropriate changes for insurance products and services, as well as established business practices and relationships.

The notices required by the 2000 Model Privacy Regulation include initial, revised and annual privacy notices, which must reflect the privacy policy, including financial information disclosure practices, of the insurance regulated entity or other licensee. It should be noted that privacy policies differ from insurer to insurer, from insurer to other licensee, etc. There is no set format required for privacy notices, although they must be "clear and conspicuous" as that term is defined in the regulation. The regulation does, however, list the topics that the privacy notice must address. Since a privacy notice reflects a specific insurer's or other licensee's own particular financial information privacy practices, notices will legitimately differ.

The 2000 Model Privacy Regulation differs from the federal agency regulations in that the model includes protections for certain health information. In general, a licensee must get an individual's approval (opt-in) prior to disclosing nonpublic personal health information, unless the disclosure falls under an exception listed in Subsection 17B or the licensee is in compliance with the health privacy regulation promulgated by the U.S. Department of Health and Human Services (HHS) pursuant to the federal Health Information Portability and Accountability Act (HIPAA). Even if the licensee is not subject to HIPAA, the 2000 Model Privacy Regulation allows the option of complying with the HHS standards as an alternative to the NAIC standards.

Operations/Management Examination Standards #12, #13, #14, #15 and #16 in this chapter are applicable for examination of compliance with the 2000 Model Privacy Regulation regarding the disclosure of customer information.

2002 Model Information Security Regulation (#673)

The 2002 Model Information Security Regulation was adopted to establish standards regarding safeguarding of customer information, also required by Title V of GLBA. It should be noted that the 2002 Model Information Security Regulation requires that a licensee establish an information security program "appropriate to the size and complexity of the licensee," as well as appropriate to the "nature and scope of (the licensee's) activities." The regulation provides illustrative examples of various factors that a licensee may consider when developing its information security program. Operations/Management Examination Standard #17 in this chapter is applicable for examination of compliance with the 2002 Model Information Security Regulation for security standards.

Insurance Data Security Model Law (#668)

Operations/Management Examination Standard #17 in this chapter is also applicable for examination of compliance with the *Insurance Data Security Model Law* (#668). Note: When reviewing a regulated entity's information security program for compliance with applicable state statutes, rules or regulations relating to Model #668, in the absence of a "Cybersecurity Event," as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data

Security Pre-Breach Checklist found in the Reference Documents of the *Market Regulation Handbook*. Regulators may access Reference Documents on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents. Non-regulators may access Reference Documents via their login credentials on NAIC Account Manager at *https://www.naic.org/account_manager.htm*.

When reviewing a regulated entity's information security program and response to a "Cybersecurity Event" for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), after a Cybersecurity Event has occurred, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Post-Breach Checklist provided as Addendum A to Operations/Management Examination Standard 17 in this chapter.

3. Tests and Standards

The operations and management review includes, but is not limited to, the following standards addressing various aspects of a regulated entity's operations. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The regulated entity has an up-to-date, valid internal or external audit program.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Audit plan and regulated entities' procedural manuals

_____ Audit reports and results

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 12
Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751), Section 11
Best Practices Organizations White Paper

Review Procedures and Criteria

Review audit reports to determine if the function is providing meaningful information to management. If external, obtain an explanation.

Determine how management is using the reports.

Determine if the regulated entity responds to internal audit recommendations to correct, modify and implement procedures.

Determine if accuracy of internal statistical data and information systems is periodically tested by the regulated entity's audit program.

Determine if the regulated entity conducts periodic reviews of creditors with respect to their credit insurance business with such creditors.

Determine if the regulated entity has adopted edit and audit procedures to screen and check data submitted by the regulated entity's statistical agent.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the regulated entity has taken appropriate corrective action.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Electronic records control, recovery/backup plan and regulated entity's procedural manuals; whether the records are electronic

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)
Standards for Safeguarding Consumer Information Model Regulation (#673)

Review Procedures and Criteria

Review regulated entity records, central recovery and backup procedures. The plan and procedures should be valid and up-to-date.

Review computer security procedures.

If the regulated entity permits changes to be made to policies either electronically or verbally, check what security procedures the regulated entity has established to permit these changes. These may include who has authority to make those changes, and what verification is done by the regulated entity with the insured after changes are made.

Ensure there is adequate security of applicant/insured data during the electronic transference of information. Identify any areas where the applicant's/insured's privacy is not properly protected.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity antifraud plan and procedural manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Antifraud Plan Guideline (#1690)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Review the regulated entity's antifraud initiatives in conjunction with applicable statutory requirements. Antifraud initiatives may include fraud investigators, who may be insurer employees or independent contractors, and an antifraud plan.

Verify that the insurer, if required by applicable state statutes, rules and regulations, submits its antifraud plan to the insurance commissioner:

- Within ninety days of receiving a certificate of authority;
- Every five years thereafter; and
- Within thirty days of a material change made to the antifraud plan.

Determine if the plan is adequate, up-to-date and in compliance with statutes, rules and regulations.

Review the regulated entity's implementation (staffing, support, etc.) of its plan and, if necessary, discuss with management.

Note: An SIU antifraud plan may cover several insurer entities within a regulated entity, if one SIU has the fraud investigation mission for all entities.

Verify that the insurer's antifraud plan includes the following five sections:

1. General Requirements
    - An acknowledgment that the SIU has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer;
    - An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the insurance department or other applicable state regulatory agency within a specific time frame;
    - A provision stating whether the SIU is an internal unit or an external or third-party unit;
    - If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments;
    - A written description or chart outlining the organizational arrangement of the insurer's antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts:
        - If the SIU is an internal unit, the insurer shall provide general contact information for the company's SIU;
        - If the SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU company; and
        - If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented;
    - A provision where the insurer provides the appropriate NAIC individual and group code numbers;
    - A statement as to whether the insurer has implemented a fraud awareness or outreach program. If the insurer has an awareness or outreach program, a brief description of the program shall be included; and
    - If the SIU is a third-party unit, a description of the insurer's policies and procedures for ensuring that the third-party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third-party vendor.

    Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

2. Prevention, Detection and Investigation of Fraud
    - A description of the insurer's corporate policies for preventing fraudulent insurance acts by its policyholders;
    - A description of the insurer's established fraud detection procedures (i.e. technology and other detection procedures);
    - A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by the SIU;
    - A description of the SIU investigation program (i.e. by business line, external form claims adjustment, vendor management Statement of Positions (SOPs); and
    - A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from its claims or underwriting departments to the SIU.

3. Reporting of Fraud
    - A description of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations;

- A description of the insurer's criteria or threshold for reporting fraud to the insurance commissioner; and
- A description of the insurer's means of submission of suspected fraud reports to the insurance commissioner (e.g., the NAIC Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system or other).

Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

Note: The examiner should be aware of any applicable state statutes, rules and regulations regarding state antifraud mandatory reporting methods.

4. Education and Training
    - If applicable, a description of the insurer's plan for antifraud education and training initiatives of any personnel involved in antifraud related efforts. This description shall include:
        - The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.;
        - If the training will be internal and/or external;
        - Number of hours expected per year; and
        - If training includes ethics, false claims or other legal-related issues.

5. Internal Fraud Detection and Prevention
    - A description of insurer's internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.; and
    - A description of the insurer's internal fraud reporting system.

Determine if the regulated entity has procedures in place to prevent persons convicted of a felony involving dishonesty or breach of trust from participating in the business of insurance.

Determine if the regulated entity has procedures in place to provide information regarding fraudulent insurance acts to the insurance commissioner and in a manner prescribed by the insurance commissioner.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 4
The regulated entity has a valid disaster recovery plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Description of the regulated entity's disaster recovery plan, procedural manuals and controls

_____ Description of protective devices for various hazards and procedures/controls for protection from those hazards

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Market Conduct Record Retention and Production Model Regulation (#910)

Review Procedures and Criteria

Determine that the regulated entity's database(s) are protected from various hazards, including environmental hazards.

Review the regulated entity's documents. Any additional areas or lack of information should be discussed with the regulated entity's management. The disaster recovery plan should be valid, specific and operational, with procedures for implementation and should also be current. Failure of the regulated entity to adequately plan for the future means the standard was not met.

Failure of the regulated entity to adequately (on an ongoing basis) provide for off-site backup, failure of the regulated entity to provide adequate controls and, in the case of a catastrophe, failure to provide for recovery, means the standard was not met.

Operations/Management Examination Standard #2 in this chapter also addresses disaster recovery issues.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 5
Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and management agreements, must comply with applicable licensing requirements, statutes, rules and regulations.

Apply to All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Service Contracts Model Act (#685)
Managing General Agents Act (#225)
Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third Party Administrator Statute (#90)

Review Procedures and Criteria

Review the contract to determine compliance with state statutes and rules.

The contract should specify the responsibilities of the subcontractor regarding recordkeeping and responsibilities of the regulated entity for conducting audits.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 6
The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

_____ Audit reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Managing General Agents Act (#225), Section 5
Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third Party Administrator Statute (#90), Section 6
Consumer Credit Insurance Model Regulation (#370), Section 12
Variable Life Insurance Model Regulation (#270)

Review Procedures and Criteria

Entities can include an MGA, GA or TPA. Suppliers of consulting, investment, administrative, sales, marketing, custodial or other services with respect to variable life insurance operations are also considered entities (*Variable Life Insurance Model Regulation* (#270), Section 3E).

Review entity contracts to determine compliance with statutes, rules and regulations. The contract should specify the responsibilities of the MGA, GA and TPA concerning recordkeeping and responsibilities of the regulated entity for conducting audits.

Review audit reports to determine whether the regulated entity is adequately monitoring the activities of the contracted entity.

Review activities of entities to ensure compliance with applicable statutes and rules.

For credit insurance, each insurer is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business. The review should ensure compliance with statutes, rules and regulations. Written records of the reviews must be maintained by the insurer.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 7
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Market Conduct Record Retention and Production Model Regulation (#910)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Model Law on Examinations (#390), Section 4
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Evaluate the orderly organization, legibility and structure of files.

Review state record retention requirements to determine regulated entity compliance.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 8
The regulated entity is licensed for the lines of business that are being written.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority or other similar documents

_____ Access NAIC financial system

_____ Regulated entity system

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Service Contracts Model Act (#685)
Nonadmitted Insurance Model Act (#870)
Unauthorized Transaction of Insurance Criminal Model Act (#890)

Review Procedures and Criteria

Review certificates of authority; compare writings with authorized lines.

Review financial annual statement submitted to the NAIC; compare writings with authorized states.

Obtain explanation of any discrepancies.

Access regulated entity system to verify that writings are in line with written premium reported in the financial annual statement.

Automation Tip:
The Financial Applications section of NAIC iSite+ contains the annual statement financial information for insurance companies that report to the NAIC. The most useful for market conduct examiners would be the annual statement Pick-a-Page. The State Page Exhibit displays the direct written premiums in any particular state for any particular year.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 9
The regulated entity cooperates on a timely basis with examiners performing the examinations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Law on Examinations (#390)

Review Procedures and Criteria

Monitor regulated entity's cooperation during the course of the examination; this may be noted in the examination report.

Automation Tip:
Requests for information or "crits" can be monitored using either a database or spreadsheet. The information that should be captured includes: area of review, type of request, contact person, date given, date due and date received. Databases and spreadsheets contain functions that will calculate the number of days between two dates. The information can be easily sorted and reviewed to see what is still outstanding and if the regulated entity is responding in a timely fashion.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 10
The regulated entity has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written procedures of regulated entity for maintaining personal information and privileged information of applicants and policyholders

_____ The "Notice of Information Practices" required to be provided to applicants and policyholders

_____ Disclosure authorization forms

_____ Written procedures for the correction, amendment or deletion of recorded personal information

Others Reviewed

____ _____

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)
Unfair Discrimination Against Subjects of Abuse in Property and Casualty Insurance Model Act (#898)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Discrimination Against Subjects of Abuse in Health Benefit Plans Model Act (#895)
The Use of Social Media in Insurance White Paper

Review Procedures and Criteria

Determine if the regulated entity appropriately provides a "notice of information practices" that contains the required information.

Determine if the content of disclosure authorization forms meet content standards.

Determine if the regulated entity properly handles the use of investigative consumer reports.

Determine if the regulated entity's procedures appropriately limit access to personal information.

Determine if the regulated entity provides specific and accurate reasons for adverse underwriting decisions.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 11
The regulated entity has developed and implemented written policies, standards and procedures for the management of insurance information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity procedure manual

_____ Regulated entity training manual

_____ Internal regulated entity claim audit procedures

_____ Regulated entity bulletins regarding insurance information

_____ Contractual arrangements between the carrier and a person other than the covered person

Others Reviewed

____ _____

____ _____

NAIC Model References

Health Information Privacy Model Act (#55), Section 5
NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 4-9

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state law.

Review contractual arrangements between the regulated entity and other persons to determine if the contracts address privacy procedures and standards for the person with whom the regulated entity is contracting.

Review the regulated entity's methods for handling, disclosing, storing and disposing of insurance information. The examiners should determine whether there are procedures in place to ensure proper authorization is obtained prior to disclosure of insurance information.

Review the regulated entity's training manual to determine whether the regulated entity's employees are properly trained on the handling of insurance information.

Verify that the regulated entity provides a "Notice of Information Practices" to all applicants or policyholders or has procedures in place for the producer to deliver the notice. The examiner should determine whether the notice contains all provisions required by applicable state law.

Verify that the regulated entity specifies those questions designed to obtain information solely for marketing or research purposes.

Verify that the regulated entity has implemented reasonable procedures to address investigative consumer reports and personal interviews.

Verify that the regulated entity has established procedures to address access to, correction, amendment or deletion of recorded personal information.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 12
The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Other regulated entity manuals/instruction books

_____ Communication provided by the regulated entity to employees and producers subject to the regulated entity's privacy policies

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the regulated entity's policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers, to verify that they comply with applicable state laws regarding privacy.

Review employee procedures regarding the treatment of nonpublic personal information to verify that they comply with the regulated entity's privacy policies, practices and procedures and with applicable state laws regarding privacy.

As applicable, verify that the regulated entity/licensee has provided a copy of its privacy notice to its producers.

Determine that the regulated entity does not unfairly discriminate against customers and consumers who are not customers who (1) have opted out from the disclosure of nonpublic personal financial information to nonaffiliated third parties; and (2) have not authorized disclosure of nonpublic personal health information, if applicable.

Review all privacy-related consumer complaints and inquiries.

Standard 13
The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample notices to customers: initial, annual, revised and simplified, if applicable

_____ Sample notices to consumers that are not customers, if applicable: initial (standard and short-form) notices and revised notice

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Review the content of the regulated entity's initial, annual and revised notices.

Verify that these notices are clear and conspicuous and accurately reflect privacy policies and practices.

Notices should include the following:

- Identification of the regulated entity, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The categories of nonpublic personal financial information that the regulated entity discloses, if applicable;
- The categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;
- The categories of nonpublic personal financial information about the regulated entity's former customers that the regulated entity discloses and the categories of affiliates and nonaffiliated third parties to whom the regulated entity discloses nonpublic personal financial information about the regulated entity's former customers, other than disclosures permitted under Sections 15 and 16 of Model #672, if applicable;

- If a regulated entity discloses nonpublic personal financial information to a nonaffiliated third party under Section 14 of Model #672, a separate description of the categories of information the regulated entity discloses and the categories of third parties with whom the regulated entity has contracted;
- An explanation of the consumer's right to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right, if applicable;
- Any disclosures that the regulated entity may make under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 USC Section 1681a(d)(2)(A)(iii) (i.e., notices regarding the ability to opt out of disclosures of information among affiliates, other than transaction and experience information);
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- If a regulated entity only discloses nonpublic personal financial information as authorized under Sections 15 and 16 of Model #672, a statement that indicates the regulated entity makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

Review the content of the regulated entity's simplified notice, if applicable, which shall include:

- Identification of the regulated entity and affiliates or subsidiaries, if applicable;
- The categories of nonpublic personal financial information that the regulated entity collects;
- The regulated entity's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and
- That the regulated entity only discloses nonpublic personal financial information to affiliates and nonaffiliated third parties, as applicable, as authorized under Sections 15 and 16 of Model #672.

Review the content of the regulated entity's short-form notice for consumers who are not customers, if applicable, which shall state that the regulated entity's privacy notice is available upon request and provide a reasonable means by which the consumer may obtain a full notice.

Verify that the regulated entity's process for delivery of notices includes:

- Initial notice, if applicable, to consumers who are not customers;
- Initial notice to all customers, as required;
- Annual notice to all customers, as required;
- Revised notice to customers and consumers who are not customers entitled to notice, if applicable;
- Where applicable, simplified notices to customers, if the regulated entity only discloses nonpublic personal financial information about customers and former customers to affiliates and nonaffiliated third parties as authorized under Sections 15 and 16 of Model #672 (or the applicable sections under state law regarding privacy); and
- Short-form notices to consumers who are not customers, in lieu of initial notices, if applicable.

Verify that a notice is delivered to the regulated entity's customers at or prior to the time the regulated entity establishes a customer relationship (initial notice), and at least once in any period of 12 consecutive months or once in each calendar year thereafter (annual notice) during the continuation of the customer relationship, if appropriate. If initial notice was provided to customers after the customer relationship was established, verify that the notice was delivered within a reasonable time after the customer relationship was established and (1) establishing the customer relationship was not at the customer's election; or (2) providing notice at or prior to the establishment of the relationship would have substantially delayed the customer's transaction and the customer agreed to receive the notice at a later time.

Verify that if the regulated entity discloses any consumer's nonpublic personal financial information to any nonaffiliated third party, other than as authorized under Section 15 or 16 of Model #672 (or the applicable sections under state laws regarding privacy), the regulated entity delivers a notice before disclosing the information.

Verify that individuals deemed consumers under applicable law are provided with an initial notice where applicable (such as where a licensee discloses a claimant's nonpublic personal financial information outside Sections 14 through 16 of Model #672 or its equivalent under state laws regarding privacy).

Verify that a notice was delivered to the regulated entity's customers and, if applicable, to consumers who are not customers in a manner that can reasonably be expected to provide actual notice.

Verify that a notice was provided to the regulated entity's customers and, if applicable, to consumers who are not customers, in writing, or, if the licensee provides and if the consumer has agreed, electronically.

Verify that the regulated entity has provided customers with clear and conspicuous initial, annual and revised notices in a manner that allows the customer to retain the notices or obtain them later in writing or, if the customer has agreed, electronically.

If the regulated entity is an excess lines insurer and does not disclose nonpublic personal financial information to nonaffiliated third parties, except as authorized under Sections 15 and 16 of Model #672, verify that the notice set forth in Section 4Q(3)(ii) of Model #672 has been delivered to all customers at the time the regulated entity established ongoing relationships with the customers. If the regulated entity makes disclosures other than as authorized under Sections 15 and 16 of Model #672, the regulated entity is required to comply with applicable initial, annual and revised notice requirements and the opt-out requirements.

Review the regulated entity's notice content and notice delivery procedures to verify that the regulated entity complies with applicable statutes, rules and regulations regarding privacy.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 14
If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample notices to customers: initial, annual and, if applicable, revised

_____ Sample notices to consumers who are not customers, if applicable

_____ Sample opt-out notice, if applicable

_____ Regulated entity records of consumers and other customers who have opted out, if applicable

_____ Communication of customers' and consumers who are not customers' opt-out elections to producers of record

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

Determine whether the regulated entity discloses nonpublic personal information relating to customers or consumers who are not customers beyond the scope permitted under Sections 14, 15 and 16 of Model #672.

- Verify that consumers who may be affected by such disclosures have been offered the opportunity to opt out before the disclosures are made. Continue with Steps 1 through 5 below.
- If not, verify that any communications the regulated entity makes regarding opt-out rights are accurate and are in compliance with applicable law.
    1. If applicable, verify that the regulated entity has policies and procedures in place so that customers and other affected consumers may opt out of the disclosure of their nonpublic personal

financial information to nonaffiliated third parties, except to the extent such disclosure is permitted under Sections 14, 15 and 16 of Model #672.

2. If applicable, review the regulated entity's policies and procedures to verify that the regulated entity has the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out.

3. If applicable, verify that the regulated entity does not disclose, directly or through any affiliate, unless authorized or permitted by applicable federal and/or state law or regulations, nonpublic personal financial information about a consumer or to a nonaffiliated third party except when:
    - The regulated entity has provided a notice to the consumer;
    - The regulated entity has provided an opt-out notice to the consumer;
    - The regulated entity has given the consumer a reasonable opportunity to opt out of the disclosure before the regulated entity discloses the consumer's nonpublic personal financial information to a nonaffiliated third party; and
    - The consumer does not opt out.

4. As applicable, determine that the regulated entity's initial, annual, revised and short-form notices accurately explain the consumer's right to opt-out, including the methods by which the consumer may exercise that right at any time, in accordance with applicable law and the regulated entity's policies and procedures.

5. If applicable, review the content of the regulated entity's opt-out notice to determine if it is clear and conspicuous and includes, either on the form or on the initial privacy notice:
    - A statement that the regulated entity discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;
    - A statement that the consumer has the right to opt out of that disclosure; and
    - A reasonable means by which the consumer may exercise the opt-out right.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 15
The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Joint marketing agreements, if any

_____ Sample service agreements, if any, with nonaffiliated third parties involved in the regulated entity's marketing activities

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If the regulated entity discloses nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes, verify that all such disclosures are in compliance with Model #672:

- Verify that the regulated entity has provided initial notices to its customers and other affected consumers that include the required information regarding the regulated entity's joint marketing and servicing activities; and
- Review joint marketing agreements, where applicable, to verify that they prohibit the nonaffiliated third party from disclosing or using the nonpublic personal financial information received from the regulated entity other than to carry out the purposes for which the regulated entity disclosed the information, including use under an exception in Sections 15 or 16 of Model #672.

Verify that the regulated entity does not disclose nonpublic personal financial information that it receives from a nonaffiliated financial institution, except in compliance with Model #672.

Review sample service agreements under which a third party markets a licensee's own products and services, if any, to verify inclusion of non-disclosure requirements.

Verify that the regulated entity prohibits disclosure of policy numbers or similar forms of access numbers or access codes for a consumer's policy or transaction account to any nonaffiliated third party, except as permitted by applicable law or regulation regarding privacy.

Standard 16
In states promulgating the health information provisions of the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity privacy policies and procedures

_____ Sample authorizations used by the regulated entity to permit disclosure of nonpublic personal health information, if applicable

_____ Regulated entity records of customer and other consumer authorizations

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Privacy of Consumer Financial and Health Information Model Regulation (#672)

Review Procedures and Criteria

If applicable, verify that the regulated entity has policies and procedures in place to secure authorizations from its customers and consumers who are not customers before disclosing their nonpublic personal health information to nonaffiliated third parties, except to the extent such disclosure is permitted under Subsection 17B of Model #672.

If applicable, verify that the regulated entity has obtained valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information, except to the extent such disclosures are permitted under Subsection 17B of Model #672. A valid authorization shall include:

- The identity of the consumer who is the subject of the nonpublic personal health information;
- A general description of the types of nonpublic personal health information to be disclosed;
- A general description of the parties to whom the licensee discloses nonpublic personal health information;
- A general description of the purpose of the disclosure of the nonpublic personal health information;
- A general explanation of how the nonpublic personal health information will be used;

- The signature of the consumer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant disclosure authority and the date signed;
- A notice of the length of time for which the authorization is valid; and
- A notice that the consumer may revoke the authorization at any time, and an explanation of the procedure for making a revocation.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 17
Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity written materials describing its information security program

_____ Regulated entity policies, procedures and other materials it uses to implement its information security program

_____ Prior to conducting an examination, the examiner should review the state's definition of "customer" and "consumer" to determine appropriate usage of the terms. The examiner should also review the various exceptions and exclusions contained in the state's privacy act/regulation.

Others Reviewed

____ _____

____ _____

NAIC Model References

Standards for Safeguarding Customer Information Model Regulation (#673)
Insurance Data Security Model Law (#668)

Review Procedures and Criteria

Note: When reviewing a regulated entity's information security program for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), in the absence of a Cybersecurity Event, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Pre-Breach Checklist found in the Reference Documents of the *Market Regulation Handbook*. Regulators may access Reference Documents on StateNet at the link Market Regulation Handbook, Handbook Updates and Reference Documents. Non-regulators may access Reference Documents via NAIC Account Manager at *https://www.naic.org/account_manager.htm*.

Note: When reviewing a regulated entity's information security program and response to a Cybersecurity Event for compliance with applicable state statutes, rules or regulations relating to the *Insurance Data Security Model Law* (Model #668), after a Cybersecurity Event has occurred, as defined in applicable state statutes, rules or regulations, please refer to the Insurance Data Security Post-Breach Checklist provided as Addendum A to Operations/Management Examination Standard 17 in Chapter 20—General Examination Standards.

Review the regulated entity's written information security program to determine whether the security program includes administrative, technical and physical safeguards.

Determine whether, when developing safeguards, the regulated entity took into consideration the:

- Size and complexity of the regulated entity; and
- Nature and scope of regulated entity's activities.

In making the assessment above, consider factors such as: (1) the products and services offered by the regulated entity; (2) the methods of distribution for the products and services; (3) the types of information maintained by the regulated entity; (4) the size of the regulated entity (which may include the number of employees and the volume of business, etc.); (5) the marketing arrangements; and (6) the extent to which, or methods by which, the regulated entity communicates electronically with customers, producers and other third parties.

Evaluate whether the regulated entity's information security program is designed to:

- Ensure the security and confidentiality of customer information;
- Protect against any anticipated threats or hazards to the security or integrity of the information; and
- Protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

GUIDANCE
Insurance Data Security Model Law (#668)

The guidance that follows should only be used in states that have enacted the *Insurance Data Security Model Law* (#668) or legislation, which is substantially similar to Model #668. Moreover, in performing work during an exam in relation to Model #668, it is important that the examiners first obtain an understanding and leverage the work performed by other units in the department, including but not limited to, financial examination-related work.

OVERVIEW
The purpose and intent of Model #668 is to establish standards for data security and standards for the investigation of and notification to the Commissioner or Director of Insurance of a Cybersecurity Event affecting Licensees.

REVIEW GUIDELINES AND INSTRUCTIONS

When reviewing a Licensee's Information Security Program (ISP) for compliance with Model #668 for the prevention of a Cybersecurity Event, as defined in Model #668, please refer to the pre-breach examination checklist in the Reference Documents of the *Market Regulation Handbook* . Regulators can access the pre-breach examination checklist on the Market Regulation Handbook Reference Documents web page on StateNet. Non-regulators may access the pre-breach examination checklist at *https://www.naic.org/account_manager.htm*.

When reviewing a Licensee's ISP and response to a Cybersecurity Event for compliance with Model #668 subsequent to a suspected and/or known Cybersecurity Event, as defined in Model #668, please refer to both the pre-breach examination checklist and the post-breach examination checklist.

When considering whether to underake such a review, refer to Section 9 of Model #668, which provides certain exceptions to compliance for licensees with fewer than 10 employees; licensees subject to the Health Insurance Portability and Accountability Act (HIPAA) (Pub.L, 104–191, 110 Stat. 1936, enacted Aug. 21, 1996); and certain employees, agents, representatives, or designees of licensees who are in themselves licensees.

ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

POST-EVENT INVESTIGATION BY LICENSEE (Section 5)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
1. Did the Licensee conduct a prompt investigation of the Cybersecurity Event? (Section 5A)	
2. Did the Licensee appropriately determine the nature and scope of the Cybersecurity Event? (Section 5B)	

NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
3. Did the Licensee provide timely notice (no later than 72 hours) to the Commissioner or Director of Insurance following the Cybersecurity Event? (Section 6A)	
4. Did the notification to the Commissioner or Director of Insurance include the following information, to the extent reasonably available? (Section 6B)	
4a. The date of the Cybersecurity Event, or the date upon which it was discovered?	
4b. A description of how the Nonpublic Information was exposed, lost, stolen or breached, including the specific roles and responsibilities of Third-Party Service Providers, if any?	
4c. How the Cybersecurity Event was discovered?	
4d. Whether any lost, stolen or breached Nonpublic Information has been recovered, and if so, how this was done?	
4e. The identity of the source of the Cybersecurity Event?	
4f. Whether the Licensee has filed a police report or has notified any regulatory, government or law enforcement agencies? *(If YES, did the Licensee provide the date(s) of such notification(s)?)*	
4g. A description of the specific types of Nonpublic Information acquired without authorization?	
4h. The period during which the Information System was compromised by the Cybersecurity Event?	
4i. A best estimate of the number of total Consumers in this state and globally affected by the Cybersecurity Event?	
4j. The results of any internal review of automated controls and internal procedures and whether or not such controls and procedures were followed?	

ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

NOTICE TO COMMISSIONER/DIRECTOR OF INSURANCE (Section 6) (CONT'D)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
4k. A description of efforts being undertaken to remediate the circumstances which permitted the Cybersecurity Event to occur?	
4l. A copy of the Licensee's privacy policy and a statement outlining the steps the Licensee will take to investigate the Cybersecurity Event and to notify affected Consumers?	
4m. The name of a contact person familiar with the Cybersecurity Event and authorized to act for the Licensee?	
5. Did the Licensee provide timely updates to the initial notification and Questions 4a–4m above? (Section 6B)	

OTHER NOTIFICATIONS (Section 6)

REVIEW CRITERIA	**NOTES *(YES, NO, NOT APPLICABLE, OTHER)***
6. Did the Licensee provide timely and sufficient notice of the Cybersecurity Event to Consumers? (*If YES, did the Licensee provide a copy of the notification to the Commissioner(s)/Directors of all affected states?)* (Section 6C)	
7. Did the reinsurer Licensee provide timely and sufficient notice of the Cybersecurity Event to ceding insurers? (Section 6E)	
8. Did the Licensee provide timely and sufficient notice of the Cybersecurity Event to independent insurance producers and/or producers of record of affected Consumers? (Section 6F)	

THIRD-PARTY SERVICE PROVIDERS

REVIEW CRITERIA	***NOTES (YES, NO, NOT APPLICABLE, OTHER)***
9. Did the Cybersecurity Event occur at a Third-Party Service Provider? *(If YES, did the Licensee fulfill its obligations to ensure compliance with this law, either directly or by the Third-Party Service Provider?)* (Sections 5C and 6D)	

ADDENDUM A TO OPERATIONS/MANAGEMENT STANDARD 17
CHAPTER 20—GENERAL EXAMINATION STANDARDS
MARKET REGULATION HANDBOOK
INSURANCE DATA SECURITY POST-BREACH CHECKLIST, CONT'D

Supplemental Incident Response Plan Investigation (Post-Breach) and Notification Cybersecurity Event Checklist for Operations/Management Standard #17
Model #668, Sections 5 and 6

Company Name	
Period of Examination	
Examination Field Date	
Prepared By	
Date	

POST-EVENT ANALYSIS

REVIEW CRITERIA	***NOTES (YES, NO, NOT APPLICABLE, OTHER)***
10. What changes, if any, are being considered to the Licensee's ISP as a result of the Cybersecurity Event and the Licensee's response?	

STANDARDS
OPERATIONS/MANAGEMENT

Standard 18
All data required to be reported to departments of insurance is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Underwriting files

_____ Regulated entity's medical professional liability closed claim reports (if applicable)

_____ Regulated entity's Market Conduct Annual Statement (MCAS) submissions

_____ Regulated entity's responses to state-specific data requests

Others Reviewed

Statutory or regulatory authority for state-specific data requests

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Medical Professional Liability Closed Claim Reporting Model Law (#77)
Market Conduct Surveillance Model Law (#693)

Review Procedures and Criteria

Interview the regulated entity's personnel who prepare loss statistical reports, medical professional liability loss reports, MCAS data and state-specific data requests; analyze regulated entity's internal communications between various departments which report same.

Determine that the regulated entity reviews data errors and subsequent changes are made.

Determine if the regulated entity's medical professional liability closed claims reports are accurate and reported within the required time frame.

Request that the regulated entity reconcile closed claims reports, state-specific data requests and MCAS data with the State Page of the annual statement to include payments, case reserves, and defense cost containment expenses, and explain differences.

Request that the regulated entity reconcile closed claims reports to data provided on the standardized data request.

B. Complaint Handling

1. Purpose

The NAIC definition of a complaint is "any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose." The examiner should review the regulated entity's procedures for processing consumer or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the regulated entity's operation.

If a regulated entity is using social media, the examiner should review the regulated entity's policies and procedures with regard to regulated entity handling of complaints received via social media, in which the regulated entity is active.

2. Techniques

A review of complaint handling should incorporate both consumer direct complaints to the regulated entity and those complaints filed with the insurance department. The examiner should reconcile the regulated entity's complaint register with a list of complaints from the insurance department. A random sample of complaints should be selected for review from the regulated entity's complaint register. If such a register is not maintained, alternative methods of isolating complaints may be implemented.

The examiner should review the frequency of similar complaints and be aware of any pattern of specific type of complaints. The examiner should take into consideration the increase of complaints that typically follows a catastrophe. Should the type of complaints generated be cause for unusual concern, specific measures should be instituted to investigate other areas of the regulated entity's operations. This may include modifying the scope of examination to examine specific regulated entity behavior.

The examiner should review the NAIC Complaints Database System (CDS) to determine the regulated entity's complaint index, along with any adverse trends in complaint volume. The examiner may wish to review complaint trends and the complaint index for the preceding three years.

The examiner should review the final disposition of the complaints and determine if the regulated entity has taken adequate steps to finalize the complaint. The examiner should determine if the actions taken are in compliance with statutes, rules and regulations.

In states that have established a statutory or regulatory standard of promptness, a study should be conducted to determine how promptly the regulated entity responds to complaints, the adequacy of the responses and what, if any, actions were taken to resolve the problems.

If the examination involves a depository institution or their affiliates, it may also be regulated by a federal agency, such as the Office of the Comptroller of the Currency, the Federal Reserve Board, the Office of Thrift Supervision or the Federal Deposit Insurance Corporation. In addition, banks may also be regulated at the state level. If the state has signed an agreement to share complaint information with these agencies, any adverse trends or pattern of concern to the examiners may be identified and relayed to the agency.

3. Tests and Standards

The complaint handling review includes, but is not limited to, the following standards addressing various aspects of a regulated entity's operations. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
COMPLAINT HANDLING

Standard 1
All complaints are recorded in the required format on the regulated entity's complaint register.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity complaint register

_____ Insurance department's complaint records

_____ Direct consumer complaints

_____ Complaints received electronically (i.e., via Internet or email)

Others Reviewed

____ _____

____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Consumer Complaints White Paper
Unfair Trade Practices Act (#880), Section 4K

Review Procedures and Criteria

All of the above should be reviewed to make sure the regulated entity is:

- Recording all complaints (both consumer direct and insurance department); and
- Recording required information in the regulated entity complaint register.

Determine if the regulated entity complaint register meets minimum standards as required by law. At a minimum, the complaint register should include:

- Line of business;
- Function (underwriting, marketing and sales, claims, policyholder services or miscellaneous); and
- Reason for complaint (underwriting, application, cancellation, recission, nonrenewal).

Automation Tip:
Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Do not specify which data to be supplied, but instead go with exactly what the regulated entity tracks. A review can be made to see if they contain the information that should be collected from each complaint. Then, a sample can be pulled to review individual complaints to see if the regulated entity's procedures are being followed.

Obtain complaint data file from the insurance department (in whatever format available; e.g., ASCII text file, Microsoft Access, etc.). Convert the data file to a format compatible to the spreadsheet/database from the regulated entity. Compare the complainant name, claim number, policy number, etc., in both files to determine if all of the insurance department complaints were correctly logged by the regulated entity.

STANDARDS
COMPLAINT HANDLING

Standard 2
The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint handling procedure manuals

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review the regulated entity's manuals to verify that complaint procedures exist.

Determine whether there are sufficient procedures in place to require satisfactory handling of complaints received, as well as internal procedures for analysis in areas developing complaints.

Determine whether there is a method for distribution of and obtaining and recording responses to complaints. This method should be sufficient to allow response within the time frame required by state law.

The regulated entity should provide a telephone number and address for consumer inquiries.

STANDARDS
COMPLAINT HANDLING

Standard 3
The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Regulated entity complaint register

_____ Complaint letter or email and regulated entity complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Regulated entity correspondence

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints documentation to determine if the regulated entity response fully addresses the issues raised. If the regulated entity did not properly address/resolve the complaint, the examiner should ask the regulated entity what corrective action it intends to take.

Criteria for reviewing complaint responses:

- The response is timely;
- The response is complete and responds to all issues raised;
- The response includes adequate documentation to support the respondent's position;
- The respondent's actions are appropriate from a business practice standpoint;
- The respondent's actions comply with all applicable statutes, rules and policy or contract provisions; and
- The appropriate remedies for the consumer are identified.

STANDARDS
COMPLAINT HANDLING

Standard 4
The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint letter or email

_____ Regulated entity response and supporting documentation

_____ Regulated entity complaint register

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Complaints White Paper

Review Procedures and Criteria

Review complaints to ensure regulated entity is maintaining adequate documentation.

Determine if the regulated entity's response is timely. The examiner should refer to state laws for the required time frame.

Automation Tip:
Most companies maintain this information in some sort of PC-based spreadsheet format, such as Lotus or Excel. Request that this spreadsheet be copied in its usual format for comparison with insurance department records. Using either an Excel spreadsheet or a Microsoft Access database, calculate the number of days between the date the complaint was received and the date a final resolution was sent to the complainant. Use the features of either application to identify those complaints where the number of days to resolve the complaint exceeds the statutory standard.

C. Marketing and Sales

1. Purpose

The Marketing and Sales portion of the examination is designed to evaluate the representations made by the regulated entity about its product(s) or services. It is not typically based on sampling techniques. The areas to be considered in this kind of review include all media (radio, television, videotape, electronic medium, social media, etc.), written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every regulated entity is required to have procedures in place to establish and, at all times, maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for the regulated entity and authorized by the regulated entity are the responsibility of the regulated entity.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a regulated entity's Internet advertisements, it is important to also review the safeguards implemented by the regulated entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
MARKETING AND SALES

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ All regulated entity advertising and sales materials, including radio and audiovisual items such as television commercials, telemarketing scripts, pictorial materials, social media or other electronic medium

_____ Policy forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

_____ Regulated entity policies and procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B
Life Insurance Disclosure Model Regulation (#580), Section 8C
Life and Health Insurance Guaranty Association Model Act (#520), Section 19A
Long-Term Care Insurance Model Act (#640)
Life Insurance Illustrations Model Regulation (#582)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Model Act (#171), Section 7(H)(1)(a)(I)
Advertisements of Accident and Sickness Insurance Model Regulation (#40)
Individual Health Insurance Portability Model Act (#37), Section 5
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Home Service Disclosure Model Act (#920)
Marketing Insurance Over the Internet White Paper
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
The Use of Social Media in Insurance White Paper
Insurance Holding Company System Regulatory Model Act (#440), Section 8G

Compact Uniform Standard References

Compact Standards for Individual Long-Term Care Advertising Materials (applicable to individual long-term care (LTC) products and associated advertising materials submitted and/or approved by the Compact)

Review Procedures and Criteria

Review advertising materials in conjunction with the appropriate policy form. If statistics are included, proper citation should be included in the documentation.

Materials should not:

- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of the surplus previously paid on the policy;
- Misrepresent any policy as being shares of stock;
- Misrepresent policy benefits forms or conditions by failing to disclose limitations, exclusions or reductions or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, regulated entity or organization in the conduct of insurance business; and
- Offer unlawful rebates or inducements.

Materials should:

- Disclose the name and address of insurer;
- Comply with applicable statutes, rules and regulations; and
- Cite the source of statistics used by the regulated entity.

Determine if the regulated entity approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Review the regulated entity's and producer's websites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the regulated entity/entities?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run an inquiry with the regulated entity's name;
- Review the regulated entity's home page;
- Identify all lines of business referenced on the regulated entity's home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the regulated entity's procedures related to producers advertising on the Internet and ensure the regulated entity requires prior approval of the producer pages, if the regulated entity name is used.

For the review of social media:

- Perform a search of social media sites with the regulated entity's name;
- Identify social media sites in which the regulated entity is active;
- Review identified social media sites and verify any product information provided by the regulated entity is accurate;
- Review the regulated entity's policies and procedures to identify the personnel involved in monitoring the regulated entity's marketing and sales-related social media activity;
- Review the regulated entity's policies and procedures for tracking marketing and sales-related social media requiring regulated entity review; and
- If the regulated entity requires preapproval of producer advertising on the Internet, review the regulated entity's preapproval procedures to determine whether the regulated entity identifies marketing and sales-related social media as also requiring regulated entity preapproval.

Automation Tip:
Enter a summary of all marketing materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as Internet or direct mail. Include fields to note exceptions, such as unsupported statistics or possible misleading statements. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one "piece" of marketing material. It is also possible that one piece of marketing material will contain more than one violation/exception.

The spreadsheet will make it easier to track any repeated statements and to identify any marketing material containing apparent multiple violations/exceptions.

STANDARDS
MARKETING AND SALES

Standard 2
Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's producer training manuals, videos and sales scripts

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Life Insurance Disclosure Model Regulation (#580), Section 5A(2)
Advertisements of Life Insurance and Annuities Model Regulation (#570)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Individual Health Insurance Portability Model Act (#37), Sections 11D and 11E
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Advertisements of Accident and Sickness Insurance Model Regulation (#40)
Group Health Insurance Standards Model Act (#100)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review all producers' training materials for compliance with state statutes, rules and regulations.

Review materials for references to employing unfair discrimination tactics or avoiding statutory compliance.

Determine whether producers' prepared materials are permitted and, if so, under what conditions and controls.

The examiners should be aware of the results of the review of common consumer complaints against the regulated entity, as that could point toward problems in this area.

Automation Tip:
Enter a summary of all training materials of whatever description in an Excel spreadsheet. Capture the regulated entity's name of the material; the form number, if any; the edition date, if any; source, if applicable; and media, such as video, sales script, etc. Include fields to note exceptions, such as incomplete disclosure or possible misleading statements. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one "piece" of training material. It is also possible that one piece of training material will contain more than one violation/exception.

The spreadsheet will make it easier to track any repeated statements and to identify any training material containing apparent multiple violations/exceptions.

STANDARDS
MARKETING AND SALES

Standard 3
Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Bulletins, newsletters and memos

_____ Organizational chart of marketing division

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Group Health Insurance Standards Model Act (#100)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review written and electronic communication between the regulated entity and producers in accordance with applicable statutes, rules and regulations.

Determine if communication includes references to new rates, rules and regulations.

Determine if communication conforms to Marketing and Sales Examination Standard #1 in this chapter when referencing advertising and sales.

Determine if the regulated entity uses email to communicate with producers. The examiner should ask to review saved, stored or archived email that was broadcast to the sales force.

Automation Tip:
Enter a summary of all producer communications of whatever description in an Excel spreadsheet. Capture the regulated entity's title or subject line for the communication, the date of the communication, source of the communication, etc. Include fields to note exceptions, such as misleading statements or instructions to producers that are in conflict with statutes or regulations. Insert each possible violation/exception in a separate field.

Statistics and statements are likely to be repeated in more than one regulated entity communication. It is also possible that a single regulated entity communication will contain more than one violation/exception.

The Excel spreadsheet will make it easier to track any repeated statements and to identify any regulated entity communications containing apparent multiple violations/exceptions.

D. Producer Licensing

1. Purpose

The producer licensing portion of the examination is designed to test a regulated entity's compliance with state producer licensing laws and rules. The focus of the standard relating to producer accounts current is to aid in the detection of fraud or misuse of funds held by the producer in a fiduciary capacity.

2. Techniques

The examiner should review and compare information obtained from insurance departments and regulated entity records pertaining to licenses held by individuals or entities soliciting business on behalf of the regulated entity. Information related to producer licensing may be obtained from the NAIC State Producer Licensing Database (SPLD). In addition to aggregate listings of licensed/appointed/terminated producers, compliance with producer licensing statutes should be verified during the review of individual policy files, which take place during other portions of the examination (see Section F Underwriting and Rating in this chapter).

The examiner should compare information obtained from insurance departments and regulated entity records pertaining to the licenses held by individuals or entities soliciting business on behalf of the regulated entity. Insurance department records may be obtained through the NAIC SPLD, if the state is actively submitting information to the database. The SPLD contains information about a producer's license and any appointments they have with a regulated entity.

3. Tests and Standards

The producer licensing review includes, but is not limited to, the following standards related to producer licensing. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PRODUCER LICENSING

Standard 1
Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with insurance department records.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department listing of producers and, if applicable, adjusters or the SPLD (State Producer Licensing Database)

_____ Regulated entity listing of currently licensed and/or appointed producers and, if applicable, adjusters

_____ Regulated entity listing of commissions

Others Reviewed

____ _____

____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Independent Adjuster Licensing Guideline (#1224)

Review Procedures and Criteria

Reconcile above regulated entity lists with corresponding insurance department lists to determine any discrepancies. If the state is actively participating in the State Producer Licensing Database (SPLD), the examiner should validate the producer's or adjuster's licensure status through the SPLD in lieu of obtaining a hardcopy of the producer's or adjuster's license.

Determine that any producer writing business in connection with a mass marketing plan is appropriately licensed.

Refer discrepancies to appropriate divisions within the insurance department.

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period, and, where applicable, all company or contracted independent adjusters licensed at any time during the examination period. Include the producer's or adjuster's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a similar list. Obtain from the regulated entity a list of all producers who received commission during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, licensed date, appointed date, type of license, date first commission received and internal regulated entity or employee number for the producer. Obtain from the regulated entity a list of all new business written during the examination period. Include the date the policy was issued and the producer's internal regulated entity or employee number.

- Compare the regulated entity's producer and adjuster licensing list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list;
- Compare the regulated entity's commissions list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers, extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare commission first earned dates to the insurance department's license/appointment dates to see if commissions were earned prior to license/appointment date; and
- Compare the regulated entity's new business written list to the insurance department's licensed producers list by comparing National Producer Numbers (NPN) or, if unavailable, Social Security numbers, Federal Employer Identification numbers or internal regulated entity/employee numbers), extracting any producers on the regulated entity's list who are not on the insurance department's list. Also compare policy issued date to the insurance department's license/appointment dates to see if policies were written prior to license/appointment date. This may need to be cross-referenced with the regulated entity's licensed producer list to correlate the producer's National Producer Number (NPN) and the internal regulated entity/employee number.

STANDARDS
PRODUCER LICENSING

Standard 2
The producers are properly licensed and appointed and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Insurance department listing of licensed and/or appointed producers or the State Producer Licensing Database (SPLD)

_____ Copy of producer's license or electronic verification of producer's license via the State Producer Licensing Database (SPLD)

_____ Regulated entity listing of all currently licensed and/or appointed producers

_____ Notice of appointment

_____ Regulated entity procedures for appointing a producer

_____ Regulated entity list of commissions paid by line of business

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)

Review Procedures and Criteria

Review the regulated entity's procedures for the appointment of producers.

Review the producer's license and the appointment records. Determine if the appointment was effective within 15 days of the producer writing business on behalf of the regulated entity.

Review the producer's authority for the types of business he/she is eligible to solicit. Determine if the producer is acting within the scope of that authority.

Determine that the producer has met continuing education requirements and, if appropriate, has met the producer training requirements for selling long-term care insurance (LTCI).

Identify the producer of each selected policy and determine proper licensure and appointment (if required).

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at anytime during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, type of license and internal regulated entity or employee number for the producer. Obtain from the insurance department's licensing division a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number or Federal Employer Identification number, name, address, licensed date, appointed date, applicable jurisdictions and type of license. Obtain from the regulated entity a list of all applications taken during the examination period. Include the date the application was taken, the producer's internal regulated entity or employee number and the jurisdiction where the application was taken. Compare these files using National Producer Numbers (NPN) or, if unavailable, Social Security numbers or Federal Employer Identification numbers and internal regulated entity/employee number for the producer and jurisdictions. Extract any producers who took applications from jurisdictions where they were not licensed/appointed.

STANDARDS
PRODUCER LICENSING

Standard 3
Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity/agency contracts

_____ Regulated entity listing of producer terminations for examination review period

_____ Regulated entity listing of commissions

_____ Insurance department listing of terminations

_____ Copies of individual termination notifications sent to terminated producers

_____ Copies of individual termination notifications sent to insurance department

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Reconcile the regulated entity's listing of producer terminations with the listing of commissions paid to determine if payouts are being made properly to terminated producers.

Review individual termination notices from the regulated entity to producers to determine compliance with termination notification periods and allowance for renewal commissions.

Refer any discovery of terminated producers still submitting new business to appropriate divisions within the insurance department.

Review the regulated entity's contract with producers to determine how commissions are paid to producers who have been terminated (e.g., vesting provisions).

Compare the regulated entity's listing of producer terminations with the National Insurance Producer Registry (NIPR) to ensure accuracy in reporting.

STANDARDS
PRODUCER LICENSING

Standard 4
The regulated entity's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of appointments and terminations for examination review period

_____ Listing of producer appointments by line of business (if applicable) by producer's business ZIP code

_____ Listing of terminations by line of business (if applicable) by producer's business ZIP code

_____ Regulated entity market plan or synopsis

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Compare the number of appointments/terminations for the current review period with previous review period and, if difference is significant, determine the reason(s).

Review the regulated entity's marketing plan.

Review ZIP code listings to determine the placement of producers and if there is evidence of under-served or over-served geographical areas.

Automation Tip:
Obtain from the regulated entity a list of all producers licensed and appointed at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, county, ZIP code, licensed date, appointed date, termination date, type of license and internal regulated entity or employee number for the producer. Extract a list of all producers that were licensed/appointed and/or terminated during the examination period. Run a count on the number of producers that are licensed/appointed by ZIP code or county and a count on the number of producers terminated by ZIP code or county. Also run a count on the original file by ZIP code or county. A comparison of the counts may show ZIP codes or counties that are under-served or over-served.

STANDARDS
PRODUCER LICENSING

Standard 5
Records of terminated producers adequately document reasons for terminations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity listings of terminated producers for examination review period

_____ Regulated entity individual files of terminated producers

_____ Insurance department's list of acceptable reasons for terminations

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine reasons for producer terminations.

Review all or sample of individual terminated producer files.

Review above documents for inadequately or inaccurately documented termination reasons. If necessary, refer to the appropriate division within the insurance department.

Compare the regulated entity's listing of producer terminations with NIPR to ensure accuracy in reporting.

Determine if the insurance department is notified of termination for cause (if applicable).

Automation Tip:
Obtain from the regulated entity a list of all producers terminated at any time during the examination period. Include the producer's National Producer Number (NPN) or, if unavailable, Social Security number, Federal Employer Identification number, name, address, termination date and reason for termination. Review the regulated entity's files for these producers to determine if the terminations were adequately documented.

Standard 6
Producer account balances are in accordance with the producer's contract with the insurer.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of producer accounts current exceeding contract limits

_____ Producer and/or agency contracts

Others Reviewed

____ _____

____ _____

NAIC Model References

Producer Licensing Model Act (#218)
Title Insurance Agent Model Act (#230)
Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Review listing of producer accounts current.

Discuss excessive balances with the regulated entity.

Accounts current exceeding contract limits may indicate producer mishandling of funds.

Refer to appropriate division within the insurance department.

E. Policyholder Service

1. Purpose

The policyholder service portion of the examination is designed to test a regulated entity's compliance with statutes regarding notice/billing, delays/no response, and premium refund and coverage questions.

2. Techniques

While larger companies may have a full staff to handle policyholder service, smaller companies may well do policyholder service as a function of the claims or underwriting department.

Policyholder service departments vary from regulated entity to regulated entity. Some companies do only what is required of them by state statute (i.e., notification of the toll-free number or policyholder complaint telephone number). In contrast, some actually contact policyholders that have had occasion to deal directly with the regulated entity, such as presenting a claim or requesting a policy change.

It is important that the examiner check with the examination coordinator to determine where the policyholder service function lies and then apply the following tests to determine the effectiveness of the unit.

3. Tests and Standards

The policyholder service review includes, but is not limited to, the following standards related to the adequacy and level of policyholder service provided by the regulated entity. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Premium notices and billing notices are sent out with an adequate amount of advance notice.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Underwriting files

_____ Underwriting procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Improper Termination Practices Model Act (#915)
Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Universal Life Insurance Model Regulation (#585), Section 7F

Review Procedures and Criteria

Check renewal business to determine if the regulated entity's procedures for handling renewals are in accordance with state guidelines.

Check underwriting files to determine if premium notices for endorsements were sent timely, and not at audit or policy expiration.

Check mailroom for billings sent out by the regulated entity to ensure timeliness.

Automation Tip:
Obtain from the regulated entity a data file of all cancellations due to nonpayment. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices, which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

Standard 2
Policy issuance and insured-requested cancellations are timely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting manuals

_____ Insured's request for cancellation

_____ Cancellation notices

_____ Procedure manuals

_____ Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if insured-requested cancellations are handled in a timely manner without excessive paperwork requirements for the insured.

Perform a time study on policy issuance to determine that policies and endorsements are issued in a timely manner.

STANDARDS
POLICYHOLDER SERVICE

Standard 3
All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity correspondence files

_____ Electronic correspondence

_____ Policy/Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670)
Unfair Claims Settlement Practices Act (#990)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Review correspondence to ensure that the response was made by the appropriate department.

Ensure the original question or problem was properly addressed in a timely manner.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions.

Review correspondence contained in the policy files from the regulated entity to determine appropriateness and timeliness of handling.

STANDARDS
POLICYHOLDER SERVICE

Standard 4
Whenever the regulated entity transfers the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has gained prior approval of the insurance department, and the regulated entity has sent the required notices to affected policyholders.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Assumption reinsurance agreements

_____ Order of insurance commissioner approving assumption reinsurance agreement

_____ Notice of transfer sent to policyholders, producers and brokers

_____ Response card sent to policyholders

_____ Written regulated entity procedures for handling inquiries regarding the assumption transaction and for processing the policyholders' response cards

Others Reviewed

____ _____

____ _____

NAIC Model References

Assumption Reinsurance Model Act (#803)

Review Procedures and Criteria

According to the model act, "assumption reinsurance agreement" means any contract which both:

- Transfers insurance obligations and/or risks of existing or in force contracts of insurance from a transferring insurer to an assuming insurer; and
- Is intended to affect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer.

Determine if any assumption reinsurance agreements exist.

Obtain a list of policyholders covered by any assumption reinsurance agreements in order to determine sample.

Determine if the class of policyholder or type of product was covered by the assumption reinsurance agreement.

Determine if affected policyholders received the notice of transfer and the response card and that each includes appropriate language.

Determine whether the regulated entity appropriately handled a policyholder's right to reject the transfer.

STANDARDS
POLICYHOLDER SERVICE

Standard 5
Policy transactions are processed accurately and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Regulated entity correspondence files

_____ Policy underwriting files involving nonforfeiture, surrenders, benefit changes, existing policy changes and other post-issue transactions

Others Reviewed

____ _____

____ _____

NAIC Model References

Modified Guaranteed Annuity Model Regulation (#255), Section 6B(1)(b)
Consumer Credit Insurance Model Act (#360)

Review Procedures and Criteria

Ensure proper documentation is maintained for the following:

- Cash surrenders;
- Policy loans;
- Bank draft acceptance and clearance; and
- Beneficiary changes.

Ensure that policyholder requests are processed as soon as reasonably possible.

Ensure that matured endowments are processed when due. Determine if the regulated entity takes appropriate steps to notify policyholders of guaranteed options to purchase additional insurance.

Premium refunds for modified guaranteed life products. Special requirements may exist, under policy provisions or state law, for calculation of refunds involving "10-day right to return" periods for life products, which include a separate account.

For credit insurance, if a debt is refinanced prior to the scheduled maturity date, the in force insurance must be terminated before any new insurance is issued.

STANDARDS
POLICYHOLDER SERVICE

Standard 6
Reasonable attempts to locate missing policyholders or beneficiaries are made.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Schedule F of the annual statement

_____ Policies scheduled for matured endowments

_____ Underwriting files

_____ Unpaid payees of returned benefit checks

Others Reviewed

____ _____

____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the regulated entity has made reasonable attempts to locate beneficiaries, policyholders and recipients of unclaimed properties.

STANDARDS
POLICYHOLDER SERVICE

Standard 7
Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Refund check or complete documentation of refund, if canceled check information is maintained on the computer system

Others Reviewed

____ _____

____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Universal Life Insurance Model Regulation (#585)

Review Procedures and Criteria

Calculate the unearned premium (short rate, pro rata or sum of digits method) in accordance with policy provisions or state law.

Verify that refunds provided to producers are properly distributed.

Verify that unearned premiums were returned to the insured in a timely manner.

Verify that the regulated entity adheres to applicable "free look" periods.

For credit insurance:

- If the creditor has opened a line of credit for a debtor and is charging for the line of credit rather than the amount of debt (i.e., credit cards), at the debtor's death the insured amount due is the amount of established credit against premium was last charged;
- If a debtor prepays the debt in full, any credit insurance shall be terminated and an appropriate refund of premium shall be paid or credited to the debtor; and
- In the event of termination, no charge may be made for the first 15 days of a month and a full month may be charged for over 16 days.

F. Underwriting and Rating

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies.

The underwriting portion of the examination is designed to provide a view of how the regulated entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

a. Rating practices;
b. Underwriting practices;
c. Use of correct and properly filed and approved forms and endorsements;
d. Termination practices;
e. Unfair discrimination;
f. Use of proper disclosures, buyers' guides and delivery receipts;
g. Reinsurance; and
h. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Symbol manuals or tables;
- Rating systems filed with regulators;
- Payment plans;
- Minimum premiums;
- Policy fees;
- Discounts;
- Dividend rating plans;
- Regulated entity automated rating systems;
- Rating materials provided to producers;
- Reinsurer policies/treaties;
- Reinsurer guidelines and manuals;
- Documentation of required disclosures and delivery receipts;
- Premium statements and billing statements;
- Premium refund documentation;
- Replacement and conservation materials;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Issued and renewed policy and certificate files;
- Canceled and nonrenewed policy and certificate files;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;

- Rescission files;
- Underwriting guidelines;
- Sample of premium audit files;
- Applicable policy forms and endorsements and summaries;
- Producer licensing information;
- Group trust and association arrangements where applicable;
- Producer compensation agreements where applicable;
- Statistical reporting requirements; and
- Underwriting files content and structure.

For purposes of this chapter, "underwriting file" means the file or files containing the new business application; renewal application; rate calculation sheets; billings; audits, including binders; engineering reports; inspection reports; risk or hazard investigative or evaluation reports; motor vehicle reports (MVRs); credit reports; all underwriting information obtained or developed; policy declaration page; endorsements; premium finance agreements with regulated entities activities; cancellation or reinstatement notices; correspondence; and any other documentation supporting selection, classification, rating or termination of the risk.

In selecting samples for testing, personal lines should generally not be combined with commercial lines. These two areas are generally not homogeneous, and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between personal lines and commercial lines as respects the various tests to be developed. Then examiners also should be familiar with the process for gathering and processing underwriting information, and the quality controls for the issuance of policies, endorsements and premium statement/billings. The list of files from which a sample is to be drawn may be generated through a computer run or in some cases through a policy register covering the period of time selected in the notice or call of examination.

Determine the regulated entity's policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as being from the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner responses should maximize objectivity; the examiner should avoid replacing examiner judgment for regulated entity judgment.

a. Rating Practices

It is necessary to determine if the regulated entity is in compliance with rating systems that have been filed with, and, in some cases, approved by the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the regulated entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a regulated entity may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a regulated entity is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a regulated entity varies between personal lines and commercial lines. There can also be considerable variation by kind of insurance. The examiner should become familiar with the regulated entity's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached. If policies are issued by an automated system, the examiner should manually rate policies based on a selection of various classes and various territories to verify that the computer has been programmed correctly. Once this has been established, the examiner should check only the input data for other policies against the information included in the inspection report or from information obtained from other sources in order to determine that they have been rated correctly. If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as use of faulty automated rating systems, or development of improperly or vaguely worded rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

Rating practices of renewal policies, as well as newly issued policies, should be reviewed. By reviewing renewal policies, the examiner can verify whether the regulated entity is updating rating components, such as vehicle-identification number (VIN) symbol changes or property protection class changes. The examiner can look for cases where initial year premium rates were set at artificially low levels for competitive reasons.

The complexity of rating systems varies greatly from line to line. Some lines require little in the way of documentation focused on the appropriate use of the rating system. Some systems are so complex that appropriate determination is difficult if a worksheet is not maintained. This is generally more true of commercial lines than it is for personal lines. The examiner should ensure that the underwriting files contain sufficient information to support the rates that have been applied to a policy. Inherent in the more complex systems is the concern for unfair discrimination.

Examiners may wish to review situations involving multiple related companies under common underwriting management for issues involving unfair discrimination between similarly situated policyholders.

Restraint of trade issues also may be involved if there are indications of two or more unrelated companies attempting to conspire to monopolize an insurance market.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the regulated entity's underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and regulated entity minutes, which may furnish evidence of anti-competitive behavior, may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also will use the above information to determine regulated entity compliance with its own manuals and guidelines. The examiner should confirm that the regulated entity's underwriters and producers consistently apply the regulated entity's guidelines for all business selected or rejected. The examination team should verify that the regulated entity has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the regulated entity the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of business.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department counsel. Ultimately, the information so obtained may be useful in drafting legislation or regulations.

In some lines of business, a survey of nonstandard (e.g., surplus lines markets and consent-to-rate filings) and residual markets (e.g., FAIR—Fair Access to Insurance Requirements Plan, JUA—Joint Underwriting Association and high-risk health pools) may provide some insight into general industry underwriting practices.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

If the forms have been approved by the Compact, the examiner should verify that the compacting state was included in the Compact-approved product filing and the form being marketed has a prefix of "ICCxx" (where "xx" represents the appropriate year the form was submitted for filing). If Compact-approved forms are being used or mixed and matched with forms approved by the compacting state, the examiner may wish to verify the forms approved by the compacting state were identified on the statement of intent schedule, which is required to be submitted, updated and maintained by the insurer in the product filing submitted to the Compact. Compacting states have access through the NAIC System for Electronic Rates and Forms Filing (SERFF) to product filings submitted to the Compact for approval and use in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information.

d. Termination Practices

The examiner should review the regulated entity's declination, cancellation and nonrenewal of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules, guidelines and policy provisions.

The review of cancellation and nonrenewal practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of canceled policies. For nonrenewals, the examiner should select the sample from the expiration list. Cancellations of specific lines of business have unique requirements. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the cancellations comply with statutory provisions and policy provisions.

Cancellation processing for nonpayment of premium should include a formal notice to the insured. Some companies use the last billing notice as the cancellation notice. If this is the case, that billing notice must clearly state the effective date of termination of coverage, the insured's rights to an explanation, as provided by statutes where required, and a concise statement of the reason for termination of coverage. Make sure that the loss payee is receiving a copy of the same notice, or separate notice from the regulated entity, to advise that coverage is being terminated. Refer to the specific statute and rule that applies.

The accuracy of return premiums on canceled policies and, in particular, pro rata vs. short rate return of premiums should be verified. When coverage other than homeowners is canceled at the request of the insured, short rate methodology should be used. Cancellations initiated by the regulated entity and all homeowner cancellations should be pro rata.

The examination team should review reinstatement offers and determine what the regulated entity practice is for offering reinstatement. Additionally, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Declination Practices

The examiner should review the regulated entity's declination of policy practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with regulated entity rules and guidelines. "Declination" includes only refusal of an insurer to issue a policy upon receipt of a written nonbinding application or written request for coverage from a producer or an applicant, or the refusal of a producer or broker to transmit to an insurer a written nonbinding application or written request for coverage.

Insurers should maintain declination files and producers should maintain files on declinations made on behalf of the regulated entity. The applicant must be provided with a written, specific reason for the declination.

The review of declination practices in a particular line of insurance should involve a request for the underwriting file for each policy selected from the random sample of declinations. The sampling should be completed separately for each product line in order to get a fair sampling for each line of business to be reviewed. The examiner should review material submitted to determine that the declinations are in compliance with the applicable rules and regulations and in conformance with the rules and guidelines for the specific line of business.

f. Reinsurance

Most state statutes include a feature that for many lines of business the regulated entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files utilized for other tests.

Adherence to the requirement is easy to test but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the regulated entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It may also reflect on the care the regulated entity's management places on its selection of business, and represent a danger to the financial health of the regulated entity. Errors in this area should result in alerts to the insurance department's financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UNDERWRITING AND RATING

Standard 1
The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Rating manuals

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

____ _____

____ _____

NAIC Model References

Property and Casualty Model Rating Law Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Law Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Stop Loss Insurance Model Act (#92)
Individual Health Insurance Portability Model Act (#37), Sections 5A–H, 5J, 5K, 7 and 9
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify all rating factors, including class, territory, symbol assignment, surcharges, deductible factors and increased limit factors.

If no source document application exists, review what procedures the regulated entity has in place to determine the accuracy of the information that was given to issue the policy.

Calculate the policy premium to verify it is in accordance with filed rates.

Verify that the proper rules are being used.

Verify that the filed implementation date is used uniformly, including at different branches.

Confirm that rates in use were filed and approved prior to use, where required.

Confirm that rates in use have been submitted as required, if system is other than prior approval.

Verify the basis of premium is correct.

Verify that the protection classes and other rating factors are correct.

Verify that the rating rules are properly utilized. The examiner should be alert for incorrect interpretation of rating rules.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:
Obtain from the regulated entity a data file that contains new business written during the examination period. The file should contain policy number, policy form, address, territory code or any other rating factor that is standardized by the regulated entity. Obtain from the regulated entity a data file that contains these standardized rating factors. For example, if the regulated entity underwrites by county, then obtain a data file that contains the county codes and a new business file that contains the policyholder's county. Compare the two files to see if the appropriate rating code is being applied. Since variations can happen, ask for explanations only in areas where the error rate is unacceptable.

STANDARDS
UNDERWRITING AND RATING

Standard 2
All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Underwriting or policy files

_____ Lapsed policies

_____ Rating/Quote information provided electronically

Others Reviewed

____ _____

____ _____

NAIC Model References

Cancer Insurance Shopper's Guide
*Model Regulation to Implement the Small Employer Insurance Portability Model Ac*t (#119)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Accident and Sickness Insurance Minimum Standards Model Act (#170), Section 5
Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), Sections 8A(10) and 8A(11)
Consumer Credit Insurance Model Act (#360)
Individual Health Insurance Portability Model Act (#37), Section 11
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Life Insurance Disclosure Model Regulation (#580), Section 5A(1)
Life Insurance Illustrations Model Regulation (#582)
Consumer Credit Insurance Model Regulation (#370)
Charitable Gift Annuities Model Act (#240)
Charitable Gift Annuities Exemption Model Act (#241)
Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act
Group Life Insurance Definition and Group Life Insurance Standard Provisions Model Act (#565)
Military Sales Practices Model Regulation (#568)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that written notice of Medicare supplement replacements are provided to applicants and existing insurers and that appropriate buyer's guides are used.

Verify that appropriate notices regarding credit-related coverages are documented.

Verify that notices regarding the existence of health insurance pools are provided, where applicable.

Review other notices and disclosures required by various jurisdictions.

Determine if state law requires that telephone help numbers be provided, including state insurance department telephone numbers and addresses.

Determine if changes in coverage are disclosed in a timely manner.

Determine if the regulated entity underwriting guidelines comply with applicable statutes, rules and regulations.

Determine if mandated optional coverages are disclosed and documented.

Verify that quotations are made accurately and in a timely manner.

Verify that delivery receipts are obtained where necessary.

Verify that changes in rates are disclosed in a timely manner and in accordance with applicable statutes, rules, regulations and policy provisions.

Determine if the regulated entity is in compliance with rules related to fair marketing.

Verify that the *Shopper's Guide to Cancer Insurance* complies with required disclosures and policy limitations.

Ensure disclosures to consumers represent the applicable consumer protections required by state law, including:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed renewals for all policies, with certain exceptions;
- Limits on the factors that can be used to establish and change premium rates; and
- Descriptive information about all available health benefit plans.

Ensure the regulated entity maintains complete and detailed descriptions of its rating and underwriting practices for individuals and small groups at its principal place of business.

Where required, individual accident and sickness insurance policies shall include with delivery or application an outline of coverage, in a prescribed format. Outlines of coverage delivered in connection with individual hospital confinement indemnity, specified disease or limited benefit health insurance coverages to persons eligible for Medicare by reason of age shall contain language that indicates "This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the regulated entity."

Insurers shall give any person applying for specified disease insurance a buyer's guide approved by the insurance commissioner. Direct response insurers shall provide the buyer's guide upon request, but not later than the time the policy is delivered.

Credit disability income products

Ensure the debtor is provided a disclosure with the following information prior to the election to purchase insurance:

- That the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;
- If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately or the multiple coverages only as a package;
- The conditions of eligibility;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;
- That within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of any of the unearned premium. However, only in those instances where insurance is a requirement for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;
- A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package; and
- That, if the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

LTC products

Verify that written notice of LTC replacements is provided to applicants and existing insurers, suitability worksheets are completed and submitted and that appropriate buyer's guides and contract or policy summaries are used.

Ensure the entity maintains, at its home office or principal office, a complete file containing one specimen copy of each disclosure document authorized and used by the entity (i.e., buyer's guide, contract, outline of coverage, statement of policy information for applicant, etc.). The file should contain one copy of each authorized form for a period of 3 years following the date of its last authorized use. Many jurisdictions have repealed the requirement for policy summaries if the product is declared to be marketed with an illustration that meets the requirements of statutes, rules and regulations.

Workers' compensation products

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Compact-approved products

If the forms and advertisements have been approved by the Compact, please note that the notices and disclosures required to be included within the approved forms and advertisements are governed by the Compact uniform standards and not state law. State law that requires notices and disclosures during the sale, underwriting and claims processes are still applicable to products and advertisements approved by the Compact, provided such state law requirements do not pertain to or affect the content or approval of the Compact-approved products and advertisements.

Standard 3
The regulated entity does not permit illegal rebating, commission-cutting or inducements.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Complaint files/logs

_____ Underwriting files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)
Interest-Indexed Annuity Contracts Model Regulation (#235)
Consumer Credit Insurance Model Regulation (#370)
Individual Health Insurance Portability Model Act (#37), Section 11
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Check commission schedule for inappropriate variances.

Determine that producer commissions adhere to the commission schedule and, if not, verify that the file documentation reflects reasons for the variance.

Check billings and invoices for varying commission percentages.

Check regulated entity advertising for indications of illegal commission-cutting or inducements.

Standard 4
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business and renewal applications

_____ All underwriting information obtained

_____ Regulated entity underwriting guidelines

_____ Underwriting bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Interoffice memoranda and regulated entity minutes

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)
Unfair Trade Practices Act (#880)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Military Sales Practices Model Regulation (#568)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Ensure that the regulated entity does not discriminate against individuals by using any of an individual's past lawful travel or future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure that the regulated entity's procedures are in compliance with the Genetic Information Nondiscrimination Act (GINA).

Some indication of industry underwriting practices may be obtained by a survey of residual markets (FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentioned, can result in unfair discrimination, including requests for supplemental information.

Examine new business and renewal applications for the required fraud warning statement.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their applicable jurisdiction.

Standard 5
All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ New business application

_____ Policy or contract determination page

_____ Regulated entity's approval register

_____ Insurance department's approval for all forms, including policies, contracts, riders, amendments, endorsements and certificates (Note: All forms submitted to the Compact for approval in the applicable compacting state can be verified through SERFF or by contacting the designated Compact representative(s) within the compacting state)

Others Reviewed

____ _____

____ _____

NAIC Model References

Health Policy Rate and Form Model [Act] [Regulation] (#165)
Individual Health Insurance Portability Model Act (#37*)*, Sections 7 and 9
Insurance Fraud Prevention Model Act (#680)
Unfair Trade Practices Act (#880)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed. Where required, determine that either prior approval has been obtained or that applicable waiting periods following the filing have been met.

Determine if the regulated entity lists, on the summary page, all forms that constitute a part of the contract.

Examine new business applications for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 6
Policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Underwriting files

_____ Application

_____ Underwriting procedure manuals

_____ Underwriting and binding guidelines

Others Reviewed

____ _____

____ _____

NAIC Model References

Anti-Arson Application Model Bill (#715)
Improper Termination Practices Model Act (#915)
Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Consumer Credit Insurance Model Regulation (#370)
Consumer Credit Insurance Model Act (#360)
Health Policy Rate and Form Model [Act] [Regulation] (#165)
Uniform Individual Accident and Sickness Policy Provision Law (#180), Sections 2A(7), 2B(5) and 5C
Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act (#171), Sections 6G and 8A(2)
Administrative Procedure Relative to Renewability and Cancellation Provisions in the Approval of Accident and Health Policies Drafted In Accordance with the Uniform Individual Accident and Sickness Provision Law, Section 8
Individual Health Insurance Portability Model Act (#37), Sections 6, 7, 8 and 11
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if policies and endorsements are issued in appropriate time frames.

Verify how much time elapses between completion of the application and issuance of coverage.

Note that this standard may need flexibility or special application when dealing with assigned risk plans, joint insurance arrangements, anti-arson applications, FAIR (Fair Access to Insurance Requirements) plans or other involuntary business.

Review new issues prior to mailing to ensure correct procedures, forms, disclosures, etc., are used.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 7
Rejections and declinations are not unfairly discriminatory.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Notice of declination

_____ Regulated entity guidelines for cancellation/nonrenewal/declination

_____ Producer records/issued policies and declinations

Others Reviewed

_____ The Genetic Information Nondiscrimination Act (GINA)

____ _____

NAIC Model References

NAIC Insurance Information and Privacy Protection Model Act (#670), Sections 10-12
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the regulated entity provides valid reasons for rejection/declination when required.

Determine if the regulated entity responds to inquiries from the applicant regarding the specific reason(s) for adverse underwriting decisions. Was the adverse underwriting decision based on previous adverse underwriting decisions?

Determine if the regulated entity uses valid reasons for rejection/declination and documents these reasons.

Review the regulated entity's procedures for rejection/declination to determine if the regulated entity is following its own guidelines.

Determine if the regulated entity monitors agency rejection/declination for appropriate practices.

Review for any unfairly discriminatory practices.

Verify appropriate refund has been made to the applicant.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 8
Cancellation/nonrenewal, discontinuance and declination notices comply with policy and contract provisions, state laws and the regulated entity's guidelines.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Agent's/MGA's/Underwriter's file or notes on a system log

_____ Producer records/notices issued

_____ Insured's request (if applicable)

_____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

____ _____

____ _____

NAIC Model References

Property Insurance Declination, Termination and Disclosure Model Act (#720)
Automobile Insurance Declination, Termination and Disclosure Model Act (#725)
Improper Termination Practices Model Act (#915), Section 8A
Unfair Trade Practices Act (#880)
Group Coverage Discontinuance and Replacement Model Regulation (#110)
Individual Health Insurance Portability Model Act (#37), Section 11
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the reason for cancellation/nonrenewal or declination was valid according to policy provisions and state law.

Review the regulated entity's procedures for cancellation/nonrenewal and declinations to determine if the regulated entity is following its own guidelines.

Review regulated entity-initiated cancellations and consider a separate sample for insured-initiated cancellation.

Determine if the regulated entity monitors agency cancellation, declination and nonrenewals for appropriate practices.

Review for any unfairly discriminatory practices.

Review declinations, including declinations made by producers on behalf of the regulated entity. Declinations shall, as required, include the specific reasons for the declination.

Review notice of cancellation/nonrenewal to determine that it was mailed or delivered by the insurer to the first named insured's last known address.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:
Obtain from the regulated entity a data file of all cancellations/nonrenewals and declinations during the examination period. Include in the file the policy number, the date the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using either a spreadsheet or database (if the file is quite large, use ACL), calculate the number of days between the date the regulated entity represents the notice was generated/mailed and the effective date of the cancellation/nonrenewal or declination. Using ACL or some other sampling software, select a sample of cancellation and premium notices that appear to conform to state requirements. Request documentation that the notice was mailed on the date reported by the regulated entity. Also extract a report of all notices which apparently fail to comply with state requirements and submit to the regulated entity for explanations.

Standard 9
Rescissions are not made for non-material misrepresentation.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ List of rescinded policies

_____ Underwriting files and supporting documentation, including claim files

Others Reviewed

_____ Case law for state impacted

____ _____

____ _____

NAIC Model References

Improper Termination Practices Model Act (#915)
Unfair Trade Practices Act (#880)
Long-Term Care Insurance Model Act (#640)
Medicare Supplement Insurance Minimum Standards Model Act (#650)
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria

Determine if rescinded policies indicate a trend toward post-claim underwriting practices.

Determine if decisions to rescind policies are made in accordance with applicable statutes, rules and regulations.

G. Claims

1. Purpose

These standards, in general, apply to insurance companies, although some or all of these standards may be applicable to other regulated entities to the extent that they address functions that have been delegated to them by insurance companies. The claims portion of the examination is designed to provide a view of how the regulated entity treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims.

For purposes of this chapter, "claim file" means the file or files containing the notice of claim, claim forms, proof of loss, medical records, health facility pre-admission certification or utilization review documentation, settlement demands, accident reports, police reports, adjusters' logs, claim investigation documentation, inspection reports, supporting bills (including electronic payment records, estimates and valuation worksheets), correspondence to and from insureds and claimants or their representatives, complaint correspondence, copies of claim checks and/or check numbers and amounts, releases, all applicable notices and correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, and any other documentation necessary to support claim-handling activity.

The review is concerned with the regulated entity's claims practices by line of business for compliance with statutes, rules and regulations and policy provisions. The areas to be considered in this kind of review include:

a. Time studies to measure acknowledgment, investigation and settlement times;
b. General handling study;
c. Total loss valuation survey;
d. Closed without payment survey;
e. Subrogation survey;
f. Litigation survey;
g. Unfair claims practices survey;
h. Claims form review;
i. Loss statistical reporting survey;
j. Time study on canceled checks; and
k. Review of other procedures, as deemed necessary.

2. Techniques

Each area of claims review involves selecting a sample of claims (open, closed without payment, closed, denied). However, it is not necessary to use different samples to review timeliness of payment, conformity to policy language or adequacy of proof.

A general approach to examination would be to:

- Define the scope of the examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage.
- Become familiar with the regulated entity's claim handling procedures for the line of business identified. Review corresponding policy forms for coverage, exclusions and nonstandard provisions. Review the methods for processing claims from notification to conclusion. Review with the claim manager or other appropriate personnel the maintenance of claim records and draft and settlement authority.

- Select a representative sample of files to be reviewed. Chapter 17—Sampling of this handbook should be reviewed. If field sizes are relatively small and the regulated entity's records appear complete, representative samples or a census should be selected. In the case of large field sizes and incomplete or complicated records, the use of audit software should be considered. Care should be taken that no adverse selection occurs.
    a. Time studies to measure acknowledgment, investigation and settlement times

       Record the date of loss/claim, the date reported to the producer or regulated entity, the date sufficient information was available to determine the regulated entity's liability and the date the regulated entity accepted or rejected the claim. Record identifying data, such as the claim/policy number and the claimant's name.

       Determine for each claim the number of days the regulated entity took to accomplish each category. Compare days required by regulated entity to appropriate state standards and document those claims that exceed standards for inclusion in the report. Delays beyond the control of the regulated entity should be excluded; e.g., a delay caused by an uncooperative insured. Establish a mean and median time to acknowledge, investigate and accept/deny claims, if necessary, to determine a business practice.

       Caution: If a file has a violation of a standard with multiple tests, and the standard is the item measured, the file can only fail one time. If the individual test is the item measured, the file can fail each test. If failure of a standard or of a test ensures failure of another standard or test under another standard, then no substitution of the file need occur. The relationship, however, should be explained.

    b. General handling study

       Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed for adequate and accurate documentation. Correct application of deductibles, coinsurance and limits of coverage should be established. Mathematical accuracy should be determined. Reductions based on depreciation, obsolescence, etc., should be reviewed for fairness and accuracy.

       Checks or drafts should be reviewed for correct payees. Files should be reviewed for specific state requirements. Compliance with the regulated entity's own standards should be established.

    c. Closed without payment review

       This includes denied, rejected, incomplete and claims not paid for any other reason, including deductibles/waiting periods not met. Conduct tests similar to "General handling study" above. Record identifying data such as claim/policy number, date of loss and claimant name. Review specific state requirements for content and method of denial notification to the claimant. Note general handling by the regulated entity to determine validity of its action in the final disposition of these types of claims.

    d. Litigation survey

       Determine the extent of suits against the regulated entity. Separate first- and third-party actions. If a review is deemed appropriate, select a representative sample or census.

Record identifying data such as claim/policy number, date of loss and claimant name. Files should be reviewed to determine the basis for suit and the regulated entity's position for denial or settlement offer. Closed litigated files should be reviewed to determine accuracy, regulated entity position and if punitive or bad faith judgments were rendered. Recognition of attorney-client privileged documents or work products should occur during the file review. A principal focus is compliance with unfair claims practices statutes and regulations.

e. Unfair claims practices review

Record identifying data such as claim/policy number, date of loss and claimant name. Review selected files for violations of specific state unfair claims practices, such as misrepresentation of policy provisions or concealment of coverage.

Calculate error ratios for the sample and field sizes. This is especially important in this study, since most unfair claims practices statutes make reference to "business practices."

f. Claim forms

Request copies of all claim forms in use for the lines of business being examined. Forms should be reviewed for content and appropriate usage. Inappropriate forms should be documented and included in the report. Claim forms also may be reviewed as they are encountered in the file reviews.

g. Review of canceled drafts/checks

This review should be considered if solvency is an issue, if the examiner determines delays in issuing a payment, or if consumer complaints indicated delays that are not supported by other time studies.

From the regulated entity's records, select a representative sample of the type of claims being reviewed. The selection should include drafts/checks reflecting a substantial payment amount on any one claim. Compare the date the regulated entity indicated the draft/check was forwarded to the claimant with the date the draft/check was presented for payment. If the review indicates significant and numerous delays in presenting drafts/checks for payment, additional investigation to determine the causes should be done.

Canceled checks should be reviewed to verify that the amount paid and the claim amount approved are the same, that payees are the same and that the information recorded in the computer system matches what is on the check (payee, amount, date of check, etc.).

h. Review of other procedures

Other review, as deemed necessary, should follow the same format for objectivity and sampling techniques as those already described. These reviews may be instituted by consumer complaints regarding specific claims practices and should be tailored to resolve specific issues.

3. Tests and Standards

The claims review includes, but is not limited to, the following standards addressing various aspects of the regulated entity's claim handling practices. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CLAIMS

Standard 1
The initial contact by the regulated entity with the claimant is within the required time frame.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and bulletins to determine if regulated entity standards exist. Determine whether the regulated entity's standards comply with applicable statutes, rules and regulations.

Determine if initial contact procedures are in place and in compliance with the mandated time frame. Perform a time study of acknowledgment times.

Determine if initial contact with claimants meets required contract standards.

Determine if subsequent responses and claim handling delay notices comply with applicable statutes, rules and regulations.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 2
Timely investigations are conducted.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manual

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Antifraud procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if investigations are initiated and concluded in compliance with state statutes.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 3
Claims are resolved in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Review of canceled claim checks

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if claim resolutions—i.e., liability, determinations, coverage questions and claims payment—are made in accordance with state requirements. Perform time studies to measure the settlement time of claims.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Automation Tip:
Obtain from the regulated entity a listing of claims closed with payment or claims closed without payment by claim feature. Include in the file the claim number(s), date the claim was reported to the regulated entity, the first payment date (if applicable), and the date the claim feature was closed. Using ACL, a database or spreadsheet, calculate the number of days from the date the claim feature was closed to the date the claim was reported. Group the number of days in any appropriate time periods, for example, 1 to 15 days, 16 to 30 days, etc., and perform a count on each time period. Investigate any patterns of untimeliness.

Standard 4
The regulated entity responds to claims correspondence in a timely manner.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Claim files

_____ Electronic claims correspondence

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Consumer Credit Insurance Model Act (#360)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if correspondence related to claims is responded to in accordance with state requirements.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 5
Claim files are adequately documented.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Electronic records of claims activities

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Claim files

_____ Claim forms

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Title Insurers Model Act (#628)
Title Insurance Agent Model Act (#230)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if quality of the claim documentation meets state requirements.

Determine if claim files retention/destruction program meets state requirements.

Determine if claim files documentation is sufficient to support or justify the ultimate claim determination.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 6
Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Regulated entity claim forms manual

_____ Regulated entity subrogation and salvage logs

_____ Claim files

_____ Regulated entity depreciation schedules

_____ Auto—total loss evaluation procedures

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Retained Asset Accounts Sample Bulletin (#573)
Consumer Credit Insurance Model Regulation (#360)
Long-Term Care Insurance Model Act (#640)
Coordination of Benefits Model Regulation (#120)
Off-Label Drug Use Model Act (#148), Section 4
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review regulated entity procedures, training manuals and claim bulletins to determine if regulated entity standards exist and whether standards comply with state statutes.

Determine if the regulated entity's procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the commissioner.

Determine if claim handling meets state-specific statutes and regulations as applied to total loss evaluations, sales tax payment, disposition of salvage, correct payees, improper release of claims, proper payment of non-disputed claims and proper referral of suspicious claims.

Determine if coverage was checked for proper application of deductible or appropriate exclusionary language.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 7
Regulated entity claim forms are appropriate for the type of product.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim forms for product being examined

_____ Electronic claims notification screens

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Standardized Health Claim Form Model Regulation (#30)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if claim form(s) include appropriate content and are used appropriately. Use of inappropriate forms should be documented and included in the examination report.

Review claim forms as they are encountered in the file reviews.

Examine all claim forms for the required fraud warning statement.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 8
Claim files are reserved in accordance with the regulated entity's established procedures.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal claims audit reports

_____ Individual claim file

_____ Average reserve data

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's claims procedure manuals for established reserving practices.

Determine if individual reserves are evaluated and posted.

Determine if reserve adjustments are made.

Determine if reserves are excessive/inadequate.

Determine if reserves are reduced, if a redundancy is apparent.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
CLAIMS

Standard 9
Denied and closed without payment claims are handled in accordance with policy provisions and state law.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity claims procedure manuals

_____ Claims training manuals

_____ Internal regulated entity claims audit reports

_____ Claim bulletins

_____ Claim files

Others Reviewed

____ _____

____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if denied and closed without payment claims are based on policy provisions and applicable state statutes and regulations.

Determine if notices of claim denials reference specific policy provisions or exclusions.

Determine if the regulated entity provides claimants with a reasonable basis for the denial, when required by statutes, rules or regulations.

Where required, determine if claimants are provided with instructions for having rebuttals to denials reviewed by the insurance department or by the regulated entity.

Determine if the regulated entity refers suspicious claims to a regulatory authority/law enforcement agency, when appropriate.

When conducting an examination on workers' compensation, it is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 10
Canceled benefit checks and drafts reflect appropriate claim handling practices.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Cashed benefit checks and drafts

_____ Regulated entity claims procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Perform a time study on canceled claim checks or drafts to ascertain whether claim proceeds are being promptly mailed or delivered.

Determine if canceled checks include the correct payee and are for the correct amount.

Ascertain whether payment checks indicate the payment is “final” when such is not the case.

Ascertain whether checks or drafts purport to release the insurer from total liability when such is not the case.

Review endorsements to see if they are consistent with the payee name listed on the check.

If drafts are used, ascertain whether there is prompt clearance by the insurer.

STANDARDS
CLAIMS

Standard 11
Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Closed litigated claim files

_____ Regulated entity claims procedure manuals

Others Reviewed

____ _____

____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Review a sample or entire population of closed litigated claim files, if feasible. Determine if litigated files indicate problematic claim handling practices. If warranted, notify the insurance department's financial examination division.

Note: The examiner should review applicable state statutes to determine which particular claims should adhere to this standard. For example, bodily injury claims may not readily fit this standard.

Chapter 21—Conducting the Property and Casualty Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a suggested format for conducting property/casualty insurance regulated entity examinations. Procedures for conducting life and health insurance regulated entity examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of property/casualty insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the regulated entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
The regulated entity's mass marketing of property/casualty insurance is in compliance with applicable statutes, rules and regulations.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy forms and certificate of insurance (such certificates will only be requested for lender-placed insurance policies)

_____ Advertising materials

_____ Disclosure materials

_____ Marketing complaints

_____ Underwriting guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Group Personal Lines Property and Casualty Insurance Model Act (#760)
Real Property Lender-Placed Insurance Model Act (#631), Sections 5, 8 and 9

Review Procedures and Criteria

Review documentation in new business policy files to determine a legitimate basis for the group. If not evident from the file, request additional documentation from the regulated entity to verify that the group is not fictitious.

Review underwriting guidelines, new business policy files, advertising materials, disclosure materials and complaints to verify:

- Compulsory participation not required for employment or group membership;
- Tie-in sales are not a condition of purchase; and
- Disclosures are provided, as required.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Claims history and loss information is provided to the insured in a timely manner.

Apply To: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Regulated entity's procedures manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880), Section 4(O)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review sample claim files to determine if the regulated entity is providing loss information for the three previous years to the first named insured within 30 days of receipt of the written request, including:

- On all claims, the date and description of occurrence and the total amount of payment; and
- For any occurrence not included above, the date and description of occurrence.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

F. Underwriting and Rating

1. Statistical Coding

In addition to the general standards, the examiner should review the regulated entity's statistical coding procedures. Coding on individual policies should be current and accurate. The examiner should determine to what statistical agencies the regulated entity reports its rating/underwriting data.

The examiner should confirm that the regulated entity is using the most current codes, classes, territories, town protection classes, ZIP codes, etc.

Errors should be noted with regard to overcharges or undercharges.

Additional introductory material is located in Chapter 20—General Examination Standards of this handbook.

STANDARDS
UNDERWRITING AND RATING

Standard 1
Credits, debits and deviations are consistently applied on a non-discriminatory basis.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files and supporting documentation

_____ Insurance department approval of deviations (if applicable)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Credits and deviations should be filed, where required.

Determine if credits and deviations are applied consistently.

Determine if the reasons for use of credits and deviations are documented.

Verify proper handling of consent-to-rate or excess rate forms.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 2
Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files, including the Individual Risk Premium Modification (IRPM) worksheet

_____ Schedule rating worksheet where IRPM worksheet is used

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Unfair Trade Practices Act (#880)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Verify that the application of the plan complies with limitations imposed by the state.

Verify that changes in the amounts of credit or debit are supported by documentation or an explanation that is consistent with the change. Also verify that the basis for use is appropriate (i.e., based on objective criteria, not on perceived competitive pressures).

Determine if the regulated entity is adjusting individual premiums to target premium levels for competitive reasons. Typically, the test for this is to review the documentation in the underwriting files.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 3
Verification of use of the filed expense multipliers; the regulated entity should be using a combination of loss costs and expense multipliers filed with the insurance department.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ National Council on Compensation Insurance (NCCI) pure premium tables

_____ Regulated entity's filed multipliers that modify the NCCI's (or similar advisory organization) filed loss costs

_____ Rate charts by classification codes (charts maintained at the regulated entity level)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)

Review Procedures and Criteria

Obtain from the regulated entity the filed expense multipliers which were applicable at the inception of the policy. (This filing should be stamped either "Approved" or "Filed" by the insurance department.)

Obtain the regulated entity's table of rates for each classification code. Check the sample's premium audit data (showing the actual rate charged to an employer for individual classification codes) against the table of rates, which includes the NCCI's (or similar advisory organization) loss costs and the filed expense multiplier, to verify accuracy.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

Standard 4
Verification of premium audit accuracy and the proper application of rating factors.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department approved and/or filed rating plans, including risk modification plans

_____ Copies of cost containment certificates and loss improvement criteria to determine cost containment discount

_____ Final rate manual tables by classification codes applicable to the period under examination (tables maintained at the regulated entity level)

_____ Workers' Compensation Experience Modification Rating Sheets pertaining to the policy sample (experience modifiers as published by the NCCI and similar advisory organizations)

_____ For lender-placed insurance, documentation showing the regulated entity's separate rates for mortgage servicer obtained lender-placed insurance versus voluntary insurance on real estate-owned property

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)
Real Property Lender-Placed Insurance Model Act (#631), Section 9

Review Procedures and Criteria

The purpose of this review is to determine that the final premium charged to the employer is being applied correctly, fairly and consistently.

The sample's premium audits should contain specific information on each policy. The sample's information should be compared to the NCCI unit statistical report and to the company's rating plan, to verify accuracy in the application and reporting of the following factors when applicable:

- Premiums by classification code;
- Payroll exposure;

- Schedule rating;
- Cost containment discount;
- Premium discounting;
- Designated medical provider discount;
- Expense loading;
- Application of the correct experience modifier;
- Small employer discount;
- Discount for rehiring previously disabled employees; and
- Any other rating elements.

The company documents should be reviewed. Any additional areas or lack of information should be discussed with company management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 5
Verification of experience modification factors.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Premium audit reports from the policy sample

_____ Experience rating rules published by the NCCI (and similar advisory organizations)

_____ Workers' compensation experience modification rating sheets pertaining to the policy sample (experience modifiers pertaining to the policy sample as published by the NCCI and similar advisory organizations)

_____ Unit statistical reports pertaining to the policy sample and used to report the regulated entity's information (data) to the NCCI and similar advisory organizations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

The experience modifier issued by the NCCI (and similar advisory organizations) should reflect the information reported to the NCCI (or similar advisory organization) using the unit statistical reports. Experience modifiers should be reconciled to what is reported on the unit statistical reports and what is shown on the workers' compensation experience modification rating sheets.

Net loss reporting should be properly applied to both large and small deductible policies.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

Standard 6
Verification of loss reporting.

Apply to: All workers' compensation examinations and lender-placed insurance examinations, as applicable

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ NCCI (and similar advisory organizations') rules governing the reporting of losses on unit statistical reports

_____ Loss data pertaining to the policy sample and maintained by the regulated entity

_____ Unit statistical reports pertaining to the policy sample and used to report regulated entity information to the NCCI (and similar advisory organizations)

_____ Applicable reports filed with the commissioner (e.g., required reporting for insurers with at least $100,000 in direct written premium for lender-placed insurance, and required rate filing for insurers with an annual loss ratio of less than 35% in any lender-placed program, except with respect to lender-placed flood insurance, for two consecutive years)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)
Real Property Lender-Placed Insurance Model Act (#631), Section 9

Review Procedures and Criteria

Losses under each policy should be clearly and accurately maintained at the regulated entity, so that paid amounts, reserves, deductibles and, with respect to losses under lender-placed insurance policies, any excess amounts paid to the mortgagor can be easily reviewed. The sample data should be compared to the unit statistical reports to verify accuracy of reporting of the following items:

- Paid losses;
- Paid loss adjustment expenses;
- Net of deductible reporting on the unit statistical reports;
- Adjustments to reserves and revised unit statistical reports; and
- Any other adjustments, such as subrogation.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

Standard 7
Verification of the regulated entity's data provided in response to the NCCI call on deductibles.

Apply to: All workers' compensation examinations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ The NCCI (or similar advisory organization) data call and resulting report made by the insurance regulated entity to the NCCI (or similar advisory organization)

_____ Loss data pertaining to sample policies written on a deductible basis and maintained by the regulated entity

_____ Unit statistical reports pertaining to sample policies written on a deductible basis and used to report regulated entity information to the NCCI (and similar advisory organizations)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Property and Casualty Model Rating Guideline (File and Use Version) (#1775)
Property and Casualty Model Rating Guideline (Prior Approval Version) (#1780)
Property and Casualty Commercial Rate and Policy Form Model Law (Condensed) (#777)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Note that a new sample (the "deductible sample") should be taken for this standard, sampling only policies with deductibles (both large and small deductibles).

During an examination, it should be verified that losses are reported on the unit statistical reports to the NCCI (or similar advisory organizations) net of deductibles. The Independent Deductible Data Call that the NCCI requests should be reported gross, including the deductibles. This must be verified with the policy sample, unit statistical reports and loss data maintained by the regulated entity.

The regulated entity's documents should be reviewed. Any additional areas or lack of information should be discussed with the regulated entity's management.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

STANDARDS
UNDERWRITING AND RATING

Standard 8
Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Real Property Lender-Placed Insurance Model Act (#631), Section 4

Review Procedures and Criteria

Decisions should be based on information that reasonably should have been developed at the inception of the policy or during initial underwriting and not, through audit or other means, before the policy went into effect or after the policy has expired.

Determine if the initial underwriting of a policy is based on the information obtained after a claim is submitted.

Standard 9
Audits, when required, are conducted accurately and timely.

Apply to: All auditable personal policies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Premium audits pertaining to the policy sample

_____ Payroll records associated with the premium audits and with the policy sample

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Verify that all auditable commercial policies have a structured system for conducting payroll or other audits used to verify final premium.

Verify what is all auditable commercial policies' procedure for waiving audits. Verify that the basis is reasonable.

Determine what is all auditable commercial policies' time frame for completion of audits. Companies typically have a time frame for the completion of an audit following expiration.

Verify if all auditable commercial policies' auditors or independent auditors conduct audits.

Perform an independent verification to ensure that return premiums are received by insureds in a timely manner.

STANDARDS
UNDERWRITING AND RATING

Standard 10
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and the regulated entity's guidelines in the selection of risks.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Regulated entity's underwriting guidelines

_____ Underwriting bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Interoffice memoranda and regulated entity minutes

_____ Policy declaration page

_____ Underwriter's file or notes on a system log

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on Basis of Blindness or Partial Blindness (#888)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

Determine if the regulated entity is following its underwriting guidelines, and that the guidelines conform to state laws and are not unfairly discriminatory.

Determine, if required, that the regulated entity's underwriting guidelines have been filed with the insurance department.

Review interoffice memoranda for evidence of anti-competitive behavior.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each regional office being examined.

Some indication of industry underwriting practices may be obtained by survey of residual markets (e.g., FAIR Plan and JUA), surplus lines markets and consent-to-rate filings.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination, including requests for supplemental information.

Examine new business applications for the required fraud warning statement.

Standard 11
All forms and endorsements forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable).

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Policy declaration page

_____ Insurance department approval for forms and endorsements

_____ Regulated entity's files or register of approved forms

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed.

Determine if the regulated entity lists all forms and endorsements that form part of the contract on the declaration page.

Examine new business applications for the required fraud warning statement.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 12
Regulated entity verifies that the VIN number submitted with the application is valid and that the correct symbol is utilized.

Apply to: All automobile lines

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Regulated entity's rating system

_____ Regulated entity's symbol or Insurance Services Office (ISO) symbol manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Insurance Fraud Prevention Model Act (#680)

Review Procedures and Criteria

Determine how the regulated entity checks the validity of the vehicle identification number (VIN) on the application. The regulated entity may use an automated program to verify the accuracy of the VIN.

Verify if the regulated entity is a member of or reports to any fraud detection bureau or organization. Some state statutes require reporting of suspected fraud.

Determine how a regulated entity handles updated symbols.

Determine if the correct symbol has been used.

STANDARDS
UNDERWRITING AND RATING

Standard 13
The regulated entity does not engage in collusive or anti-competitive underwriting practices.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ For lender-placed insurers, books and records containing compensation, contingent commissions, profit sharing and other payments dependent on profitability or loss ratios

_____ For lender-placed insurers, third-party agreements for outsourced services

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Real Property Lender-Placed Model Act (#631), Section 6

Review Procedures and Criteria

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to insurance department legal counsel. This would include engaging in collusive underwriting practices that may inhibit competition; e.g., entering into an agreement with other companies to divide the auto market within the jurisdiction by territory.

The examiner should be aware of unlawful pricing and other prohibited anti-competitive acts or practices.

STANDARDS
UNDERWRITING AND RATING

Standard 14
The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in its application of mass marketing plans.

Apply to: All property and casualty companies with mass marketing plans

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business policy files

_____ Underwriting guidelines

_____ Canceled and nonrenewed policies

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Mass Marketing of Property and Liability Insurance Model Regulation (#710)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Review documentation in new business policy files and underwriting guidelines to determine that the regulated entity does not apply underwriting standards to a mass marketing program that are more restrictive than those applied to an individually underwritten program.

Review underwriting guidelines, canceled and nonrenewed policy files to verify that failure of the employer or group to remit premium is not regarded as "nonpayment of premium" for the insured, unless the insured is sent appropriate notice and has failed to make timely payment.

Review underwriting guidelines and policy forms to verify that the employee or group member is given the right to continue coverage for 60 days after leaving employment or the group.

Review canceled and nonrenewed policies to verify that the notice of right to employee or member is given at cancellation or nonrenewal; allowing the employer or group to provide additional explanation why the individual should not be canceled.

STANDARDS
UNDERWRITING AND RATING

Standard 15
All group personal lines property and casualty policies and programs meet minimum requirements.

Apply to: Group personal lines property and casualty insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Master policy

_____ Program rules

_____ Certificates

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Personal Lines Property and Casualty Insurance Model Act (#760)

Review Procedures and Criteria

Check for state jurisdictional requirements regarding group policies.

Verify that conversion options are included in notices of individual terminations.

Determine that conversion policies issued on an individual basis effective upon termination or ineligibility date have coverage and limits at least equal to the minimum coverage and limits required by statute.

Determine that program rules do not contain any provision making participation in the group program a condition of employment or membership in a group, nor subject employees or members to any penalty for non-participation.

Determine that group coverage is not contingent upon the purchase of any other insurance, product or service.

Confirm that any experience refund or dividend is applied for the sole benefit of the insured employee or member to the extent that any experience refund or dividend exceeds the policy or certificateholder's contribution to the premium for the period covered.

Standard 16
Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Insurance department's approval of forms

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Regulated entity's cancellation/nonrenewal guidelines

_____ Certificate of mailing

_____ Producer records/notices issued

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and state law.

Does the notice of cancellation include the specific reason for cancellation where required?

Are adverse underwriting decision notices provided where required?

Review cancellation notice and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the form, if necessary, has been approved by the insurance department.

Review the notice and the certificate of mailing to ensure that adequate notice of cancellation/nonrenewal was provided to the insured and any mortgagees or lien holders.

Does the regulated entity lull insureds into a false sense of security through use of misleading billing notices, grace period descriptions, reinstatement offers, lapse notices, etc.?

If cancellation was at the insured's request, ensure that there is proper documentation.

Standard 17
All policies are correctly coded.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Regulated entity's rating system

_____ Regulated entity's coding manual

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine that the regulated entity confirms that the coding as reported by the producer is correct and current.

Determine that the regulated entity promptly updates all coding manuals and programs.

Determine that the regulated entity correctly codes all policies according to current codes.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 18
Application or enrollment forms are properly, accurately and fully completed, including any required signatures, and file documentation adequately supports decisions made.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Application

_____ Underwriting files

_____ Electronic documentation

_____ Policy

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Application should be complete and signed, where required (includes electronic signatures).

Determine that the underwriting file contains necessary information to tell the regulated entity what exposure it has.

Determine when and under what conditions the regulated entity requires a physical inspection, a motor vehicle report (MVR), an inspection report, a credit report or other underwriting information to confirm exposure or premium basis.

Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable state statutes and regulations.

G. Claims

In addition to the general examination techniques, the examiner should define the scope of the property/casualty claims examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible; e.g., physical damage coverage rather than automobile coverage. Types of claims covered should differentiate between first-party and third-party claims or total losses and partial losses.

Claim procedure manuals, adjuster training manuals and claim bulletins should be reviewed. Regulated entity procedures for total loss settlement, salvage disposition and subrogation efforts should be determined. If the jurisdiction licenses company or independent adjusters, licensing records should be cross checked with claim adjustment records to ensure that assigned adjusters are properly licensed.

a. Total loss survey

   Record identifying data, such as claim/policy number, date of loss and claimant's name. Review files for accuracy and adequacy of documentation. Review files for method of vehicle evaluation and compare with specific state requirements. Review reductions in value for appropriateness and accuracy. Review file for state-specific additions to value, such as sales tax or title fees.

   Review file for correct disposition of salvage and compliance with specific state requirements for disposition of title and registration.

b. Subrogation survey

   From the regulated entity's records, select a representative sample of the subrogated files with complete or partial recoveries. Record identifying data such as claim/policy number, date of loss and claimant name. Review files to determine if the subrogated amount included the insured's deductible. It should also be determined if the deductible was recovered and whether it was returned to the insured.

   If a partial recovery was made, was a pro rata amount returned? Specific state requirements should be reviewed to determine the regulated entity's compliance. Determine if the insured's recovery was reduced by collection charges. Determine if the specific state law permits the reductions. Determine if recovery was reduced by written or oral agreements with other companies. Determine if such agreement is in compliance with specific state laws.

c. Loss statistical reporting

   Determine to which statistical agencies the regulated entity reports its loss data. Review claim drafts to determine if loss data is correctly coded as to the proper line of business. Review drafts to determine if claim expenses are separated from claim payments. If the review indicates significant errors in coding, the data should be included in the report.

STANDARDS
CLAIMS

Standard 1
Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's claim procedure manuals

_____ Claim training manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Review the regulated entity's procedures manual to determine if guidelines exist for the use of the reservation of rights letter and notice of excess of loss.

Claims where the regulated entity has reason to question coverage should have a reservation of rights letter sent to the insured.

Claims where it is apparent that the amount of loss will exceed policy limits should have an excess of loss letter send to the insured.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 2
Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

Apply to: All regulated entities

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Subrogation register

_____ Subrogation files

_____ Review the regulated entity's subrogation and recovery procedures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine if the regulated entity refunds deductibles from subrogation proceeds.

Determine if, upon complete recovery, the insured's deductible is promptly refunded.

Determine if refunds are made periodically on no less than a pro rata basis for long-term subrogation cases. Requirements may vary among states.

Determine if recovery payments are made to employees under workers' compensation, when applicable.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Standard 3
Loss statistical coding is complete and accurate.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Regulated entity's claims coding manual

_____ Regulated entity's coding system

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)
Guidelines for the Filing of Workers' Compensation Large Deductible Policies and Programs (#1970)
Guidelines for Regulations and Legislation on Workers' Compensation Coverage for Professional Employer Organization Arrangements (#1950)

Review Procedures and Criteria

Determine that the regulated entity codes the correct loss data onto the draft copies or system.

Determine that the regulated entity promptly updates all coding manual and programs.

Determine that the regulated entity accurately codes the loss amounts. Determine that the regulated entity separates loss amounts from loss expense amounts.

Determine that the regulated entity reviews data errors and subsequent changes are made.

It is recommended that separate samples be obtained for standard voluntary market, assigned risk (if applicable), large deductible (if applicable) and PEO accounts.

Chapter 21A—Conducting the Property and Casualty Travel Insurance Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a format for conducting travel insurance company examinations. Procedures for conducting property/casualty (P/C) insurance company examinations and other types of specialized examinations, such as third-party administrators (TPAs) and surplus lines brokers, may be found in separate chapters.

The examination of travel insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and Chapter 21—Conducting the Property and Casualty Examination and the standards set forth below.

1. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
MARKETING AND SALES

Standard 1
Ensure the advertising and/or sales materials being utilized by the limited lines travel insurance producer and travel insurer: (i) provide the information required by Section 4(C) of the model law [or state equivalent]; (ii) are consistent with the travel protection plan being offered; (iii) are not deceptive or misleading; and (iv) otherwise comply with state law.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ The travel insurer's approved brochures or other written materials used in offering or disseminating travel insurance to prospective purchasers

_____ Policy forms and fulfillment materials are accurately represented in advertising and sales materials

_____ Producers' own advertising and sales materials, including travel retailers under the direction of a limited lines travel insurance producer

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Examiners should request a listing of all marketing materials and select a sample according to the jurisdiction's sampling protocols. If the examiner is unable to obtain the requested information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.

Review specimen or actual copies of all of the brochures or other written materials in conjunction with the appropriate policy forms, endorsements, policies, rate filings, and certificates of insurance.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous; and
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization.

Materials should:

- Clearly disclose name and address of the insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Clearly describe the type of policy being advertised;
- Indicate that the travel protection plan being marketed is insurance; and
- Comply with applicable statutes, rules and regulations.

Determine if the travel insurer approves producer sales materials and advertising.

STANDARDS
MARKETING AND SALES

Standard 2
The disclosures combinations of travel insurance, non-insurance travel assistance services, and cancellation fee waivers are compliant with applicable statutes, rules and regulations.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms and fulfillment materials are accurately represented in advertising and sales materials

_____ Producers' own advertising and sales materials and travel retailers acting under the direction of a limited lines travel insurance producer

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)
*Unfair Trade Practices Ac*t (#880)

Review Procedures and Criteria

Examiners should request information from the travel insurer or limited lines travel insurance producer that is sufficient to determine compliance with this standard. If the examiner is unable to obtain the information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.

STANDARDS
MARKETING AND SALES

Standard 3
The limited lines travel insurance producer has established and maintains a register of each travel retailer that offers travel insurance on the producer's behalf.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

STANDARDS
MARKETING AND SALES

Standard 4
The limited lines travel insurance producer has documentation sufficient to demonstrate compliance that the travel retailers (acting under the limited lines travel insurance producer's license) comply with 18 USC § 1033.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Standard 5
Determine that consumers were provided with information and an opportunity to learn more about the pre-existing condition exclusions: (i) at any time prior to the purchase; and (ii) in the fulfillment materials.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy form, fulfillment materials, advertising/sales materials, and disclosures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Determine that information about pre-existing condition exclusions is provided prior to the time of purchase, including whether the purchaser of travel insurance: (i) has the ability to waive the pre-existing condition exclusion; (ii) under what circumstances it can be waived; and (iii) whether the purchaser of travel insurance has been advised that the coverage for pre-existing conditions can be purchased, if applicable.

Determine that the fulfillment materials provide information about pre-existing condition exclusions.

Determine that the policies or certificates and fulfillment materials clearly define pre-existing conditions as intended in the exclusions.

STANDARDS
MARKETING AND SALES

Standard 6
Determine that descriptions of the following are provided to the purchasers of travel insurance: (i) the material or actual terms of the insurance coverage; (ii) the process for filing a claim; (iii) the review or cancellation process for the travel insurance policy; and (iv) the identity and contact information of the travel insurer and limited lines travel insurance producer.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Examiners should request information from the travel insurer or limited lines travel insurance producer that is sufficient to determine compliance with this standard. If the examiner is unable to obtain the information from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.

STANDARDS
MARKETING AND SALES

Standard 7
The limited lines travel insurance producer has an adequate training program in place, containing instructions on the types of insurance offered, ethical sales practices, and required consumer disclosures, that is required of each employee and authorized representative of the travel retailer whose duties shall include offering and disseminating travel insurance.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Limited lines travel insurance producer's policies and procedures, including the standards for product training

_____ Limited lines travel insurance producer's instruction/training files and training materials for travel retailer employees and authorized representatives offering or disseminating travel insurance

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Review policies and procedures to ensure that the limited lines travel insurance producer has adequate procedures in place to provide instruction and training that is appropriate for and consistent with the type(s) of travel insurance being offered. Review the limited lines travel insurance producer's procedures used to inform travel retailers of the regulated entity's standards for travel insurance product training and of applicable state statutes, rules or regulations regarding the solicitation and sale of travel insurance products.

Determine that the limited lines travel insurance producer has adequate procedures in place to verify that the employees and authorized representatives of a travel retailer have completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the employees and authorized representatives to sell travel insurance for that insurer.

Contact other state insurance regulators that may have conducted a recent review of the training standards.

Determine if the training materials are appropriate and accurately reflect the coverage provided by the travel insurance product.

Review a regulated entity's records to determine if, when and how training occurred prior to the employees or authorized representatives of a travel retailer's recommendation of a travel insurance product.

Standard 8
The limited lines travel insurance producer has designated a "Designated Responsible Producer."

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

STANDARDS
MARKETING AND SALES

Standard 9
Sales practices do not include "negative option or opt out."

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sales and marketing

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Review a sampling of marketing materials and policies to confirm that customers were not offered or sold a policy through negative option or opt out.

STANDARDS
MARKETING AND SALES

Standard 10
Blanket coverage is not marketed or described as "free" coverage.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Review the use of the words/phrases "free," "no cost," "without cost," "no additional cost," "at no extra cost," or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true.

Standard 11
If the aggregator's website provides a short summary of the coverage, determine that the consumer has access to the full provisions of the policy by electronic means.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and Chapter 21—Conducting the Property and Casualty Examination and the standards set forth below.

STANDARDS
PRODUCER LICENSING

Standard 1
Determine that the travel insurer or limited lines travel insurance producer has provided the information required in Section 4(B)(1) [or state equivalent] to the purchasers of travel insurance.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Determine if the requested coverage is issued.

Examiners should request proof from the travel insurer or limited lines travel insurance producer sufficient to demonstrate that the actual information was provided. If the examiner is unable to obtain proof from the travel insurer or the limited lines travel insurance producer, the examiner may request the information directly from the travel retailer.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and Chapter 21—Conducting the Property and Casualty Examination and the standards set forth below.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Fulfillment materials were provided to the policyholder or certificate holder, as required.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Examiners should request documentation from the travel insurer or limited lines travel insurance producer that is sufficient to demonstrate that the fulfillment documents were provided to the purchasers of travel insurance.

Standard 2
The policy documents disclosed whether the travel insurance was primary or secondary to other coverage.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

Examiners should request documentation from the travel insurer or limited lines travel insurance producer that is sufficient to demonstrate that the policy documents state whether the coverage provided is primary or secondary to other coverage.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and Chapter 21—Conducting the Property and Casualty Examination and the standards set forth below.

STANDARDS
UNDERWRITING AND RATING

Standard 1
Minimum data collection standards to ensure proper allocation for payment of premium tax have been established.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)

Review Procedures and Criteria

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, Chapter 21—Conducting the Property and Casualty Examination, and the standards set forth below.

STANDARDS
CLAIMS

Standard 1
The policies issued contain benefits for which a claim and claim payment could have been made.

Apply to: All property and casualty travel insurance products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

____ Review policy forms and endorsements

_____ Claim files

_____ Claim complaint records

_____ Claim procedure/underwriting manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Travel Insurance Model Act (#632)
Unfair Trade Practices Act (#880)
Unfair Property/Casualty Claim Settlement Practices Model Regulation (#902)

Review Procedures and Criteria

To determine compliance with this requirement, examiners will: (i) review a sample set of policies to confirm that benefits are being offered under the policies issued and a payment for a claim could have been made; and (ii) review a sample of denied claims to confirm that the denials were appropriate based on the policy language.

Chapter 22—Conducting the Title Insurance Company and Title Insurance Agent Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a suggested format for conducting title insurance company and title insurance agent examinations. Procedures for conducting life and health insurance company examinations, property/casualty company examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

For the purpose of licensing standards, the term "producer" is used, instead of "title agent." It will be necessary to refer to Chapter 20—General Examination Standards of this handbook relating to producer licensing.

The examination of title insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Escrow, Settlement, Closing or Security Deposit Funds
I. Title Insurance Producer (Agent) Licensing and Relations
J. Special Considerations for Title Insurance Companies and Title Insurance Agents
K. Example Title Letter
L. Example Title Interrogatory
M. Sample Checklist

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the title insurance company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). In addition, banks may also be regulated at the state level. Many states have executed an agreement to share complaint information with one or more of these federal or state agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal or state agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The title insurance company acts within the scope of its license.

Apply to: All title companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority

_____ Title insurance company system

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

No title insurance company may transact any class, type or kind of business other than title insurance.

Title insurance may not be transacted, underwritten or issued by any title insurance company transacting or licensed to transact any other class, type or kind of business.

The title insurance company shall do only title insurance business, reinsure title insurance policies and perform ancillary activities, including examining titles to real property and any interest in real property and procuring and furnishing related information and information about relevant personal property when not in contemplation of, or in conjunction with, the issuance of a title insurance policy.

A title insurance company shall not engage in the business of guaranteeing payment of the principal or the interest of bonds or mortgages.

The title insurance company is expressly authorized to issue closing or settlement protection to a proposed insured upon request, if the title insurance company issues a preliminary report, binder/commitment or title insurance policy.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
No member of the board of directors of the title insurance company may be a title insurance agent who wrote 1 percent or more of the direct premiums for the previous calendar year.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

This requirement does not apply if the relationship is covered by the state's insurance holding company act.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The agency and all applicable employees have in place an errors and omissions policy, fidelity coverage, and/or a surety bond (or alternative financial arrangement, where permitted), if required by statutes, rules and regulations.

Apply to: All title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ Records of errors and omissions policy, fidelity coverage, surety or financial arrangement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Some jurisdictions require fidelity coverage to cover all individuals who handle escrow, security deposits and/or closing funds.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 4
Business is diversified as required by statutes, rules and regulations.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Annual statement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Business is diversified as required by statutes, rules and regulations. Prior written approval from the insurance department may override the following restrictions.

An independent title insurance agent's aggregate premiums may not exceed a percentage of the title insurance company's gross premiums written during the prior calendar year (as required by applicable statutes, rules and regulations).

Direct operations business may not be accepted from a single source in excess of the allowed percentage of the title insurance company's gross premiums written during the prior calendar year.

A single source means a person that refers business to the title insurance company and any other person that controls, is controlled by or is under common control with that person.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 5
There is a periodic review and testing of the title plant built, owned, controlled or maintained by a title agent.

Apply to: All title plants where a title insurance agent builds, owns, controls or maintains the title plant

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ Title insurance company or title insurance agent standards for title plant construction, use and maintenance

_____ Title plant

_____ Agency contract, if applicable

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

Determine if there are established title plant standards and periodic tests to see that standards are met.

Review claim files to determine if losses paid arise from faulty search of title.

Determine if adequate provisions concerning the title plant are in the agency contract, if applicable.

Note: In some instances, the title insurance company is responsible for overseeing the activities of its agents with respect to maintenance of the title plant. The examiner should be aware that in other instances, the title insurance company and the title insurance agent may be in direct competition with each other. In those situations, the title insurance agent is accountable for ensuring standards for appropriate maintenance of the title plant.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
Controlled business is handled in accordance with statutes, rules and regulations.

Apply to: All title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, and regulations, including the federal Real Estate Settlement Procedures Act (RESPA) (12 U.S. Code §2601)

_____ RESPA 12 USC 2602 – Definitions – AfBA

_____ RESPA 12 USC 2607 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 USC 2608 – Title companies; liability of seller (Section 9)

_____ RESPA 12 USC 5565 – Relief available (penalties)

_____ RESPA 12 CFR 1024 – Use of HUD-1 or HUD-1A settlement statement

_____ RESPA 12 CFR 1024.14 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 CFR 1024.15 – AfBA

_____ RESPA 12 CFR 1024.16 (Section 9)

_____ Affiliated business arrangement disclosures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)

Review Procedures and Criteria

The title insurance agent must advise customers prior to commencing a transaction of the controlled business arrangement, if required by statutes, rules, bulletins and regulations. Compare any disclosure form to RESPA Appendix D, which refers to affiliated business arrangements and any additional state-based disclosure requirements that pertain to affiliated entities or controlled businesses.

If a referral is received from an individual who constitutes a controlled business arrangement, the person being referred must be notified that he or she is not required to use a specified title insurance agent or title insurance company, if required by statutes, rules and regulations.

- Referrals must be in compliance with the provisions of applicable state and federal statutes, rules and regulations as they relate to controlled business. Federal guidelines applicable to affiliated businesses can be found in RESPA, Section 8. With regard to national banks and their affiliates conducting title insurance, see 15 USC §6713. Recent enforcement actions and rulings ordered by the Consumer Financial Protection Bureau (CFPB) can be found on the CFPB web page at *www.consumerfinance.gov/*.

STANDARDS
MARKETING AND SALES

Standard 2
Inducements are not provided, directly or indirectly, in consideration of referral of title insurance business, escrow or other services provided by a title insurance agent.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, and regulations, including the federal Real Estate Settlement Procedures Act (RESPA) (12 U.S. Code §2601)

_____ RESPA 12 USC 2602 – Definitions – AfBA

_____ RESPA 12 USC 2607 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 USC 2608 – Title companies; liability of seller (Section 9)

_____ RESPA 12 USC 5565 – Relief available (penalties)

_____ RESPA 12 CFR 1024 – Use of HUD-1 or HUD-1A settlement statement

_____ RESPA 12 CFR 1024.14 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 CFR 1024.15 – AfBA

_____ RESPA 12 CFR 1024.16 (Section 9)

_____ Title insurance company's correspondence files

_____ Closing statements

_____ Policy files

_____ Customer/affiliated business arrangement (AfBA) list or chart

_____ AfBA documents, including contracts and bank accounts

_____ Financial and operational documents for title agency and AfBA operations

_____ Fee schedule

_____ Services schedule

_____ Service fee invoices, bills and accounting records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

All transactions must be in compliance with the provisions of applicable statutes, rules and regulations as it relates to referrals.

Test for discounting of, or waiving of, service fees, including escrow, as a form or illegal inducements. Test to ensure affiliate business referrers are not receiving preferential services or pricing of common services. Review closing statement and policy files to identify improper discounting, waiving of service fees or any other thing of value or otherwise illegal behavior. Compare services offered and prices charged to affiliated and nonaffiliated entities to determine if preferential treatment is provided to affiliated entities. Ensure that comparison includes like products or services as there are many different title products available in most states, including new or existing home purchases and refinance arrangements. Review closing statements and policy files for application of appropriate charges and discounts. Refer to Chapter 20 for sampling procedures appropriate to the size of the company.

The customer/affiliated business arrangement (AfBA) list or chart should include all referring customers for the examination period.

The examiner collects a list of all AfBAs in effect during the examination period, as well as a copy of any and all documents, including agreements/contracts between members and affiliates, however structured.

AfBA agreements include corporate/LLC/partnership operating, membership, and specific work and/or product agreements.

Service schedule: Examiner should collect a list of all (title, escrow/closing/settlement and AfBA) services the entity provides during the examination period, including but not limited to:

- Closing services;
    - Closings/settlements;
    - Document preparation;
    - Receiving and sending wires;
    - Sending or couriering overnight packages;
    - Processing (if separate charge from other services); and
    - Recording handling.
- Title services; and
    - Abstracting/searching;
    - Examining title/underwriting;
    - Creating commitment or title search report (TSR);
    - Updating title commitments (before closing, before issuing policies);
    - Clearing title defects;

    - Ordering payoffs;
    - Scheduling closings; and
    - Writing/issuing policies.
- AfBA services.
    - Title services listed above;
    - Closing services listed above;
    - Management;
    - Advertising/marketing;
    - Accounting; and
    - Compliance regulatory.

Fee schedule: The examiner should collect a complete fee schedule for the examination period that includes all services listed in the services schedule, which also should include variations for all transaction types, including, but not limited to, purchase transactions (full and bifurcated/split closing), refinance, construction, vacant land, for sale by owner (FSBO) and foreclosures. Fee schedules also should include any changes (up or down) during the examination period, each with an explanation and/or justification.

Testing of fees and services should begin with a cross comparison to ensure that all services are represented by a fee. The examiner should determine the appropriateness when a service is provided without a fee, according to state and federal statutes and regulations, and regional common practice.

Fee testing can be done against a series of samples (random, judgmental or consensus, depending on the examinee's size and/or situation), including referrer customer files (for consistency across customers), transaction types (for consistency across transaction type) or a random sample of transactional files (applying Chapter 17 sampling methodology) to test for overall operational fee consistency. Any deviations from stated fees or variations between customers or transaction-type fees should be included as a preliminary finding and sorted out using a crit issued to the examinee before determining if there is a violation.

When testing AfBA documents directly, agreements, invoices, bills and accounting records should be scrutinized, in addition to fee testing of customer samples, to ensure that AfBAs are charged no more or less for services than any other customer. Examiners should review AfBA agreements as well to ensure that all contracted services are included in the service and fee schedules mentioned above. Ultimately, the examiner will determine if any customer, including affiliated customers, are receiving services for less than normally charged, including for free.

Referrals may not be originated from a producer or other person that requires, directly or indirectly, placement of the title insurance through a particular agency or title insurance company as a condition precedent to providing a loan, credit, sale, property, contract, lease or service, if prohibited by statutes, rules and regulations.

Thing of Value: The definition of (illegal) rebating, including through inducements, in Section 4H of the *Unfair Trade Practices Act* (#880), as has been adopted by many states, includes the statement or as adopted, statements of such similar meaning, "… paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement …" and "or anything of value whatsoever …". The emphasis of this guidance focuses on the "directly or indirectly" and "anything of value" or more accurately, the any "thing-of-value" items that may constitute an illegal rebate by inducement. Ultimately, the examiner should know his or her respective state's regulations that address rebating and illegal inducements.

Certain financial and operations records of the title entity, including AfBA operations, should be collected or available to inspect in order to do a proper review for potential rebating and illegal inducements. These items include, but are not limited to, profit and loss (P&L) statements, balance sheets, business and officer tax returns, third-party and internal accounting audit reports, bank account records, reconciliations and statements for all escrow and operations accounts, operational accounts payable receipts, positive pay and reverse-positive pay records, cancelled/cleared checks (or access to on line check review programs), advertising and co-advertising agreements and receipts, employee and officer expense account reports, sales reports, and employee time sheets and salary/payroll records.

As title insurance is primarily generated through business referrals, it does not focus so much on inducements directed at the prospective insured, but instead focuses on inducements or kickbacks to the referring customers/clients, including, but not limited to, AfBA client referrers. Review and consider whether the affiliated person is paying or receiving no more than a reasonable market value for the things and services provided, and that those things and services are actually being provided and performed. Consideration also can be given to these same schemes from a RESPA Section 8 illegal kickback perspective and through which a "thing of value" can be found more formally defined. "Consideration" is something of value given by both parties to a contract that induces them to enter into the agreement to exchange mutual performances (*www.legal-dictionary.thefreedictionary.com/consideration*). The examiner should test to see if there is any additional consideration given beyond the written consideration of the contract, such as the referral of title orders.

A direct rebate (directly from premium or profit derived from premium) as inducement can be found in the form of a cash or other direct monetary payment (checks) for the referral of business. Cash payments can be difficult to trace, however, as it is uncommon for businesses to have legitimate reason for significant cash withdrawals. All cash withdrawals from business accounts should be tracked, justified and substantiated with legitimizing documentation provided by the title entity being examined. All cash payments to officers, owners or employees of the company, which may be disguised as legitimate business payment, including profit distributions, should be substantiated, including through the verification of year-end tax documents for inclusion in the case of personal distributions. Other monetary payments (checks) to referrer clients also should be scrutinized to ensure they are proper, legitimate and legal payments. For AfBAs, profit sharing (dividends) based upon ownership interests is an example of a legitimate and legal payment, while payments to a sham entity is an example of an illegitimate payment.

An indirect thing-of-value can be found to include just about anything and, therefore, all outgoing payments from business accounts should be scrutinized to ensure that whatever the payment is for, even if it appears to be legitimized under a sound agreement, is an actual payment for actual services that actually occur, and that the consideration for the agreement is not the thing-of-value that constitutes a quid pro quo (this for that) situation, which makes it an illegal inducement or kickback. State laws may provide that actual referral or placement of business (this for that) is not required.

Some items such as tickets to sporting events, Broadway-style shows and other entertainment festivities will be more obvious. Although the payment is not hidden, the underlying reality may still be obscured by erroneous explanations, such as that the events were sales meetings. An apparent legitimate event may actually be in excess of a reasonable amount for a "sales meeting," or it may turn out that the client attended the event alone, negating the possibility of any actual "meeting" taking place. Other more or less conspicuous items may include the title agency or company monetarily sponsoring the referrer's social, business and/or even "charity" events, including golf outings, customer appreciation galas, open houses (at the referrer's offices or providing refreshments or giveaway prizes at real estate open houses) and end-of-the-year parties.

Other forms of indirect things of value may include, but are not limited to:

- Furnishing or offering to furnish, without reasonable charge, all or part of the time or productive effort of any employee of the title entity for the benefit of the referrer, including the referrer's title production. (Review agreements, time sheets and payroll records.);
- Providing or offering to provide, without reasonable charge, any business, office or computer equipment, or any title or non-title services (escrow, computerized bookkeeping or programming, forms management, etc.). (Review agreements and account payable receipts for title and AfBA entity. AfBAs should have receipts for all equipment they purchased.);
- Providing or offering to provide, without reasonable charge, any advertisements, in any form, for the benefit of the referrer entity. (Review advertisement agreements and accounts payable receipts.);
- Disbursing escrow funds prior to the actual deposit or prior to conditions of the escrow having been met. (Review escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements.);
- Paying or offering to pay cancellation fees for title orders or preliminary title reports. (Review agreements, time sheets, cash withdrawals and payroll records.);
- Paying or offering to pay the fees of charges of any outside professional including, but not limited to, an attorney, engineer, appraiser or surveyor whose services are required for a prospective transaction or for the referrer entities' business operations. (Review escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements. Verify the title entity is collecting and retaining 100% of his or her monies due at closing.);
- Paying or offering to pay any part of the salary of an employee of the referrer entity. (Review agreements, time sheets, cash withdrawals and payroll records.);
- Paying or offering to pay the salary or any part of the salary of a relative of any producer of title business in which payment is in excess of the reasonable value of work performed. (Review agreements, time sheets, cash withdrawals and payroll records. Interview staff, verify salaries are in line with all other employees performing the same or similar functions, and verify work is being done for subject employees.);
- Paying or offering to pay for services by any referrer in which services are required to be performed by the referrer in his or her capacity as a real estate or mortgage broker or salesperson or agent that are and should normally be paid by the referrer in that capacity. (Review escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements. Verify the title entity is collecting and retaining 100% of his or her monies due at closing.);
- Overpaying for office rental space within the referrer entity's offices or real estate or paying for space that is not in use by the title entity. (Review rental and AfBA agreements, verify use and reasonable prices for the regional area, and verify monies properly changed hands.);
- Providing or offering to provide rental space to the referrer client for occupancy for any amount below actual cost. (Review rental and AfBA agreements, verify use and reasonable prices for the regional area, and verify monies properly changed hands.); and
- Providing or offering to provide, waiving or offering to waive reimbursement for escrow cash advances for the referrer clients' customer's benefit, including payoff administrative fees, subordination agreement fees or any other similar fees. (Review the escrow account and individual transactional escrow accounting records, including ledgers, settlement statements, disbursement summaries, and deposit and bank statements.).

STANDARDS
MARKETING AND SALES

Standard 3
Affiliated business arrangements are organized and operated in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, and regulations, including the federal Real Estate Settlement Procedures Act (RESPA) (12 USC §2601)

_____ RESPA 12 USC 2602 – Definitions – AfBA

_____ RESPA 12 USC 2607 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 USC 2608 – Title companies; liability of seller (Section 9)

_____ RESPA 12 USC 5565 – Relief available (penalties)

_____ RESPA 12 CFR 1024 – Use of HUD-1 or HUD-1A settlement statement

_____ RESPA 12 CFR 1024.14 – Prohibition against kickbacks and unearned fees (Section 8)

_____ RESPA 12 CFR 1024.15 – AfBA

_____ RESPA 12 CFR 1024.16 (Section 9)

_____ Policy files

_____ Response(s) to pre-examination AfBA interrogatories

_____ Accounting records, including but not limited to, copies of cancelled checks, front and back, and disbursements to owners from operating accounts

_____ Ownership documents

_____ Applications, reports and disclosures to the regulatory authority, if required

_____ Documentation of disclosures to consumers, if required

_____ Contracts and service agreements between affiliates

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

All arrangements must be organized and operated in compliance with the provisions of applicable statutes, rules and regulations as they relate to referrals, illegal kickbacks, and providing things of value to agency/company owners, referrers of business and potential referrers of business.

Core services are performed by in-house agency/company staff, including title examinations, determination of insurability, clearance of exceptions or objections, the issuance of preliminary commitment, issuance of title policies, and if normally performed by title agents in the state, conducting the title search and handling of the closing.

All contracted services provided by a party related to the affiliated business entity are obtained at fair market prices, including, for example, accounting, information technology, human resources, payroll, title search, title examination, providing preliminary commitment or issuing title policy. Review contracts, services agreements and disbursements to analyze such affiliate transactions.

Analyze performance of core services, including a review of employee activities and disbursements for contracted services.

Analyze the original source of business. Make note of common settlement producers and the amount of business being referred by each. If the majority of referrals are being submitted by a few persons or entities, examine the ownership/relationship of the referring settlement producer and the entity under examination. Review disbursements for marketing, sales and core service activities to analyze potential referral fees.

The agency/company must be capitalized in compliance with applicable statutes, rules and regulations.

If a referral is received from a person or entity who is part of the affiliated business arrangement, the agency/company and/or referrer must provide its customers in a timely manner with all disclosures required by statutes, rules and regulations, including, for example, disclosure of the affiliated business arrangement and notification that the person being referred is not required to use a specific agency/company. If documentation of disclosure is required, review such documentation. Compare the disclosure form to RESPA Appendix D, which refers to affiliated business arrangements and any additional state-based disclosure requirements that pertain to affiliated entities or controlled businesses. Consider contacting a sample of customers to verify that they received required disclosures.

Determine if reports, applications or disclosures of the affiliated business arrangement to the regulatory authority are required under state statutes, rules and regulations. If so, determine if such documents have been properly filed.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the title insurance company treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

a. Rating practices;
b. Underwriting practices;
c. Use of correct and properly filed and approved forms and endorsements;
d. Unfair discrimination;
e. Use of proper disclosures, buyers' guides and delivery receipts; and
f. Statistical coding.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Rating systems filed with regulators;
- Policy fees;
- Discounts;
- Title insurance company automated rating systems;
- Rating materials provided to title insurance agents;
- Underwriting guidelines;
- Applicable policy forms and endorsements;
- Title insurance agent compensation agreements, where applicable;
- Statistical reporting requirements; and
- Underwriting/closing/escrow files content and structure.

For purposes of this chapter, "underwriting/closing/escrow file" means the file or files containing rate calculation sheets, billings, and audits—including binders/commitments, all underwriting information obtained or developed, policy schedules A and B, endorsements, the lender's written closing instructions, settlement statements (HUD-1) and Good Faith Estimate (HUD-GFE) forms (if available), correspondence, and any other documentation. In many cases, all applicable documentation will not be contained in one file, but rather will be found in separate underwriting and closing files. Additionally, it should be noted that, since HUD-GFE forms are not required to be given to the title entity, such forms might not be available in all circumstances.

In selecting samples for testing, residential coverages should generally not be combined with commercial coverages. These two areas are not always homogeneous and conclusions or inferences to be made from the results of sampling may not be valid if combined. The examiner should be familiar with any statutory or regulatory distinctions made between residential coverages and commercial coverages with respect to the various tests to be developed. The examiner also should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies and endorsements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice or call of examination.

Determine the title insurance company's policy population (policy count). Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the development of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for title insurance company judgment.

a. Rating Practices

It is necessary to determine if the title insurance company is in compliance with rating systems which have been filed with and, in some cases, approved by, the various state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the title insurance company's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a title insurance company may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate that a title insurance company is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The procedure for determining adherence to rates filed or used by a title insurance company may vary between residential coverages and commercial coverages. The examiner should become familiar with the title insurance company's policy form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached.

When possible, the examination team should make use of audit software to verify correct application of specific rating components. This allows for a more thorough review and can save time during the examination process.

Rating practices of policies and endorsements should be reviewed. The examiner should ensure that the underwriting/closing/escrow files contain sufficient information to support the rates that have been applied to a policy or endorsement. Inherent in the more complex systems is the concern for unfair discrimination.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the title insurance company's underwriting guidelines, underwriting bulletins, agency agreements and correspondence with title insurance agents. The examiner may review interoffice memoranda and title insurance company minutes for indications of anti-competitive behavior or unfairly discriminatory practices. The examination team also will use the above information to determine title insurance company compliance with its manuals and guidelines. The examiner should confirm that the title insurance company underwriters and title insurance agents consistently apply the title insurance company guidelines for all business selected. The examination team should verify that the title insurance company has correctly classified insured individuals.

File documentation should also be sufficient to support underwriting decisions made. Underwriting decisions that are adequately documented generally afford management of the title insurance company the opportunity to know what business it has selected through its underwriters and title insurance agents. Files should be reviewed for compliance with all written instructions provided by relevant parties. In most cases, this will apply to lenders' closing instructions. However, other written instructions, such as tax or escrow agreements, disbursement instructions, etc., should also be reviewed. The examiner should verify that properly licensed and appointed (where applicable) title insurance agents have been used in the production of business.

Any practice suggesting anti-competitive behavior may involve legal considerations which should be referred to insurance department legal counsel. Ultimately, the information so obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. Additionally, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should also be mindful of possible outdated forms or endorsements. If coverages and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Unfair Discrimination

The examination team should be mindful of company underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

e. Use of Proper Disclosures, Buyers' Guides and Delivery Receipts

The examiner should inquire into any reinsurance agreements or affiliated business arrangements or agreements with a third party whereby insurance is arranged, reinsured, purchased through or ceded on title business written on personal or commercial properties. Errors should be noted with regard to overcharges or undercharges.

f. Statistical Coding

The examiner should review the title insurance company's statistical coding procedures. Coding on individual policies should be current and accurate. The examiner should determine to what statistical agencies the title insurance company reports its rating/underwriting data.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the title insurance company's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UNDERWRITING AND RATING

Standard 1
Re-issue and refinance credits are applied consistently in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ Policy schedules A and B

_____ Settlement statement forms including, but not limited to, HUD-1, TILA-RESPA Integrated Disclosure (TRID) and any applicable state-specific settlement statement forms

_____ Good Faith Estimate (GFE), (HUD) and final settlement statement forms (if applicable)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

A copy of the previously issued title insurance policy should be maintained on file, if necessary, pursuant to rate requirements.

Documentation should be maintained to ensure there was adequate inquiry made regarding the existence of a prior title insurance policy, if necessary, pursuant to rate requirements.

In cases where a prior policy is not required in the application of a re-issue or refinance rate, documentation should be maintained to ensure there was adequate inquiry and/or examination made regarding the applicability of discounts used in calculating rates.

Standard 2
The title insurance company does not engage in collusive or anti-competitive underwriting practices.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting/closing/escrow files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Any practice suggesting anti-competitive behavior may involve legal considerations which should be referred to insurance department legal counsel. This would include engaging in collusive underwriting practices that may inhibit competition.

The examiner should be aware of unlawful pricing and other prohibited anti-competitive acts or practices.

Standard 3
Charges or fees other than premium for providing coverage are in compliance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Applicable state fee filings

_____ Underwriting/closing/escrow files

_____ Settlement statement forms including, but not limited to, HUD-1, TILA-RESPA Integrated Disclosure (TRID) and any applicable state-specific settlement statement forms

_____ Good Faith Estimate (GFE) (if applicable)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Review a random sample of real estate transaction underwriting and/or closing/escrow files to determine whether charges and fees, other than premium, being charged to consumers are in accordance with applicable filings, laws, rules or regulations (if any). Review applicable statutes, rules, and regulations relating to such charges and fees. The laws in this area will vary widely by state from prior-approved all-inclusive rates to non-regulated rates and fees.

Review charges and fees to determine if such charges and fees are RESPA (Real Estate Settlement Procedures Act, Section 4 and Section 8) compliant.

Review settlement statement forms associated with the above random sample of real estate transaction closing/escrow files to confirm that all charges and fees identified above are properly disclosed on applicable settlement statement forms. In the event that charges required to be disclosed on a settlement statement form vary from charges previously issued to the consumer, verify that proper revised settlement forms have been re-issued to the consumer, within the time period established by and in accordance with RESPA rules.

If a settlement provider chooses to use average pricing as a means of calculating and disclosing settlement charges, review fee filings to verify that there is proper documentation of (1) all charges qualifying for average pricing and (2) the average pricing structure in effect at the time of closing, pursuant to applicable state statutes, rules and regulations.

Review closing/escrow files to determine if (1) any agreements between the lender and the title agent, or (2) any guarantees made by the title agent to the lender, guaranteeing any prices other than the title agent's filed fees or charges, have been made.

Review written documentation of the written instructions in the closing/escrow files to verify that all instructions provided by the relevant parties were followed. Review closing/escrow files to determine if transactions in escrow are ever closed in the absence of written instructions.

Standard 4
Other than closing or settlement protection, the title insurance company does not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement or closing services.

Apply to: All title insurance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Settlement statement forms including, but not limited to, HUD-1, TILA-RESPA Integrated Disclosure (TRID) and any applicable state-specific settlement statement forms

_____ Good Faith Estimate (GFE) (if applicable)

Others Reviewed

_____ Case law for state impacted

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Review all coverage being offered and/or issued by the title insurance company to determine if it is within the definition of title insurance under the applicable statutes, rules and regulations.

Some jurisdictions require that all forms be filed and approved prior to use. In such jurisdictions, review forms to confirm that forms have been properly filed with the appropriate insurance department.

Standard 5
The closing or settlement protection conforms to the terms of coverage and form of instrument as required by statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ Case law for state impacted

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Where permitted or required, determine if closing or settlement protection is being offered by the company and/or agent.

Confirm that any closing or settlement protection being offered is in a form that complies with the applicable statutes, rules and regulations.

Some jurisdictions require that all closing or settlement protection forms be filed and approved prior to use. In such jurisdictions, review forms to confirm that forms have been properly filed with the appropriate insurance department.

STANDARDS
UNDERWRITING AND RATING

Standard 6
Reports and disclosures are made in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Commitment issuance procedure

_____ Underwriting procedures

_____ Underwriting documents

_____ Affiliated business arrangement (AfBA) and other state-required disclosures

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The title insurance report and/or commitment shall be furnished to the purchase-mortgagor or its representative as soon as reasonably possible prior to closing if the report includes an offer to issue an owner's policy covering the resale of the owner-occupied residential property and all disclosures, including, but not limited to, AfBA disclosures if applicable, shall be furnished on a timely basis to the consumer.

Documentation of the reason for delay is maintained for title insurance reports, which are not delivered prior to the day of closing.

Required disclosures are made on reports not delivered prior to the day of closing:

> "Please read the exceptions and the terms shown or referred to herein carefully. The exceptions are meant to provide you with notice of matters, which are not covered under the terms of the title insurance policy and should be carefully considered.
>
> It is important to note that this form is not a written representation as to the condition of title and may not list all liens, defects and encumbrances affecting title to the land."

In accordance with applicable law, a written statement is provided or obtained when a lender's title insurance policy is issued in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan where no owner's title insurance policy has been requested.

The notice must be provided to the purchaser-mortgagor at the time the commitment is prepared.

The notice shall explain that a lender's title insurance policy is to be issued protecting the mortgage-lender and that the policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased.

The notice shall explain what a title insurance policy insures against through the purchase of an owner's policy.

The notice shall explain that the purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified or approximate cost, if the proposed coverages or amount of insurance is not known.

Copies of written notices prepared when a lender's title insurance policy is issued in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan where no owner's title insurance policy has been requested are maintained in the underwriting file for at least five years after the effective date of the policy.

Test to ensure AfBA personnel engaged in abstracting and examining of title and writing commitments are qualified, fit and proper. Test to ensure an affiliate business referrer does not receive preferential underwriting or relaxed underwriting standards.

Testing personnel qualifications of an AfBA employee engaged in abstracting, examining, and preparing and editing title insurance commitments includes determining and comparing what functions the employee actually performs against the employee's qualifications and obtaining evidence satisfactory to demonstrate that the employee is actually performing the purported work.

Underwriting documents include all underwriter-provided policies, procedures, bulletins, directive and/or guidelines for the production of title commitments and policies. Underwriter bulletins vary, so if the examinee is an agency, then underwriting documents must be collected and reviewed for each separate underwriter with whom the agency is appointed.

Testing to ensure that an affiliate business referrer is not receiving preferential underwriting is accomplished by reviewing underwriting documents and cross-comparing the underwriting requirements to actual underwriting practices. This can be accomplished by interviewing abstractors and title examiners performing underwriting for both affiliated and nonaffiliated customers' business, and reviewing sample transaction files for nonaffiliated business, to establish a baseline of underwriting practices, and then comparing those practices with practices applied to AfBA business. Ultimately, the examiner is substantiating that the AfBA business is receiving the same level of underwriting as all other business, according to the underwriter's requirements, and that no undue influence by anyone with a potential conflict of interest is resulting in a higher underwriter risk for the AfBA business—that is, no one is pushing deals through faster than they should or eliminating defects erroneously.

STANDARDS
UNDERWRITING AND RATING

Standard 7
The title insurance company complies with statutes, rules and regulations regarding the recording, reporting and validation of revenue, loss and expense experience.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Validation may include certification by oath of the title insurance company's or title insurance agent's president, vice president or secretary.

Audits may be required by the insurance department. The audit should be conducted by an independent certified public accountant.

An actuarial certification is required to be filed with the title insurance company annual statement. The actuarial certification must conform to the NAIC annual statement instructions.

Standard 8
All policies are correctly coded.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Title insurance company's rating system

_____ Title insurance company's coding manual

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Determine that the title insurance company confirms the coding as reported by the title insurance agent is correct and current in accordance with applicable statutes, rules and regulations.

Determine that the title insurance company promptly updates all coding manuals and programs.

Determine that the title insurance company correctly codes all policies according to current codes.

G. Claims

1. Purpose

The claims portion of the examination is designed to provide a view of how the title insurance company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims. For purposes of this chapter "claim file" means the file or files containing the notice of claim; claim forms; settlement demands; claim investigation documentation; correspondence to and from insureds and claimants or their representatives; complaint correspondence; copies of claim checks or check numbers and amounts; releases; all applicable notices and correspondence used for determining and concluding claim payments or denials and any other documentation necessary to support claim handling activity.

The review is concerned with the title insurance company's claims practices for compliance with statutes, rules and regulations and policy provisions. In addition to the general areas of review discussed in Chapter 20—General Examination Standards, a loss statistical reporting survey should also be performed.

Determine to which statistical agencies the title insurance company reports its loss data. Review claim drafts to determine if loss data is correctly coded as to the proper line of business. Review drafts to determine if claim expenses are separated from claim payments. If the review indicates significant errors in coding, the data should be included in the report.

STANDARDS
CLAIMS

Standard 1
Indemnification of a proposed insured solely against the loss of settlement funds may only be made for events as authorized by statutes, rules or regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Title insurance company's claim manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Where addressed by applicable statutes, rules and regulations, ensure that the closing or settlement protection only indemnifies against the following acts of a title insurance agent:

- Theft of settlement funds; and
- Failure to comply with written closing instructions by the proposed insured when agreed to by the title insurance agent relating to title insurance coverage.

Standard 2
Loss statistical coding is complete and accurate.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim files

_____ Title insurance company's claims coding manual

_____ Title insurance company's coding system

_____ Rating organization's coding manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)
Title Insurers Model Act (#628)
Unfair Claims Settlement Practices Act (#900)
Unfair Property/Casualty Claims Settlement Practices Model Regulation (#902)

Review Procedures and Criteria

Determine that the title insurance company codes the correct loss data onto the draft copies or system.

Determine that the title insurance company promptly updates all coding manuals and programs.

Determine that the title insurance company accurately codes the loss amounts.

Determine that the title insurance company separates loss amounts from loss expense amounts.

H. Escrow, Settlement, Closing or Security Deposit Funds

1. Purpose

Title insurance companies, title insurance agents, approved attorneys and escrow companies provide services that reflect the unique nature of real estate transactions in our society. Services provided vary from one area of the country to another and may include acting as escrow agent, obtaining releases and conducting the actual closing or settlement. However, the essential purpose is the same; i.e., to assist the parties in real estate transactions by ensuring the acquisition or transfer of property interest can be effected with a maximum degree of efficiency, security and safety.

An escrow is a transaction in which an impartial third party acts in a fiduciary capacity as an agent for the seller, buyer, borrower and lender. In some states or jurisdictions, this function is performed by the title insurance company or agency.

The escrow holders have fiduciary and contractual responsibility for prudent processing, safeguarding and accounting for funds entrusted to them by escrow customers. Accordingly, this responsibility results in significant exposure to losses from inadvertent or intentional failure to execute their duties properly.

2. Techniques

The authority for review of escrow, settlement, closing and security deposit funds activities may or may not belong to the state insurance department. The examiner should ensure this area falls under their department's jurisdiction prior to review of these standards.

3. Tests and Standards

The escrow, settlement, closing and security deposit funds review includes, but is not limited to, the following standards addressing various aspects of these fiduciary responsibilities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 1
All escrow, settlement, closing or security deposit funds are submitted for collection to or deposited in a separate fiduciary trust account in a qualified financial institution promptly and in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The funds are the property of the person(s) entitled to them and are segregated for each depository by escrow, settlement, security deposit or closing in the records which allows individual identification.

The funds are applied in accordance with the terms of the individual instructions or agreements by which the funds were accepted.

Ensure the funds are handled as follows:

- Funds held in escrow are disbursed pursuant to the written instruction or agreement specifying how and to whom the funds should be disbursed;
- Funds held in a security deposit account are disbursed in accordance with the written agreement; and
- The written agreement for funds held in a security deposit account complies with requirements of statutes, rules and regulations:
    - The agreement includes what actions the indemnitor needs to take to satisfy his or her obligation under the agreement; and
    - The agreement includes the duties of the title insurance company and title insurance agent with respect to the disposition of the funds held.
    - There is a requirement to maintain evidence of the disposition of the title exception or objection before any balance may be paid over to the depositing party or their designee.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 2
Interest received on funds deposited in connection with any escrow, settlement, security deposit or closing shall be paid in accordance with applicable statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Administrative costs (i.e.., the cost of maintaining the accounts) may be recovered from the interest.

Instructions for the funds or a governing statute may override this standard.

Refer to local statutes, rules and regulations relative to administrative/interest cost recovery. In the event of remittance delays that are contrary either to local law or the agency contract itself, the examiner may wish to explore the agency's financial condition vis-à-vis cash flow problems. If a pattern of delay exists relative to tax statements, and if funds are found to be commingled (i.e., funds in the premium account are being used in addition to an operating account; operating costs are being paid out of a trust account; etc.), for solvency reasons, examiners should report such findings to their appropriate financial examination section.

STANDARDS
ESCROW, SETTLEMENT, CLOSING OR SECURITY DEPOSIT FUNDS

Standard 3
Disbursements made from an escrow, settlement or closing account are done in accordance with statutes, rules and regulations.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

Expedited Funds Availability Act, 12 USC Section 4001 et seq. as amended, and related regulations of the Federal Reserve System

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

Files should be balanced prior to closing to ensure sufficient deposits have been made to equal calculated disbursements. Disbursements should be made only from collected funds related to the same escrow.

"Collected funds" as used herein means:

- Cash;
- Wire transfers that are unconditionally received and available for disbursement;
- Certified, cashier and teller checks from an institution insured by the Federal Deposit Insurance Corporation (FDIC) or the National Credit Union Share Insurance Fund (NCUSIF);
- U.S. Treasury checks; or
- Checks that have cleared the banking system.

I. Title Insurance Producer (Agent) Licensing and Relations

Use the standards set forth below.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 1
Written underwriting contracts, which include required provisions, are in place between title insurance agencies and all applicable title companies, and business is not placed without a contract.

Apply to: All title insurance companies and title insurance agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The agreement shall set forth the responsibilities of each party and explain the division of responsibilities if a particular function is a shared responsibility between the two parties.

The agreement should incorporate underwriting guidelines and limitations on title claims settlement authority.

The written agreement should include the following:

- Responsibilities of each party and division of responsibilities clearly specified;
- Provisions applicable to contract termination and notice of cancellation;
- Provisions specifying requirements for reporting and remittal of funds.
- Provisions related to the fiduciary capacity and handling of title insurance company funds;
- Provisions related to ownership and access to policy records, escrow files and claim files;
- Provisions applicable to assignment of the contract;
- Guidelines related to the basis of rates charged, types of risks which may be written, maximum limits of liability, territorial limitations, title searches, examinations and underwriting;
- Provisions regarding the reporting of claims, claim settlement authority and risk retention;
- Where prohibited, the contract may not permit title insurance agents to bind reinsurance on behalf of the title insurance company or appoint a title insurance sub-agent; and
- The title insurance agent shall not bind reinsurance or retrocessions on behalf of the title insurance company.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 2
Policies and premiums are reported and remitted on a timely basis.

Apply to: All title insurance companies and title insurance agents

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Listing of title insurance agent accounts current exceeding contract limits

_____ Title insurance agent and/or agency contracts

_____ Agency listing of issued and unexpired commitments where the final title insurance policy has not yet been issued

_____ Agency listing of issued title insurance policies that have not yet been reported to the title insurer

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurance Agent Model Act (#230)
Title Insurers Model Act (#628)

Review Procedures and Criteria

The focus of this standard relating to title insurance agent accounts current is to aid in the detection of fraud or misuse of funds held by the title insurance agent in a fiduciary capacity.

In many cases, title insurance premium is paid to the agency at the time of a real estate closing. Following the closing, certain conditions—such as mortgage releases or filings—may need to be met prior to issuance of the policy. Payment of premium to the title insurer by the agency often occurs after policy issuance. Examiners should request a listing of all files where agents have issued commitments but the final title insurance policies have not been issued. Preferably, the listing should provide an aging of those files. If not, the examiner should sample the files to determine the aging and reasons why final policies have not been issued. Examiners should determine what procedures are in place at the agency to follow-up on those files to hasten completion, especially for those files in which premium payment has been received by the agency. In instances where a listing is not readily available, the examiner should physically inspect all locations where such files are stored to obtain an inventory or approximation.

Examiners should request a listing of all files where the agency has issued final title policies, but not yet reported the policies to the title insurer. Determine that reporting is being handled in accordance with the insurer/agency agreement and ascertain an estimated reporting date and reason for any policies outside the scope of that agreement.

For both issued commitments pending issuance of the title policy (where the agency has collected premium) and issued policies not yet reported to the insurer, the examiner should obtain an estimated premium owed. The examiner should determine that the agency has kept those funds available for remittance to the insurer.

Review a listing of title insurance agent accounts current.

Discuss excessive balances with the title insurance company.

Refer to the appropriate division within the insurance department, if necessary.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 3
The title insurance company maintains a record of financial stability for each title insurance agent under contract with the title insurance company.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Errors and omissions, fidelity coverage and surety bonds

_____ Credit history report

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Verify that errors and omissions, fidelity coverage and surety bonds are in place, if required by statutes, rules and regulations.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 4
The title insurance company conducts a review of underwriting, claims and escrow practices of the title insurance agent in accordance with statutes, rules and regulations.

Apply to: All title insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurer audit reports of agent reviews

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

This review should include a review of the title insurance agent's policy inventory and processing operations.

If the title insurance agent does not maintain separate bank or trust accounts for the premiums for each title insurance company the agent represents, the title insurance company shall verify that the funds held on its behalf are reasonably ascertainable from the books of account and records of the title insurance agent.

Note: In some jurisdictions, the title insurance company is required to conduct this review on-site.

STANDARDS
TITLE INSURANCE PRODUCER (AGENT) LICENSING AND RELATIONS

Standard 5
The title insurance company maintains an inventory of all policy forms or policy numbers allocated to each title insurance agent.

Apply to: All title insurance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy register, stock list, log or similar record

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Title Insurers Model Act (#628)

Review Procedures and Criteria

Reconcile policies on hand with the policy register, stock list, log or similar record, if applicable.

J. Special Considerations for Title Insurance Companies and Title Insurance Agents

In title insurance, there is risk elimination where potential defects that would produce loss are identified and specifically excluded from coverage or where certain risks may be over-insured, excluded or corrected. The policy is written to indemnify against losses to the title to real property, as stated in the policy on the date of policy issuance and has no expiration. Coverage is provided at any time thereafter, if the title was not as stated in the policy at that precise point in time.

Title insurance companies and title insurance agents may also be regulated or governed by banking authorities, the U.S. Department of Housing and Urban Development (HUD) or other authorities. In some states, title insurance statutes reference the federal Real Estate Settlement Procedures Act (RESPA), in which case the examiner should be familiar with the provisions of RESPA, 12 USC Section 2607, as amended. The Expedited Funds Availability Act, 12 USC Section 4001 et seq. as amended and related regulations of the Federal Reserve System should also be referenced.

Many of the requirements in this chapter are in accordance with the *Title Insurers Model Act* (#628) and the *Title Insurance Agents Model Act* (#230). Examiners should be familiar with the applicable statutes in their jurisdiction and apply only those standards and tests suggested in this chapter that are based in statute, rule or regulation in their jurisdiction.

An examination of title insurance agencies should include verification of compliance with issues which are both common with other types of insurance and unique to title insurance. In addition to licensing, appointment, disclosure, policyholder treatment and record retention requirements, the examiner should review issues relating to referrals, controlled or affiliated business relationships, underwriting contracts with companies, bond and errors and omissions coverage requirements, escrow accounts and audits.

An understanding of terms, definitions and typical business practices which are unique to title insurance is also helpful. An example is the term "producer" as used by the title insurance profession. Whereas the term "producer" in most lines of insurance may be used to refer to an insurance agent or broker, the term "producer," as it relates to title insurance, refers to persons involved in the buying and selling of real estate, mortgage loans, lenders or attorneys. It is significant that many in the title insurance profession do not view the property owner as their customer. They view persons involved in the buying and selling of real estate, mortgage loans, lenders or attorneys as their customer—as these are entities that frequently exercise the ability to select a title insurer or title insurance agent on behalf of the named insured. The examiner should be aware that in some jurisdictions, on a purchase transaction, policies are commonly issued to both an owner and mortgagee, while in other jurisdictions, on a purchase transaction, policies may only be issued to a mortgagee, although the owner always has the option to purchase a policy. When the transaction involves a refinance, the mortgagee commonly purchases a policy but the owner does not, although the owner always has the option to purchase a policy. When the transaction involves a refinance, the mortgagee commonly purchases a policy but the owner does not.

In most jurisdictions, title insurance is a monoline policy, which can only be written by title insurance companies who are prohibited from writing any other line of business. In addition to issuing a title policy, in some jurisdictions, title insurance agencies may perform a variety of functions, including performing title searches, abstracting, performing underwriting functions, establishing and handling escrow funds and performing real estate closings. Approved attorneys, depending on the jurisdiction, will perform many of the same tasks as a title agent, but generally do not issue title policies. Approved attorneys are licensed by their local state bar association and are not licensed by the insurance department.

The agreement by the title insurer to provide the typical title insurance policy is usually referred to as a "commitment" or "preliminary commitment to title insurance." The commitment generally specifies what defects need to be corrected prior to title policy issuance, together with the conditions, exclusions or exceptions that will appear in the title policy, when issued. When issued, a title policy may cover the interests of the real estate lender or the buyer whose interests differ. Title insurance rates vary from state to state and are regulated in a variety of

ways: promulgation, prior approval, file and use, use and file and no direct regulation. Under all of the above, there is usually a discount applied for simultaneously issued policies, refinancing or to a property for which a previous title policy was issued within some specified period of time.

In many instances, the examiner will need to access and review records at the title insurance agent's office during a title insurance company examination.

In some jurisdictions, there are "title plants" that duplicate the public record affecting real property and reorganize those records, typically by legal description. In those jurisdictions in which the title insurance agent builds, owns, controls or maintains a title plant used to search title preliminary to the issuance of a title policy, it is important that the examiners verify that there are appropriate standards for maintenance of the title plant. It is also critical that the insurer provide an adequate level of oversight of such an agent.

The examiners should request the following items upon initiating a title insurance agent examination:

- Issued commitment files with no policy issued;
- A listing of all files or orders in which commitments have been issued, but policies have not yet been issued (whether or not outstanding conditions have been met and reported);
- Issued policies not yet reported to the underwriter; and
- A listing of all issued title policies and endorsements for which reporting to the title insurer is pending or not yet accomplished, as of the date of the request.

K. Example Title Letter

DATE

Address

Re: **Affiliated Business Arrangements**

Dear

The _____ Division of Insurance is conducting an investigation of affiliated business arrangements ("AfBAs") in the title insurance industry. The Division is sending this letter to all title insurance agencies licensed in the State of _____ to facilitate the investigation. **Please respond to this inquiry within ten (10) business days from the date of this letter**.

According to _____ law, the term "affiliated business arrangements" means:

"Settlement producer" means: _____.

"Affiliate" means: _____.

State insurance commissioners are authorized to enjoin violations of the federal Real Estate Settlement Procedures Act (RESPA).

RESPA defines an affiliated business arrangement (AfBA) as:

(A)n arrangement in which (A) a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally-related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than 1 percent in a provider of settlement services; and (B) either of such persons directly or indirectly refers such business to that provider or affirmatively influences the selection of that provider. 12 USC §2602(7).

Furthermore, RESPA defines "associate" as follows:

The term "associate" means one who has one or more of the following relationships with a person in a position to refer settlement business: (A) a spouse, parent or child of such person; (B) a corporation or business entity that controls, is controlled by, or is under common control with such person; (C) an employer, officer, director, partner, franchisor or franchisee of such person; or (D) anyone who has an agreement, arrangement or understanding, with such person, the purpose or substantial effect of which is to enable the person in a position to refer settlement business to benefit financially from the referrals of such business. 12 USC §2602(8).

Using the definitions contained in Division of Insurance regulation _____ and RESPA, please respond to the following questions. Submit your response to the Division of Insurance within seven (7) business days of the date of this letter. An officer of the company must attest to the accuracy of the responses and sign the responses. Failure to supply complete, signed responses within the seven (7) day time frame subjects your company to monetary or other penalties pursuant to Division of Insurance regulation _____.

Please note that in accordance with §_____ all working papers, claim files, recorded information and documents disclosed to the Division of Insurance will be given confidential treatment until the informal investigation is concluded. If documentation submitted to the Division of Insurance is additionally protected from disclosure under the exceptions to the _____ Open Records Act of §_____, you must mark each document

as confidential. In addition, you must submit an index of the documents that describes the content of each document, the basis for the claim of confidentiality and the supporting rationale for the claim. This index must accompany the documentation.

Finally, please be advised that you may or may not receive further correspondence from the Division of Insurance concerning AfBAs, regardless of how you respond to the following question:

Is the title entity to which this letter is addressed, or any of its affiliates or associates, an affiliated business arrangement as defined by Division of Insurance regulation _____ or RESPA?

Please mark the appropriate response:

☐ YES ☐ NO

As an officer of the company who is authorized to sign on behalf of the company, I do hereby attest to the accuracy of the above responses.

Company Name (as licensed)

Company Officer (print full name) Title

Signature of Company Officer Date

Please return this entire letter with complete, signed response to:

_____ *Division of Insurance* *Scan and email to:*

or

Thank you for your cooperation and prompt response.

Very truly yours,

L. Example Title Interrogatory

Affiliated Business Arrangements Interrogatories

The following terms, definitions and law shall apply when answering all questions:

State Law Definitions:
"Affiliate" means _____.

"Affiliated Business Arrangements" means _____.

(See _____ Division of Insurance Regulation _____)

"Settlement producer" means _____.

"Title entity" means _____.

"Title insurance business" means _____.

Federal Law Definitions:
In addition to enforcing state laws, state insurance commissioners are authorized to enjoin violations of the federal Real Estate Settlement Procedures Act (RESPA). The following RESPA definitions shall also apply when answering these questions:

"Affiliate Relationship" means the relationship among business entities where one entity has effective control over the other by virtue of a partnership or other agreement or is under common control with the other by a third entity or where an entity is a corporation related to another corporation as parent to subsidiary by an identity of stock ownership. 24 CFR §3500.15(c)(2).

"Affiliated Business Arrangement" means (a)n arrangement in which (A) a person who is in a position to refer business incident to or a part of a real estate settlement service involving a federally-related mortgage loan, or an associate of such person, has either an affiliate relationship with or a direct or beneficial ownership interest of more than 1 percent in a provider of settlement services; and (B) either of such persons directly or indirectly refers such business to that provider or affirmatively influences the selection of that provider. 12 USC §2602(7).

"Associate" means one who has one or more of the following relationships with a person in a position to refer settlement business: (A) a spouse, parent or child of such person; (B) a corporation or business entity that controls, is controlled by, or is under common control with such person; (C) an employer, officer, director, partner, franchisor or franchisee of such person; or (D) anyone who has an agreement, arrangement or understanding, with such person, the purpose or substantial effect of which is to enable the person in a position to refer settlement business to benefit financially from the referrals of such business. 12 USC §2602(8).

"Beneficial ownership" means the effective ownership of an interest in a provider of settlement services or the right to use and control the ownership interest involved even though legal ownership or title may be held in another person's name. 12 CFR §1024.

Please submit detailed written responses to the following questions along with the requested documentation to the Division of Insurance within twenty (20) calendar days of the date of this letter. An officer of the company must attest to the accuracy of the responses and sign the responses. Failure to supply complete, signed responses within the twenty (20) day time frame subjects your company to monetary or other penalties pursuant to _____ Division of Insurance Regulation_____.

Please note that in accordance with §_____ (cite state law), all working papers, claim files, recorded information and documents disclosed to the Division of Insurance will be given confidential treatment until the informal investigation is concluded. If documentation submitted to the Division of Insurance is additionally protected from disclosure under the exceptions to the _____ Open Records Act, you must mark each document as confidential. In addition, you must submit an index of the documents that describes the content of each document, the basis for the claim of confidentiality and the supporting rationale for the claim. This index must accompany the documentation.

For each of the following questions, please be sure to include all relevant dates and provide full and complete copies of all relevant written documents to the Division of Insurance with your responses.

Identify any and all AfBAs that exist or have existed between and among the title entity to which this letter is addressed and any other title entities or settlement producers. Indicate the dates of creation of all such AfBAs and provide full and complete copies of all written documents relating to affiliation with all such AfBAs to the _____ Division of Insurance with your responses, including all agreements of any kind between the title entity and the AfBAs.

If no such AfBAs exist or have existed between and among your title entity and any other title entities or settlement producers, please indicate this fact and you do not need to answer the remaining questions. If you are unsure whether AfBAs exist or have existed, please respond to the following questions:

Explain in detail how and when the title entity to which this letter is addressed was initially capitalized and state the net worth for each year from January 1, 2000, to the present, explaining how this figure was derived.

Provide a list of the names, addresses and occupations of all persons who contributed initial capital to the title entity to which this letter is addressed. Include the amount of capital obtained from each source and the respective capitalization ratios.

For each identified person, indicate whether this person took out a loan to cover any part of his/her contribution to the initial capital of the title entity to which this letter is addressed. Indicate the dollar amount and source of the loan.

For each identified person, state whether the title entity to which this letter is addressed has or has ever had any loan agreements with the identified person. Indicate the dates of all such loan agreements and provide full and complete copies of all written documents relating to all such loan agreements to the Division of Insurance with your responses.

Provide full and complete copies of any and all financial pro forma statements prepared by or for the title entity to which this letter is addressed. Indicate the date(s) on which each financial pro forma statement was prepared.

For each financial pro forma statement provided, explain in detail the reason(s) the financial pro forma statement was prepared.

For each financial pro forma statement provided, identify all persons who were involved in the preparation of the financial pro forma statement.

Has the title entity to which this letter is addressed ever owned or been owned, in whole or in part, by one or more settlement producers? If so, respond to the following:

Provide a list of the names, addresses and occupations of any and all settlement producers who have, in whole or in part, owned or been owned by the title entity to which this letter is addressed.

For each identified settlement producer, state the commencement date of the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed. Provide full and complete copies of all written documents relating to the commencement of the ownership arrangement(s).

For each identified settlement producer, state the termination date of the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed. Provide full and complete copies of all written documents relating to the termination of the ownership arrangement(s).

For each identified settlement producer whose ownership arrangement(s) with the title entity to which this letter is addressed was terminated or otherwise extinguished, state the reason(s) for the termination of the ownership arrangement(s) on the identified date(s). Provide full and complete copies of all written documents substantiating the reason(s) for the termination of the ownership arrangement(s).

For each identified settlement producer, indicate whether the ownership arrangement(s) between the settlement producer and the title entity to which this letter is addressed was adjusted or changed in any way. Indicate the date(s) on which the identified ownership arrangement(s) was adjusted or changed and provide full and complete copies of all written documents relating to any adjustments or changes that were made in the ownership arrangement(s).

For each identified settlement producer whose ownership arrangement(s) with the title entity to which this letter is addressed was adjusted or changed, state the reason(s) for the adjustment or change in the ownership arrangement(s) on the identified date(s). Provide complete copies of any and all written documents substantiating the identified reasons for the adjustments or changes in the ownership arrangement(s).

Provide a complete list of all employees who are currently or have ever been employed by the title entity to which this letter is addressed and indicate their dates of employment.

Respond to the following:

Provide a complete list of the names and job titles of all employees of the title entity to which this letter is addressed.

For each identified employee, identify any and all affiliated or associated businesses for which he/she performs services.

For each identified employee, identify any and all unaffiliated businesses for which he/she performs services.

Explain the proportion of time allotted by each such employee to each affiliated and/or unaffiliated business as a percentage of 100 percent.

Provide a complete list of the names and job titles of all employees who are not full-time employees of the title entity to which this letter is addressed.

For each identified part-time employee, identify any and all affiliated or associated businesses for which he/she performs services.

For each identified part-time employee, identify any and all unaffiliated businesses for which he/she performs services.

Explain the proportion of time allotted by each such employee to each affiliated and/or unaffiliated business as a percentage of 100 percent.

Explain in detail the specific job functions performed by each identified employee.

Explain in detail all services provided by the title entity to which this letter is addressed that have not already been identified as being performed by the identified employees of the title entity to which this letter is addressed.

Identify all employment-related licenses held by each identified person; e.g. title insurance producer, real estate agent, attorney, etc.

Provide full and complete copies of all 1096 (Annual Summary and Transmittal of U.S. Information Returns) forms filed with the IRS by or for the title entity to which this letter is addressed.

Provide full and complete copies of all Unemployment Insurance Quarterly Wage and Tax Reports filed with the State of _____ by or for the title entity to which this letter is addressed.

Provide a list of the names and job titles of all persons not listed above who manage or have ever managed the business affairs of the title entity to which this letter is addressed and indicate their dates of employment.

Respond to the following:

Describe when, how and by whom each identified person is compensated.

Describe the job-related duties performed by each identified person.

Identify any and all affiliated or associated businesses for which each identified person performs or has performed services, and describe those services.

Identify any and all unaffiliated businesses for which each identified person performs or has performed services, and describe those services.

Does the title entity to which this letter is addressed perform any of the following core title services: (1) title searches, (2) title examinations; (3) abstracts; (4) title evaluations to determine insurability; (5) prepare and/or issue title commitments and/or title policies; (6) maintain policy records; (7) receive premiums; (8) closing and settlement services; (9) solicit and negotiate for the issuance of your title commitments; (10) maintain escrow accounts? If so, please respond to the following questions for *each* of the above core title services:

Provide a list of the names and job titles of all persons who have performed each core title service for the title entity to which this letter is addressed from January 1, 2000, to the present.

For each identified person, state the number of each core title service performed per year by that person for the title entity to which this letter is addressed from January 1, 2000, to the present. In addition, state this number as a percentage of the total number of each core title service performed per year by the title entity to which this letter is addressed.

For each identified person, state the name of any and all employers of that person.

For each identified employer, state whether that employer is an affiliated or associated business.

For each identified employer, state whether the employer is a settlement producer and describe how they meet this definition as described in _____ Division of Insurance Regulation _____.

For each identified person, describe in detail the specific activity or activities performed to accomplish the identified core title services.

For each identified person, state the name of the business that appears on each person's paycheck and/or paystub.

Has the title entity to which this letter is addressed ever contracted out any part of its work relating to the performance of title services? If so, please respond to the following:

Provide a list of all persons to whom the title entity to which this letter is addressed has contracted out any part of its work relating to the performance of title services.

Identify all licensed producers who conduct or have conducted title insurance business for the title entity to which this letter is addressed. For each identified licensed producer, indicate the dates that the licensed producer conducted business for your title entity.

Identify all underwriters for whom the title entity to which this letter is addressed is or has been authorized to conduct title insurance business. For each identified underwriter, indicate the dates that your title entity was authorized to conduct title insurance business for the underwriter and provide full and complete copies of all underwriting agreements to the Division of Insurance with your responses.

For each identified person, state whether that person is or was an affiliate or associate of the title entity to which this letter is addressed.

For each identified person, state whether that person is or was a settlement producer, and describe how they meet this definition as described in _____ Division of Insurance Regulation _____.

Identify any and all agreements, written or oral, that the title entity to which this letter is addressed has made relating to the contracting out of any part of its work relating to the performance of title services. Indicate the date on which each agreement was made and provide full and complete copies of all such written agreements.

Identify any and all payments that the title entity to which this letter is addressed has made or received for the contracting out of any part of its work relating to the performance of title services. Indicate the date on which each payment was made and provide full and complete copies of all written documents relating to all such payments.

Has the title entity to which this letter is addressed ever rented office space, facilities, items or services *to* or *from* any other title entities or settlement producers? If so, respond to the following:

Describe in detail all rented spaces, facilities, items or services. Indicate the date(s) for which each identified space, facility, item or service was rented and provide full and complete copies of all written documents relating to all such rental agreements.

State the amount of rent paid for each identified space, facility, item or service and explain how the identified amount was derived.

State the name of the person(s) from whom each identified space, facility, item or service was rented.

Are any of the persons identified affiliates or associates of the title entity to which this letter is addressed? If so, please identify their affiliations or associations.

Are any of the identified persons settlement producers, as defined in regulation _____ If yes, please identify in what capacity they are settlement producers.

Respond to the following questions concerning (1) affiliated settlement producers; (2) affiliated title entities; (3) unaffiliated settlement producers; and (4) unaffiliated title entities:

Since January 1, 2000, has the title entity to which this letter is addressed attempted to obtain business from one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of all affiliated settlement producers and/or title entities that the title entity to which this letter is addressed has attempted to obtain business from since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, describe in detail any and all marketing or advertising used from January 1, 2000, to the present by the title entity to which this letter is addressed in its attempt to obtain business from the affiliated settlement producer.

For each identified affiliated settlement producer and/or title entities, describe in detail any and all marketing or advertising agreements made with the affiliated settlement producer from January 1, 2000, to the present in its attempt to obtain business from the affiliated settlement producer.

Include all relevant dates and copies of all related documents.

Since January 1, 2000, has the title entity to which this letter is addressed received business from one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of the names and addresses of all affiliated settlement producers and/or title entities that the title entity to which this letter is addressed has received business from since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, indicate both the total number of customers and the total dollar amount of business received from the affiliated settlement producer and/or title entities from January 1, 2000, to the present.

Include all relevant dates and copies of all related documents.

Since January 1, 2000, has the title entity to which this letter is addressed sent business to one or more settlement producers and/or title entities affiliated or associated with the title entity to which this letter is addressed? If so, respond to the following:

Provide a list of the names and addresses of all affiliated settlement producers and/or title entities to which the title entity to which this letter is addressed has sent business since January 1, 2000.

For each identified affiliated settlement producer and/or title entities, indicate both the total number of customers and the total dollar amount of business sent to the affiliated settlement producer and/or title entities from January 1, 2000, to the present.

Include all relevant dates and copies of all related documents.

Does a settlement producer who refers business to the title entity to which this letter is addressed receive any services or products at a below market or discounted rate from an affiliate of the entity to which this letter is addressed?

Provide a list of the names and addresses of all settlement producers and affiliates of the entity to which this letter is addressed who receive or give services or products at a below market or discounted rate, as well as identification of which services or products are provided.

Identify all relevant documentation, including documentation consulted to prepare your responses. In addition, you may provide any other documentation, including a position statement, which you feel is relevant to this inquiry.

Please attach the following attestation form to the back of your written responses. Electronic answers will NOT be accepted. Please mail or hand-deliver your written responses and supporting documents to:

_____ Division of Insurance

Please direct any inquiries concerning the above questions to:

Attn:

As an officer of the company to which this letter is addressed, who is authorized to sign on behalf of the company, I do hereby attest to the accuracy of the above responses.

Company Name (as licensed)	Company Address
Company Officer (print full name)	Title
Signature of Company Officer	Date

This letter commences an informal investigation of your company's practices. Your responses to these questions must be postmarked no later than twenty (20) calendar days from the date of this letter to avoid imposition of monetary penalties permitted under_____.

M. Sample Checklist

TITLE INSURANCE COMPANY CHECKLIST OF EXAMINATION REQUIREMENTS

All documents, lists and reference materials must be prepared for the period under examination and be ready at the commencement of the examination. If there were any substantive changes during the period under examination—i.e. a rate change or substantive underwriting rule change—your documents must so note and specifically describe how this change was implemented. Whenever possible, please supply the requested information in electronic format.

ADDITIONAL REQUESTS FOR INFORMATION MAY BE MADE BY THE EXAMINERS AT ANY TIME DURING THE EXAMINATION PROCESS.

1. Provide a brief narrative history of its business in general and specifically in _____ (state). Include, at a minimum, the state(s) in which the company is licensed to do business, when the company was licensed in (state), premium writings as of the last day of the examination period for the line of business being examined and any other historically significant detail pertinent to _____ (state). Provide an annual statement for the period(s) under examination.

2. Identify all internal audits performed by the company from the beginning date of the examination period to the present and provide a copy of same.

3. Provide a specimen of each policy and endorsement form in use during the examination period; include samples of manuscripted endorsements when applicable. Prepare a copy of all title insurance rate filings applicable to the period under examination and stamped by the _____ (state) Division of Insurance. Provide a schedule of fees and charges for closing and settlement services, which has been stamped by the _____ (state) Division of Insurance.

4. Provide a copy of the company's antifraud plan, if required by statute.

5. If the company possesses its own title plant, provide a detailed explanation of the company's procedures for the maintenance of this title plant.

6. Provide a copy of the underwriting rules, manual, guidelines, memoranda and directives and procedures manuals applicable to (state) business written during the period under examination.

7. Provide a copy of the (state) claims manual, guidelines, memoranda, directives and procedures for the processing of claims during the period under examination.

8. Provide a copy of all promotional and advertising materials utilized by the company or its agents during the period of examination.

9. Provide a list of all promotional and advertising activities—including, but not limited to, products, services, seminars, conventions, gifts and prizes—utilized by the company or its agents during the period of examination. Outline any incentive programs available to realtors, lenders, builders, et al., provided by the company or its agents during the period of examination.

10. Provide a list of policies issued during the period under examination. Include at least the policy number, effective date, named insured, named lender/mortagee, amount of coverage and premium.

11. Provide a list of claims made during the period under examination. Include at least the claim number, named insured, date claim made and status; i.e., open/amount reserved and closed/amount paid.

12. Provide a list of all affiliated entities.

13. Provide a list of all disbursements pertaining to advertising, sales and marketing and promotional activities.

Chapter 23—Conducting the Life and Annuity Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a format for conducting life insurance and annuity company examinations. Procedures for conducting property/casualty insurance company examinations and other types of specialized examinations—such as managed care organizations, third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of life insurance/annuity operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims (Several specialized checklists are available in Sections H–J of this chapter)
H. Checklist for Marketing and Sales Standard #1
I. Checklist for Marketing and Sales Standard #4
J. Checklist for Marketing and Sales Standard #8

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

IIPRC-Approved Products
When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (Compact) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The Compact website is *www.insurancecompact.org* and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rates and Forms Filing (SERFF) to product filings submitted to the Compact for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each Compact-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The Compact office should be included when a compacting state(s) is concerned that a Compact-approved product constitutes a violation of the provisions, standards or requirements of the Compact (including the uniform standards).

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The regulated entity files all certifications with the insurance department, as required by statutes, rules and regulations.

Apply to: All regulated entities

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of certifications made by the regulated entity

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570)
Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest* (AG 49)

Review Procedures and Criteria

The illustration actuary should file a certification with the insurance department annually for all policies for which illustrations are used (Model #582, Section 11). For indexed universal life (IUL) illustrations, AG 49 expands upon and supersedes the illustration requirements in Model #582.

A responsible officer of the insurer, other than the illustration actuary, should certify annually that the illustration formats meet all applicable requirements and that the scales used in insurer-authorized illustrations are those scales certified by the illustration actuary. In addition, the officer must certify that the regulated entity has provided its producers with information about the expense allocation method used and disclosed by the regulated entity in its illustrations (Model #582, Section 11).

Note: The annual certifications should be provided each year by a date determined by the insurer.

Each insurer should file with its annual statement a certificate of compliance executed by an authorized officer stating that the advertisements which were disseminated by or on behalf of the insurer during the statement year complied, or were made to comply, in all respects with the rules governing the advertising of life insurance (Model #570, Section 9C).

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the company about its product(s). It is not typically based on sampling techniques, but it can be. The areas to be considered in this kind of review include all written and verbal advertising and sales materials.

2. Techniques

This area of review should include all advertising and sales material and all producer sales training materials to determine compliance with statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of information provided or to obtain additional information.

As with all of its advertising, regardless of the medium, every insurance company is required to have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of all of its advertisements. All of these advertisements maintained by or for and authorized by the insurer are the responsibility of the insurer.

The exact same regulations and statutes (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. Bearing that in mind, when the examiner is reviewing a company's Internet advertisements, it is important to also review the safeguards implemented by the company.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear so as to avoid deception. The advertisement shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined upon reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence within the segment of the public to which the advertisement is directed.

There may be special requirements for applicants age 60 or older. The examiner should refer to statutes, rules and regulations to determine what requirements apply.

In addition to reviewing advertising, examiners should be aware that several NAIC models impose additional duties on regulated entities which go beyond the delivery of accurate information to consumers. If an insurance product is involved and a regulated entity, producer or a registered representative makes a recommendation regarding that insurance product, both insurance suitability laws and insurance replacement laws may apply to the transaction. A person who is advising a consumer about an insurance product, even if it is to replace it with a non-insurance product, must hold an insurance license. An insurance producer who does not hold a license as a registered representative should not give advice or recommendations about securities products.

The *Life Insurance and Annuities Replacement Model Regulation* (#613) was thoroughly updated and expanded in 1998. The new model applies to annuities and life insurance products and requires delivery of certain notices if the proposed purchaser has any existing life insurance or annuity products. Under the new model, insurers are required to have systems in place to monitor compliance with replacement procedures. Under the old model, which is still in place in a number of states, producers generally make a

decision at the point of sale as to whether the transaction involves a replacement. Under either model, market regulators should review insurer systems and should also sample transactions that are not reported as replacements to verify that the insurer's system is effective in properly identifying replacement transactions.

Historically, replacement ratios were quite low. This was due in part to the fact that the definition of a replacement under the "old" *Life Insurance and Annuities Replacement Model Regulation* (#613) only applied to life insurance products and external replacements. Under the prior model, either the producer or the insurer made a decision as to whether the transaction involved a "replacement."

The new model covers internal and external replacement and, if any funds for the new product come from an existing product, the transaction is a replacement and must be reported as such. There are several limited exceptions. Another factor in the increase in replacement activity is the tendency of consumers to move funds between investment and insurance products when the stock market fluctuates. In such transactions, an analysis should be performed to determine whether the insurer has systems in place to supervise its producers. Regulators should review transactions involving the sale or replacement of variable products involving the insurer and its products to verify that a system is in place to confirm that its producers are properly licensed. In the context of the examination, an examiner or analyst is only responsible for reviewing the conduct of insurance producers and conduct which requires an insurance producer license.

The *Suitability in Annuity Transactions Model Regulation* (#275) was adopted in 2006. Previously, this model was known as the *Senior Protection in Annuity Transactions Model Regulation*. The 2006 amendments to the previous model removed all references to "senior." The model has been adopted in some states in various forms. Model #275 was revised in 2010 to include new provisions regarding insurer supervision and monitoring of annuity recommendations and continuing education and training requirements for producers. While the previous version of the model imposed a duty on insurers and producers, or the entities they subcontract with, the revised model places the responsibility of supervision and monitoring on the insurer. The language of the revised model provides that an insurer's issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued. The model was also updated to include a revised definition of annuity, a definition of "replacement" and provisions expanding the scope of the model to include replacement of annuity products.

Market regulators should also be aware that sales of products, such as fixed-index annuities (formerly referred to as equity-indexed annuities) and index life insurance products (such as universal index life insurance) continue to increase. These products typically include features that require an understanding of bonuses, guaranteed elements and an array of interest-crediting methods. In some cases, existing NAIC model laws and regulations may not give specific guidance on all aspects of all products. In such instances, examiners may rely on general principles found in Model #880, the *Life Insurance Disclosure Model Regulation* (#580) and the *Annuity Disclosure Model Regulation* (#245).

Model #582 sets out a variety of requirements to prevent insurers from using misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582. It provides guidance and limitations for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

Evaluation of compliance with annuity suitability may best be accomplished through a process and procedure review coupled with sampling. The process and procedure portion of the review is a good example of a function where states may wish to coordinate their reviews and share responsibilities. A continuum approach, such as use of a desk audit, may also be appropriate. Sampling enables examiners to evaluate whether the established processes have been clearly communicated and implemented rather than to function as a means to "second-guess" each individual suitability determination. Company programs for reviewing suitability may vary widely and should not be considered a "once-size-fits-all" approach. Annuity products can be designed or tailored to serve a wide variety of clientele and customer objectives.

Some insurers may outsource the administration of their suitability review, while maintaining ultimate responsibility for the outcomes. It may be instructive for examiners to become familiar with the structure and practices of commonly used services that perform suitability reviews. Examiners may also want to become familiar with vendor-owned services commonly used by insurers to document their suitability reviews.

The NAIC *Stranger-Originated Annuity Transactions Sample Bulletin* was adopted by the NAIC in October 2011. The bulletin was developed to address stranger-originated annuity transactions (STOA). Similar to stranger-originated life insurance transactions (STOLI), STOA transactions provide annuity contracts for the benefit of investors.

In STOAs, insurance producers and/or investors offer an individual, who is usually a “stranger” to the producer and/or investor, a nominal fee for the use of the individual’s identity as the annuitant in an investment-oriented annuity.

Typically, individuals targeted to serve as annuitants are in extremely poor health and are not expected to live beyond the first year of the policy. In order to find individuals who meet the aforementioned criteria, producers and/or investors have been known to take out advertisements in papers as well as solicit individuals residing in nursing homes or hospice facilities.

Once an individual has agreed to the set of conditions posed, the producer will complete the annuity application, ensuring that particular riders, such as a bonus rider or a guaranteed minimum death benefit, are in place to maximize the rate of return for those financing the transaction. Depending on the number of companies the producer represents and the commission policies in effect, the producer may seek to use multiple policies from various companies.

To avoid added scrutiny of the policy or detection of the scheme, producers and/or investors involved in STOAs will often take precautions to ensure that the dollar amount of the annuity falls below specific underwriting guidelines, while other annuities above these dollar amounts are subject to more stringent underwriting. After the annuity is issued, then the investor will significantly increase their investment in the annuity. A trust or an organization may additionally be named as beneficiary of the annuity in order to hide the true identity of those who will benefit from the annuitant's death.

As the financial implications of STOA transactions could be detrimental to both companies and consumers, the adopted bulletin recommends that insurance companies take certain actions to mitigate their exposure to STOA transactions, which are outlined in the NAIC *Stranger-Originated Annuity Transactions Sample Bulletin*.

It is appropriate for the examiner to remind annuity insurers of this bulletin and to ask if the insurer has considered this bulletin when implementing compliance and/or enterprise risk management procedures.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
MARKETING AND SALES

Standard 1
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All company advertising and sales materials, including radio and audiovisual items, such as television commercials, telemarketing scripts and pictorial materials

_____ Policy forms, including any required buyers' guides as they coincide with advertising and sales materials

_____ Producers' own advertising and sales materials

_____ All documents related to the development of crediting rates used in illustrations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Risk-Based Capital (RBC) for Insurers Model Act (#312), Section 8B
Modified Guaranteed Annuity Model Regulation (#255), Section 4B
Life Insurance Disclosure Model Regulation (#580), Section 8C
Unfair Trade Practices Act (#880)
Annuity Disclosure Model Regulation (#245), Section 6 plus appendix
Long-Term Care Insurance Model Act (#640)
Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49)
Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Military Sales Practices Model Regulation (#568)

Review Procedures and Criteria

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements—regardless of by whom written, created, designed or presented—are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either 4 years or until the filing of the next regular report on examination of the company, whichever is the longer period of time.

Review advertising materials in conjunction with the appropriate policy form.

Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead a prospective buyer to believe that he/she is purchasing an investment or savings plan. Problematic terminology may include such terms as: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable, or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required" if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. Enrollment periods may not be described as terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised, because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate the fact, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in an advertisement;

- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact;
- Contain an assertion, representation or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation;
- Use the existence of the insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the association;
- Misrepresent the dividends or share of the surplus to be received on any policy;
- Make a false or misleading statement as to the dividends or share of surplus previously paid on a policy;
- Misrepresent any policy as being shares of stock; and
- Illustrations of benefits payable under any modified guaranteed life insurance[28] shall not include projections of past investment experience. Hypothetical assumed interest credits may only be used if it is made clear that such are hypothetical only.

Materials should:

- Clearly disclose name and address of insurer;
- If using a trade name, disclose the name of the insurer, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to a policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed;
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact, and any proprietary relationship or payment for the testimonial must be disclosed; and
- The sales material for any modified guaranteed life insurance must clearly illustrate there can be both upward and downward adjustments to nonforfeiture benefits, due to the application of the market value adjustment formula.

Determine if the company approves producer sales materials and advertising. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as a life insurance agent. Improper terms may include financial planner, investment advisor, financial consultant or financial counseling, if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Determine if the company has procedures in place to monitor the use of senior-specific certifications or professional designations used by producers that solicit for the company.

[28] "Modified Guaranteed Life Insurance Policy" means an individual policy of life insurance, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. It contains nonforfeiture values that are based upon a market value adjustment formula if held for shorter periods. The formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the policy must be in a separate account during the period or periods when the policyholder can surrender the policy.

Determine if the company allows its life and annuity products to be marketed to the military. If so, review the company procedures to ensure that the procedures are in compliance with all applicable laws and regulations regarding sales to military personnel.

Determine if analogies between a life insurance policy's cash values and savings accounts or other investments and between premium payments and contributions to savings accounts or other investments are complete and accurate.

Determine if the advertisement states or implies in any way that interest charged on a policy loan or the reduction of death benefits by the amount of outstanding policy loans is unfair, inequitable or in any manner an incorrect or an improper practice.

If nonforfeiture values are shown in any advertisement, ensure the values are shown, either for the entire amount of the basic life policy death benefit, or for each $1,000 of initial death benefit.

Review the use of the words/phrases "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words/phrases of similar import. Such words/phrases should not be used with respect to any benefit or service being made available with a policy, unless true. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a life insurance policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

If an advertisement represents a pure endowment benefit as a "profit" or "return" on the premium paid, rather than as a policy benefit for which a specified premium is paid, it is deemed deceptive and misleading and is prohibited.

Determine that company procedures and materials relative to long-term care (LTC) products comply with "right to free look" requirements.

Review the company and producer's websites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised product is (or is not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?

For the review of Internet advertisements:

- Run an inquiry with the company's name;
- Review the company's home page;
- Identify all lines of business referenced on the company's home page;
- Research the ability to request more information about a particular product and verify the information provided is accurate; and
- Review the company's procedures related to producers' advertising on the Internet and ensure the company requires prior approval of the producer pages, if the company name is used.

A summary of special requirements is available for the following:

- Products sold using enrollment periods;
- Direct response products;
- Graded or modified benefit policies;
- Policies with premium changes;
- Policies with non-guaranteed elements;
- Products sold to students;
- Individual deferred annuity products or deposit funds; and
- Combination life insurance and annuity products.

Review advertising carefully for use of the term "guarantee." Verify that the scope and duration of any guarantee is accurately described. Determine that the regulated entity has accurately portrayed non-guaranteed elements. Verify that complete information is provided regarding the scope and duration of guarantees.

Review advertising carefully for use of the term "bonus." Review the functioning of any such bonus payments and verify that the information provided is accurate in describing the amount and the conditions for payment, retention or recoupment of the bonus.

Review advertising carefully for explanations of surrender periods and charges. Review the functioning of any such surrender charge and, in particular, how the charge is calculated in death claims. Verify that the information provided regarding the amount of the charge and the conditions for assessment are accurate.

Index products

For advertising for interest-sensitive products, review explanations of the crediting methods and terms. Review the functioning of the crediting methods to determine that the explanations are understandable and accurate. Verify that accurate information is provided regarding the options available to the consumer and the methods by which the consumer is to exercise the options.

In addition to reviewing the advertising of indexed products, the examiner should review the illustration for compliance with Model #582 to ensure that, among other things, unreasonable or deceptive crediting rates are not being used in the illustrations and that the illustrations provide the consumer with the information required by Model #582 and, for indexed universal life (IUL) products, AG 49. Determine whether the explanations and information provided regarding the options available to the consumer are consistent with the requirements and limitations of Model #582 in AG 49.

Review the methods used by the regulated entity, annually or otherwise, to convey ongoing information about policy/contract values and options available to the consumer to change interest-crediting methods or exercise other policy/contract features in future terms.

Standard 2
The insurer's rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Loan and surrender files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Military Sales Practices Model Regulation (#568)

Review Procedures and Criteria

Review loan and surrender files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm receipt of sales material or required statement. Copies of sales material other than regulated entity-approved sales material, if permitted, must also be in the file.

Review replacement disclosure forms for completeness and signatures, as required.

If the applicable state's definition of "recommendation" encompasses replacements, review policy/underwriting files to verify that the producer's treatment of and classification of replacements is in compliance with the applicable state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of

reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that producer written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
    - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
    - The consumer would benefit from product enhancements and improvements; and
    - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to determine that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurance producer has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

Standard 3
The insurer's rules pertaining to replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register/Data

_____ Policy/Underwriting files

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Agency sales/lapse records

_____ Regulated entity systems manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (as adopted 1998) (#613)
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Military Sales Practices Model Regulation (#568)
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Determine if the regulated entity has advised its producers of its replacement policy.

Determine if the regulated entity has provided timely notice to the existing insurer(s) of the replacement.

Examine for effectiveness the regulated entity's system of identifying undisclosed replacements.

Determine if the regulated entity has the capacity to produce data required by replacement regulation to assess producer replacement activity.

Determine if the regulated entity has issued letters in a timely manner to policyholders, advising of the effects of loans and other disbursements on policy values.

Review policy/underwriting files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the regulated entity provides required credit for suicide and contestability periods on replacements.

If the applicable state's definition of "recommendation" encompasses replacements, review regulated entity procedures to verify that the regulated entity's treatment of and classification of replacements is in compliance with the state's definition of "recommendation."

Review policy/underwriting files to ensure that the insurance producer, or the insurer where no producer is involved, when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, has adequate written documentation of reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs, including the consumer's suitability information.

Ensure that regulated entity written documentation regarding suitability contains adequate and complete information to demonstrate that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information.
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
    - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
    - The consumer would benefit from product enhancements and improvements; and
    - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting files to ensure that prior to the execution of a replacement of an annuity resulting from a recommendation, an insurer, where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;
- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

Note: All documents necessary to review the appropriateness of a sale may not be in the insurer's possession. It may be necessary to give the insurer additional lead time to obtain the documents from a producer, a third party reviewer or other entity.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin* because sales of stranger-originated annuities may be an indicator of potentially fraudulent transactions.

Standard 4
An illustration used in the sale of a policy contains all required information and is delivered in accordance with statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ All documents related to the development of crediting rates used in illustrations

_____ Underwriting file

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49)
Universal Life Insurance Model Regulation (#585)
Variable Life Insurance Model Regulation (#270)
Life Insurance Disclosure Model Regulation (#580)
Disclosure for Small Face Amount Life Insurance Policies Model Act (#605)

Review Procedures and Criteria

Note: Some policies may be deemed to be sold without an illustration.

If a jurisdiction continues to require surrender cost indices, ensure it is appropriately disclosed in the Statement of Policy Cost and Benefit.

Ensure that the insurer, its producers or authorized representatives do not:

- Represent the policy as anything other than a life insurance policy;
- Use or describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
- State or imply that the payment or amount of non-guaranteed elements is guaranteed;
- Use an illustration that does not comply with statutes;
- Use an illustration that at any policy duration depicts policy performance more favorable to the policyowner than that produced by the illustrated scale of the insurer whose policy is being illustrated;
- Provide an applicant with an incomplete illustration;
- Represent in any way that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;

- Use the terms "vanish," "vanishing premium" or similar terms that imply that the policy becomes paid-up, to describe a plan for using non-guaranteed elements to pay a portion of future premiums;
- Except for policies that can never develop nonforfeiture values, use an illustration that is "lapse-supported"; or
- Use an illustration that is not "self-supporting."

Ensure that the insurer has a documented, reasonable methodology for the manner in which it determines its index-crediting strategy. Verify that the insurer has a system which monitors the interest rates used by its insurance producers in illustrations for compliance with the insurer's credited interest rates.

Model #582 sets out a variety of requirements to prevent insurers from using unreasonable or misleading illustrations in the sale of life insurance. AG 49, originally adopted by the NAIC in 2015, expands upon and supersedes some of the illustration requirements of Model #582 for indexed universal life (IUL) illustrations. In simple terms, Section 4 and Section 5 of AG 49 set maximum crediting rates for illustrations. Section 6 addresses illustrations of policy loans, and Section 7 requires illustrations beyond those required in Model #582. The implementation of AG 49 was phased as follows:

- Section 4 and Section 5 shall be effective for all new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015;
- Effective March 1, 2017, Section 4 and Section 5 shall be effective for all in force life insurance illustrations on policies within the scope of this actuarial guideline, regardless of the date the policy was sold; and
- Section 6 and Section 7 shall be effective for all new business and in force life insurance illustrations on policies sold on or after March 1, 2016.

Testing the compliance of illustrations with Model #582 and AG 49 will be complex, and the examiner will likely seek assistance from an actuary familiar with and capable of testing compliance with Model #582 and AG 49. In such cases, the examiner should work with the actuary to determine the appropriate information to request from the insurer necessary to enable the actuary and examiner in testing the compliance of the illustrations.

The examiner may be able to test implementation compliance issues by confirming that IUL illustration changes were made on or before the effective dates set out above. For example:

- Did the insurer implement on or before Sept. 15, 2015, a compliant crediting rate methodology for new and in force illustrations on policies sold on or after Sept. 15, 2015?
- Did the insurer implement on or before March 1, 2016, a compliant credit rate methodology for all new illustrations produced on or after March 1, 2016, on in force policies?
- Did the insurer implement the policy loan and additional illustration scales requirement of Section 6 and Section 7 of AG 49 on or before March 1, 2016?

The following are more complex requirements of AG 49, which may require the assistance of an actuary or other person with expertise in evaluating illustration crediting methodologies and calculations:

- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the credited rate for the Illustrated Scale has been limited according to the requirements of Section 4;
- For new business and in force life insurance illustrations on policies sold on or after Sept. 1, 2015, determine whether the earned interest rate for the Disciplined Current Scale has been limited according to the requirements of Section 5;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that if the illustration includes a loan, the illustrated rate credited as compared to the illustrated loan charge has been limited according to the requirements of Section 6;
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a ledger using the Alternate Scale shown alongside a ledger using the illustrated scale with equal prominence according to the requirements of Section 7.A;

- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates as referenced in Section 7.B; and
- For new business and in force life insurance illustrations on policies sold on or after March 1, 2016, ensure that the basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated, as required by Section 7.C.

Ensure that the insurer has established requirements for producers to provide universal life applicants with a "Statement of Policy Information." The statement should substantially follow the format set forth in the *Universal Life Insurance Model Regulation* (#585). Insurers that use direct response solicitation of universal life insurance products should provide such a statement at the time of policy delivery.

Ensure illustrations are retained in accordance with statutes, rules and regulations. A copy of the basic illustration and a revised basic illustration (if any) signed, as applicable, or a certification that either no illustration was used or that the policy was applied for other than as illustrated, should be retained until 3 years after the policy is no longer in force.

Determine if the illustration is submitted to the regulated entity as required.

- If a basic illustration is used by an insurance producer or other authorized representative of the insurer in the sale of a life insurance policy and the policy is applied for as illustrated, a copy of the illustration must be submitted to the insurer at the time of policy application. A copy must also be provided to the applicant.
- If the policy is issued other than as applied for:
    - A revised basic illustration conforming to the policy as issued should be sent with the policy;
    - The revised illustration should be labeled "Revised Illustration";
    - The illustration should be signed and dated by the applicant or policyowner and producer or other authorized representative of the insurer no later than the time the policy is delivered; and
    - A copy must be provided to the insurer and the policyowner.
- If no illustration is used by an insurance producer or other authorized representative, or if the policy is applied for other than as illustrated:
    - The producer or representative must certify to that effect in writing on a form provided by the insurer;
    - The applicant should acknowledge (on the same form) that no illustration conforming to the policy applied for was provided and also acknowledge an understanding that an illustration conforming to the policy as issued will be provided no later than the time of policy delivery; and
    - The form must be submitted to the insurer at the time of application.
- If the basic or revised illustration is sent by mail from the insurer:
    - It should include instructions for the applicant/policyowner to sign the duplicate copy of the numeric summary page and return the signed copy; and
    - An insurer's obligation will be satisfied if it demonstrates a diligent effort to obtain the signature. Diligent effort includes the mailing of a self-addressed postage-prepaid envelope with instructions for the return of the signed page.

Ensure a signed copy of the basic illustration and revised basic illustration, if any, or a certification that either no illustration was used or that the policy was applied for other than as illustrated is retained until 3 years after the policy is no longer in force. (A copy does not have to be retained if the policy is not issued.)

A summary of illustration requirements is available with special requirements for:

- Basic illustrations;
- Supplemental illustrations;
- Interest-indexed universal life;
- Universal life; and
- Variable life.

Standard 5
The insurer has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Variable Life Insurance Model Regulation (#270), Section 3C
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper
Stranger-Originated Annuity Transactions (STOA) NAIC Sample Bulletin

Review Procedures and Criteria

Determine if multiple sales of the same product have been made to individuals. Identify and review a random sample of policyholders for which multiple policies exist.

Determine if underwriting guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine whether marketing materials encourage multiple issues of policies; e.g., use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the regulated entity has a system to discourage "over-insurance" of policyholders as defined by the regulated entity's underwriting requirements.

For annuity products, ensure the regulated entity maintains a written statement specifying the standards of suitability used by the insurer. The standards should specify that an insurer's issuance of an annuity shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

Review whether the insurer has established a system of STOA-related oversight (underwriting criteria). If not, discuss the existence of the STOA bulletin with the insurer. The examiner should be mindful that the provisions within the bulletin may not be legally required by their jurisdiction.

Inquire if the company has detected any STOA transactions and if so, the examiner may want to determine if there were any suitability issues surrounding the sale of the STOA. If there were suitability issues, the examiner may want to inquire as to what actions were taken by the company to prevent further suitability issues and if the company took any action against the producer.

Note: Sales made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. Examiners should be mindful of the fact that both variable annuity sales and variable life sales are typically sold using FINRA requirements.

Examiners may wish to remind insurers that sell annuities of the existence of the *Stranger-Originated Annuity Transactions NAIC Sample Bulletin* because sales of stranger-originated annuities may result in adverse suitability situations.

Standard 6
Preneed funeral contracts or prearrangement disclosures and advertisements are in compliance with statutes, rules and regulations.

Apply to: All preneed products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance Disclosure Model Regulation (#580), Section 7
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 5Y

Review Procedures and Criteria

Ensure there is evidence that the disclosures have been made in accordance with statutes, rules and regulations.

A summary of special requirements for preneed disclosures is available.

Advertisements for a preneed funeral contract or prearrangement that is funded or is to be funded by a life insurance policy or annuity contract should disclose the following:

- The fact that a life insurance or annuity contract is involved or being used to fund a prearrangement; and
- The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

Standard 7
The regulated entity's policy forms provide required disclosure material regarding accelerated benefit provisions.

Apply to: All individual and group life insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Claim procedure/underwriting manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

The terminology "accelerated benefit" shall be included in the descriptive title.

Disclosure is required that receipt of accelerated benefits may be a taxable event, and assistance should be sought from a personal tax advisor.

Disclosure providing description of accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant.

Products marketed under this regulation shall not be described as long-term care insurance (LTCI) or as providing LTC benefits.

Standard 8
Policy and contract application forms used by depository institutions provide required disclosure material regarding insurance sales.

Apply to: All individual and group life insurers and depository institutions

All covered persons[29] as defined by the Gramm-Leach-Bliley Act. This includes any person who sells, solicits, advertises or offers an insurance product or annuity to a consumer at an office of the depository institution or on behalf of a depository institution.

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Underwriting manuals

_____ Policy and contract application forms

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Bulletin pertaining to Voluntary Expedited Filing Procedures for Insurance Applications Developed to allow Depository Institutions to meet their Disclosure Obligations under Section 305 of the Gramm-Leach-Bliley Act

Review Procedures and Criteria

One notice provides the written disclosures that must be given to a consumer in connection with an initial purchase of an insurance or annuity product that is unrelated to an extension of credit.

The other notice provides the written disclosures that must be given to a consumer in connection with the solicitation, offer or sale of an insurance or annuity product that is related to an extension of credit.

For notices unrelated to an extension of credit: (1) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (2) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank or any affiliate; and (3) that there is the potential for investment risk, including the possible loss of value. (Note: The last requirement may not be required for all products.)

[29] Please refer to the bulletin for a detailed explanation of what constitutes a covered person.

For notices related to an extension of credit (which includes solicited, offered or sold): (1) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer also purchasing an insurance product or annuity from the bank or the bank's affiliate; (2) the bank or savings association must inform the consumer that it cannot condition the extension of credit upon the consumer not obtaining an insurance product or annuity from an entity not affiliated with the bank. In addition, (3) the disclosure notice must inform the consumer that neither insurance nor annuities are a deposit, other obligation of, or guaranteed by the bank or any affiliate of the bank; (4) that neither insurance nor annuities are insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or any affiliate; and (5) that there is the potential for investment risk, including the possible loss of value. Note: The last requirement may not be required for all products.

STANDARDS
MARKETING AND SALES

Standard 9
Insurer rules pertaining to producer requirements with regard to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Other relevant files

_____ New business reports

_____ Policy/Underwriting files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

If the insurer has a business rule that calls for completion of a fact-finder or similar disclosure document, review policy files to determine if forms have been completed regarding suitability.

Review policy files. Copies of sales material other than insurer-approved materials, if permitted, must also be in the file or made available to the regulator upon request.

Examine for effectiveness the insurer's system of verifying that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Examine for effectiveness the insurer's system for review or oversight of annuity transactions that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A customer refused to provide relevant suitability information and the annuity transaction was not recommended; or;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Review completed annuity transactions and compare the information obtained by the insurance producer to the type of product purchased to verify that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another transaction or series of transactions, the insurance producer, or the insurer, where no producer is involved, had reasonable grounds for believing that the product was suitable on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245));
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;

- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
    - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
    - The consumer would benefit from product enhancements and improvements; and
    - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Review policy/underwriting/other files to verify that an insurance producer has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

Standard 10
Insurer rules pertaining to suitability in annuity transactions are in compliance with applicable statutes, rules and regulations.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Underwriting files

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Regulated entity's systems manual

_____ Regulated entity's producer training materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

Determine if the insurer has advised its producers of applicable state statutes, rules and regulations regarding suitability of annuity products and of the insurer's product-specific standards, policy and procedures regarding verification of suitability of annuity products.

Note: Determine if the insurer has the capacity to produce data required by the applicable state suitability statute, rule or regulation. If optional recordkeeping provisions of the *Suitability in Annuity Transactions Model Regulation* (#275) have been adopted, review policy files to determine that the insurer is retaining required records for required time frames.

Examine insurer's procedures for verifying producer supervision and compliance with requirements on suitability.

Examine for effectiveness the insurer's system of monitoring and reviewing that when recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his/her investments and other insurance products and as to his/her financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- The consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity, mortality and expense fees, investment advisory fees, potential charges for and features of riders, limitations on interest returns, insurance and investment components and market risk. (Note: If the applicable state has adopted the *Annuity Disclosure Model Regulation* (#245), examiners should be aware that the criteria of this examination standard are intended to supplement and not replace the disclosure requirements of the *Annuity Disclosure Model Regulation* (#245)).
- The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization or death or living benefit;
- The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on his or her suitability information; and
- In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable including taking into consideration whether:
    - The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;
    - The consumer would benefit from product enhancements and improvements; and
    - The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

Monitor and determine that an insurance producer or, where no insurance producer is involved, the responsible insurer representative, has at the time of sale:

- Made a record of any recommendation subject to applicable state annuity suitability statutes, rules and regulations;
- Obtained a customer signed statement documenting a customer's refusal to provide suitability information, if any; and
- Obtained a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

Monitor and determine that, prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer or an insurer where no producer is involved, has made reasonable efforts to obtain the consumer's suitability information.

Examiners should be familiar with the term "suitability information" as defined in applicable state statutes, rules or regulations. "Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including:

- Age;
- Annual income;
- Financial situation and needs, including the financial resources used for the funding of the annuity;
- Financial experience;
- Financial objectives;
- Intended use of the annuity;
- Financial time horizon;

- Existing assets, including investment and life insurance holdings;
- Liquidity needs;
- Liquid net worth;
- Risk tolerance; and
- Tax status.

Examine the insurer's procedures to verify that the insurer has not issued an annuity recommended to a consumer unless there was a reasonable basis to believe the annuity was suitable based on the consumer's suitability information.

Examine for effectiveness the insurer's system of recording or monitoring whether an insurance producer or an insurer, proceeded with an annuity transaction that either may have violated the insurer's suitability procedures or where no suitability analysis was performed because:

- No recommendation was made;
- A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;
- A consumer refused to provide relevant suitability information and the annuity transaction was not recommended;
- A consumer decided to enter into an annuity transaction that was not based on a recommendation of the insurer or the insurance producer.

Verify that the insurer has established a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with applicable state suitability statutes, rules and regulations, including, but not limited to the following criteria:

- Examine the regulated entity's suitability policies and procedures to verify that the insurer maintains reasonable procedures to inform its insurance producers of the requirements of applicable state suitability statutes, rules and regulations. Verify that the requirements of applicable state suitability statutes, rules and regulations are incorporated into relevant insurance producer training manuals;
- Review the regulated entity's producer training materials to verify that the insurer establishes standards for insurance producer product training and maintains reasonable procedures to require its insurance producers to comply with the requirements of Section 7 of the *Suitability in Annuity Transactions Model Regulation* (#275). For more information on the requirements of Section 7 of Model #275, see Marketing and Sales Standard 11 in this chapter;
- Examine the regulated entity's producer training materials to ensure that the insurer provides adequate product-specific training and training materials which fully explain all material features of its annuity products to its insurance producers;
- Review the regulated entity's suitability policies and procedures to ensure that the insurer maintains adequate procedures for review of each recommendation, prior to issuance of an annuity, that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. An insurer's review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and the insurer's review process may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

- Verify that the insurer maintains reasonable procedures to detect recommendations that are not suitable. Insurer procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. If there is no provision in applicable state suitability statutes, rules or regulations to the contrary, an insurer may demonstrate compliance in this area by applying sampling procedures, or by confirming suitability information after issuance or delivery of the annuity; and
- Verify that the insurer annually provides a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

An insurer may contract for performance of one or more functions (including maintenance of procedures) under the criteria set forth in Section 6F(1) of the *Suitability in Annuity Transactions Model Regulation* (#275). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 8 of Model #275 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (b) of Section 6F(2) of Model #275.

An insurer's supervision system as described above should include supervision of contractual performance by third parties. This includes, but is not limited to, the following criteria:

- Verify that the insurer is monitoring and, as appropriate, conducting audits to assure that contracted function(s) are properly performed; and
- Review insurer procedures to verify that the insurer is annually obtaining a certification from a senior manager who has responsibility for the contracted function(s) that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

Review agency files and related documentation to verify that insurance producers do not dissuade, or attempt to dissuade, a consumer from:

- Truthfully responding to an insurer's request for confirmation of suitability information;
- Filing a complaint; or
- Cooperating with the investigation of a complaint.

Verify that the insurer has adequate procedures in place for monitoring that sales are made in compliance with Financial Industry Regulatory Authority (FINRA) requirements pertaining to suitability and supervision of annuity transactions. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this regulation. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

Note: Noncompliance with FINRA requirements means that the broker-dealer transaction is subject to compliance with the suitability requirements of the applicable state's statutes, rules and regulations.

Review the insurer's system of monitoring sales made in compliance with FINRA annuity suitability and supervision requirements and applicable state annuity suitability statutes, rules and regulations. An insurer may demonstrate compliance in this area by:

- Monitoring the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and
- Providing to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

Review insurer records of corrective action taken in mitigation of apparent violations of suitability standards for sales directly by the insurer and by any insurance producers who are acting as agents for the entity.

Determine whether the insurer has elected to maintain records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions, or if the insurer has elected to require its producers to maintain these records. Verify that such a system is in place and is monitored by the insurer.

Note: Review the insurer's denials for suitability reasons. Review underwriting data to determine if an annuity was subsequently issued to the client. If an annuity was subsequently issued, the examiner may want select a sampling to ensure the sale was appropriate.

STANDARDS
MARKETING AND SALES

Standard 11
The insurer has procedures in place to educate and monitor compliance with insurer-specific education and training requirements and with applicable statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity producer education/training files

_____ Producer continuing education files

_____ Producer new business/replacement log

_____ Regulated entity producer training materials

_____ Regulated entity standards for product training

_____ Regulated entity policies and procedures

_____ Complaint logs, complaint files and producer complaint logs/producer investigation files, if applicable

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)

Review Procedures and Criteria

Review regulated entity policies and procedures to ensure that the regulated entity has adequate procedures in place to provide training, including product-specific training that is appropriate to the specific product being sold. Review the regulated entity's procedures to inform producers of the regulated entity's standards for annuity product training and of applicable state statutes, rules or regulations regarding the solicitation, recommendation and sale of the annuity product.

Monitor and determine if the insurer has taken any actions against producers who lack adequate product knowledge and if so, was the action appropriate for the circumstances.

Compare data in producer continuing education files to applicable data in state insurance department producer continuing education records to monitor and determine that any insurance producer who engages in the sale of annuity products has met the one-time 4 hour credit training course in accordance with applicable state statutes, rules and regulations.

Determine that the regulated entity has adequate procedures in place to verify that a producer has completed necessary training, as required by applicable state statutes, rules and regulations, before allowing the producer to sell an annuity product for that insurer.

Review content of producer training materials for compliance with applicable state statutes, rules and regulations regarding solicitation, recommendation and sales of annuity products. Determine if the insurer product-specific training materials are appropriate and accurately reflect the features of the specific annuity.

Review complaint logs, any applicable complaint files and any producer investigation files for allegations of unsuitable, improper or misleading sales.

Automation Tip:
Examiners should request underwriting, policy and claim data using the NAIC standardized data requests for a period of three to five years. The expanded time frame allows the examiner to trend sales practices for a number of years.

Examiners should then use a program such as ACL to review underwriting data, product data and claims data for possible unsuitable sales.

Examiners can review and trend this data for:

- Sales from producers who were the subject of complaints and/or investigations that alleged unsuitable sales, misrepresentations, or improper sales activities;
- Sales of producers who had a materially large number of replacements or exchanges;
- Sales of producers who sell a materially large number of annuities that pay the highest commissions and have the longest surrender period or have the highest surrender amounts;
- Sales of producers who have had previous sales denied based on suitability reasons;
- Sales of producers who had disciplinary actions – Financial Industry Regulatory Authority (FINRA) and state disciplinary actions;
- Sales from producers who have sold a materially large number of deferred annuities to consumers over age 75;
- Withdrawals from products where the consumer incurred a penalty (a contractual penalty or IRS tax penalty) for taking the withdrawal within two years of purchase of the annuity; and
- Sales from producers who have sold multiple annuities to the same consumer.

Examiners should realize that trending data is not a definitive means to identify unsuitable sales. Further review of the individual transaction will be necessary to determine suitability.

Examiners should cross-reference new business data and data in the replacement logs with the regulated entity's producer education/training files to ensure that prior to a sale of an annuity product the insurance producer has been trained in the regulated entity's standards for the specific annuity product and trained in the applicable state statutes, rules and regulations regarding the solicitation, recommendation and sale of annuity products.

Standard 12
The insurer has product-specific training standards and materials designed to provide producers with adequate knowledge of the annuity products recommended prior to soliciting the sale of annuity products. The insurer also must have reasonable procedures in place to require its producers to comply with applicable producer training requirements.

Apply to: All annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Agency sales/lapse records

_____ Systems manuals

_____ Producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Suitability in Annuity Transactions Model Regulation (#275)
Unfair Trade Practices Act (#880)
Producer Licensing Model Act (#218)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

Contact other regulators that may have conducted a recent review of the insurer's training standards.

Review regulated entity's records to confirm that it verifies producers complete a one-time 4 credit hour general annuity training course prior to soliciting the sale of an annuity product.

Determine if the insurer product-specific training materials are appropriate and accurately reflect the specific annuity being recommended. Review regulated entity's records to determine if, when and how product-specific training occurred prior to a producer recommending an annuity.

Note: Testing is not a requirement of the *Suitability in Annuity Transactions Model Regulation* (#275). Assessing compliance with this standard may require the examiner to access compliance with many facets of Model #275. The insurance producer training requirement of the model regulation requires that producers not solicit the sale of an annuity product unless the producer has adequate product knowledge to recommend the annuity. It is the insurer's responsibility to establish standards for product specific training for its producers. Insurers must also establish reasonable procedures to require its producers to have adequate product knowledge prior to the producer recommending an annuity.

If the examiners believe an unsuitable sale may have occurred, the examiner may need to determine the cause of the unsuitable sale.

Examiners will need to assess the product-specific training materials and determine if the materials were appropriate for the specific product. According to *Suitability in Annuity Transactions Model Regulation* (#275), insurance producers may rely on insurer-provided product-specific training materials and standards to comply with Section 7 of Model #275.

Examiners will also need to assess the procedures the insurer established to require its producers have an adequate product knowledge before the producer recommends the annuity. Specifically the examiners will need to determine if the training for the specific product took place before the recommendation of an annuity, how the producer was trained and if the training was reasonably designed to require the producer to have adequate product knowledge prior to the sale.

Based upon the complexity of the product being offered, there is an expectation that the content of training materials and the way the training occurs may differ.

STANDARDS
MARKETING AND SALES

Standard 13
The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving fixed-index annuity products, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All fixed-index annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Systems manuals

_____ Producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Annuity Disclosure Model Regulation (#245), Section 6 plus appendix
Suitability in Annuity Transactions Model Regulation (#275)
Suitability of Sales of Life Insurance and Annuities White Paper

Review Procedures and Criteria

Review policy files to determine that required records are retained for required time frames.

Examine procedures for verifying producer compliance with established policies and procedures.

Review complaint log for complaints alleging improper or misleading sales practices.

Review claim files for proper crediting and computation of surrender charges at death.

Review commission structure and note any differences between indexed and non-indexed annuity products. If it appears that the difference may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

STANDARDS
MARKETING AND SALES

Standard 14
The insurer has procedures in place to provide full disclosure to consumers regarding all sales of products involving index life, and all sales are in compliance with applicable statutes, rules and regulations.

Apply to: All index life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ All documentation demonstrating the development of crediting rates used in illustrations

_____ Claim files

_____ Complaint log

_____ Agency sales/lapse records

_____ Regulated entity's systems manual

_____ Regulated entity's producer training materials

_____ Contracts with third-party vendors with compliance responsibilities

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Advertisements of Life Insurance and Annuities Model Regulation (#570), Section 3B
Life Insurance Disclosure Model Regulation (#580), Section 8C
Unfair Trade Practices Act (#880)
Life Insurance Illustrations Model Regulation (#582) and *Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49)

Review Procedures and Criteria

Review policy files to determine that the regulated entity is retaining required records for required time frames.

Examine the regulated entity's procedures for verifying producer compliance with the regulated entity's policy and procedures

Review complaint log for complaints alleging improper or misleading sales practices.

Review documentation to ensure compliance of the insurer's illustration methodologies with Model #582, generally, and with AG 49, specifically for indexed universal life (IUL) products. Review documentation to confirm implementation of AG 49 at required effective dates.

Review claim files for proper interest crediting and computation of death claims.

Review commission structure and note any differences between indexed and non-indexed life insurance products. If it appears that differences noted may be significant enough to provide incentive to a producer to recommend one product over another regardless of suitability, perform further analysis to test that hypothesis.

Standard 15
The insurer's underwriting requirements and guidelines pertaining to travel are in compliance with applicable statutes, rules and regulations.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Life insurance applications and related disclosure and consent forms

_____ Related questionnaires for applicants

_____ Underwriting guidelines and field underwriting guidelines for producers

_____ Review contracts with reinsurers of life insurance and all applicable guidelines from the reinsurer

_____ Regulated entity's guidelines regarding lawful travel

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure the regulated entity does not discriminate against individuals by using an individual's past lawful travel to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual.

Ensure the regulated entity does not discriminate against individuals by using an individual's future lawful travel plans to refuse life insurance, refuse to continue existing life insurance, or limit the amount, extent or kind of life insurance available to an individual, unless:

- The risk of loss for individuals who travel to a specified destination at a specific time is reasonably anticipated to be greater than if the individuals did not travel to that destination at the time; and
- The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience.

Examples of the exceptions outlined above are future lawful travel plans to areas where the Centers for Disease Control and Prevention (CDC) have issued a highest level alert, including a recommendation for non-essential travel or to areas where there is an ongoing armed conflict involving the military of a sovereign nation foreign to the country of conflict.

Review the life insurers' and reinsurers' underwriting guidelines for guidelines pertaining to past and future travel.

Review applications and any related questionnaires for questions related to past and future travel plans.

Review contracts with applicable reinsurers for content regarding past and future lawful travel plans.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Reinstatement is applied consistently and in accordance with policy provisions.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Notice of reinstatement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine that notices were sent out in a timely manner.

Verify that reinstatement provisions were applied consistently and in a non-discriminatory manner.

Reinstatements should be applied per policy provisions.

STANDARDS
POLICYHOLDER SERVICE

Standard 2
Nonforfeiture options are communicated to the policyholder and contractholder and correctly applied in accordance with the policy contract.

Apply to: All life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ Underwriting file

_____ Policy and contract history file

_____ Regulated entity's procedures manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Standard Nonforfeiture Law for Life Insurance (#808)
NAIC Procedure for Permitting Same Minimum Nonforfeiture Standards for Men and Women Insured Under 1980 CSO and 1980 CET Mortality Tables (#811)
Life Insurance Disclosure Model Regulation (#580)
Variable Life Insurance Model Regulation (#270)
Model Policy Loan Interest Rate Bill (#590)
Standard Nonforfeiture Law for Individual Deferred Annuities (#805)
Annuity Nonforfeiture Model Regulation (#806)

Review Procedures and Criteria

Determine if the correct policy option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to the nonforfeiture values, refer to statutes, rules and regulations regarding the calculation of nonforfeiture values for details on calculating the values.

Review the regulated entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Cash Surrender Values

- Review the issue date of the policy to determine whether the policy is mature enough to provide surrender values (usually by the end of the second or third year);
- Calculate the service time to process the surrender by subtracting the date the request was received from the date the surrender check was mailed (should be within 60 days);
- Review the calculation of the net cash value to determine the appropriate surrender value (include any outstanding policy loans, policy loan interest and policy dividends);
- Compare calculated surrender value with illustration surrender value. Confirm that any variance can be explained and is in accordance with policy provisions (i.e., interest rates, surrender charges, policy fees);
- Confirm with the regulated entity that there is an audit procedure in place to verify the calculation of surrender values (they are usually calculated systematically);
- Review cash surrender check for accuracy, including mail date; and
- Review returned mail procedures.

Extended Term Insurance (ETI)

- Determine if the ETI was automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Confirm the regulated entity's calculated policy value by taking the face value of the policy adjusted for any indebtedness, such as policy loans or paid-up additions;
- Check to make sure the regulated entity issued the correct amount of term insurance; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Reduced Paid-Up (RPU)

- Determine how the RPU option came about, whether automatic at lapse or policyowner-requested;
- Review the policy's contract language for content;
- Review the calculation of net cash value (including years the policy was in force) to verify the amount used as the net single premium to purchase the paid-up life insurance. Verify that the paid-up insurance is of the same type of policy as the original policy; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Additional Paid-Up

- Review the policy for content and time schedule for allowed increases in coverage;
- Review the policyowner's request to elect the additional paid-up option benefit; and
- Check that evidence of insurability was required before the rider was added to the in force policy.

Automatic Premium Loan (APL)

- Review the policy's contract language for content;
- Review the application to see if the insured elected another option. If not, verify that the grace period expired prior to the initiation of the APL;
- Check the net cash value calculation to make sure that the proper amount was used to deduct the overdue premium; and
- Confirm with the regulated entity that there is an audit procedure in place to verify the values and calculations made.

Note: The examiner should be alert to occurrences of producers automatically selecting the APL option on the insurance application.

Ensure the regulated entity notifies policyowners of material changes to any non-guaranteed factors in accordance with statutes, rules and regulations.

For variable life products with flexible premiums, ensure that a report is sent to the policyholder if the amounts available under the policy on any policy processing day to pay the charges authorized by the policy are less than the amount necessary to keep the policy in force until the next following processing day. The report should include the minimum payment required under the terms of the policy to keep it in force and the length of the grace period for payment of the amount.

Ensure that at the time of processing policy loans, the insurer notifies policyholders of the initial rate of interest, maximum interest rates and the frequency at which rates may be adjusted. Such notice is to be provided within a reasonable time after processing premium loans.

Ensure the insurer sends advance notice to policyholders with loans, advising of any increases in loan rates.

For annuity contracts that provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall any cash value benefit be less than the minimum nonforfeiture amount. The death benefit shall be at least equal to the cash surrender benefit.

For annuity contracts that do not provide cash surrender benefits, review the benefit provided to ensure it meets the requirements of statutes, rules and regulations. In no event shall the present value of a paid-up annuity be less than the minimum nonforfeiture amount.

STANDARDS
POLICYHOLDER SERVICE

Standard 3
The regulated entity provides each policyowner with an annual report of policy values in accordance with statutes, rules and regulations and, upon request, an in force illustration or contract policy summary.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance Illustrations Model Regulation (#582), Section 10
Life Insurance Disclosure Model Regulation (#580), Section 5C(1)
Variable Annuity Model Regulation (#250), Section 8
Variable Life Insurance Model Regulation (#270), Section 9
Modified Guaranteed Annuity Model Regulation (#255) Section 11
Universal Life Insurance Model Regulation (#585), Section 9

Review Procedures and Criteria

Note: Traditional life (not universal or variable life) products that are not illustrated or that were issued prior to a jurisdiction's adoption of the equivalent of the *Life Insurance Illustrations Model Regulation* (#582) may not be required to provide annual reports.

If required, ensure annual reports are being provided annually.

For universal life, ensure the report includes:

- The beginning and end date of the current report period;
- The policy value at the end of the previous report period and at the end of the current report period;
- The total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);
- The current death benefit at the end of the current report period on each life covered by the policy;
- The net cash surrender value of the policy as of the end of the current report period; and
- The amount of outstanding loans, if any, as of the end of the current report period.

For fixed premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect should be included in the report.

For flexible premium universal life policies, ensure the report includes:

- If, assuming guaranteed interest, mortality and expense loads, the policy's net cash surrender value will not maintain insurance in force until the end of the next reporting period, unless further premium payments are made, a notice to this effect should be included in the report.

For traditional life policies, where applicable, ensure the report includes:

- Current death benefit;
- Annual contract premium;
- Current cash surrender value;
- Current dividend;
- Application of current dividend; and
- Amount of outstanding loan.

Ensure that if there are policies that do not build nonforfeiture values, an annual report is provided for those years when a change has been made to non-guaranteed policy elements by the insurer.

Determine if the annual report includes an in force illustration. If it does not, it should contain the following notice displayed prominently: "**IMPORTANT POLICYOWNER NOTICE:** You should consider requesting more detailed information about your policy to understand how it may perform in the future. You should not consider replacement of your policy or make changes in your coverage without requesting a current illustration. You may annually request, without charge, such an illustration by calling (insurer's telephone number), writing to (insurer's name) at (insurer's address) or contacting your producer. If you do not receive a current illustration of your policy within 30 days from your request, you should contact your state insurance department." The insurer may vary the sequential order of the methods for obtaining an in force illustration.

If an adverse change in non-guaranteed elements that could affect the policy has been made by the insurer since the last annual report, the annual report should contain a notice of that fact and the nature of the change prominently displayed.

For variable annuity products, ensure there is a statement or statements reporting the investments held in a separate account. The statement report period should be not more than 4 months prior to the date of mailing. The statement should also include the number of accumulation units and the dollar value of an individual unit or the value of the contractholder's account.

For variable life products, ensure the annual report includes the following:

- The cash surrender value;
- Death benefit;
- Any partial withdrawal or policy loan;
- Any interest charge; and
- Any optional payments.
- The following disclosures:
    - In accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease;
    - Prominent identification of any value which may be recomputed prior to the next annual report;
    - A statement if the policy guarantees the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in the report;
    - For flexible premium policies, a reconciliation of the change since the previous report in cash value and cash surrender value, if different, because of payments made (less deductions for expense charges), withdrawals, investment experience, insurance charges and any other charges made to the cash value;

- The projected cash value and cash surrender value, if different, as of one year from the end of the period covered by the report, assuming that planned periodic premiums, if any, are paid as scheduled;
- Guaranteed costs of insurance are deducted;
- The net return is equal to the guaranteed rate or, in the absence of a guaranteed rate, is not greater than zero;
- If the projected value is less than zero, a warning message should be included that the policy may be in danger of terminating without value in the next 12 months, unless additional premium is paid;
- A summary of the financial statement of the separate account based on the last annual statement filed with the insurance department;
- The net investment return of the separate account for the last year, and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of not less than 5 years, when available;
- A list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the insurance department;
- Any charges levied against the separate account during the previous year; and
- A statement of any change since the last report in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account or to the investment advisor of the separate account.

Annual reports for modified guaranteed life insurance policies shall state that the cash value may increase or decrease and shall prominently identify any value that may be recomputed prior to the next statement.

Determine if, upon the request of the policyowner, the insurer furnishes an in force illustration of current and future benefits and values based on the insurer's present illustrated scale. No signature or other acknowledgment of receipt of this illustration is required.

Also, determine, if a policyowner requests one, the insurer provides policy data for the policy. Unless otherwise requested, the data should be provided for 20 consecutive years beginning with the previous policy anniversary and include cash dividends according to the current dividend scale, the amount of outstanding policy loans and the current policy loan interest rate. Values shown should be based on the dividend option in effect at the time of the request. A reasonable fee may be charged for the preparation of the statement.

STANDARDS
POLICYHOLDER SERVICE

Standard 4
Upon receipt of a request from a policyholder for accelerated benefit payment, the regulated entity must disclose to the policyholder the effect of the request on the policy's cash value, accumulation account, death benefit, premium, policy loans and liens. The regulated entity must also advise that the request may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Apply to: All individual and group life products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620), Sections 4, 6D and 8

Review Procedures and Criteria

Review the above documents to determine that proper disclosure has been made.

Verify that prior to payment of accelerated benefits the insurer has obtained from any assignee or irrevocable beneficiary a signed acknowledgment of concurrence for accelerated benefit payout.

The regulated entity may offer waiver of premium in absence of such provision in an existing policy. At the time accelerated benefits are claimed, the insurer must explain any continuing premium requirements to maintain the policy in force.

Unfair discrimination is prohibited.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
UNDERWRITING AND RATING

Standard 1
Pertinent information on applications that form a part of the policy and contract is complete and accurate.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Compact uniform standards for products approved by the Compact)

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the regulated entity has a verification process in place to determine the accuracy of application information.

Verify if applicable nonforfeiture options and dividend options are indicated on the application.

Determine how automatic premium loan options are disclosed on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Standard 2
The regulated entity complies with the specific requirements for Acquired Immune Deficiency Syndrome (AIDS)-related concerns in accordance with statutes, rules and regulations.

Apply to: All life and annuity products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Life insurance applications and related disclosure and consent forms

_____ Health questionnaires for applicants

_____ Medical underwriting guidelines

_____ Regulated entity's guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure the regulated entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

- Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional;
- Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test and should be a part of the underwriting file; and
- Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the regulated entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

- Questions may ask if the applicant has been diagnosed with AIDS or AIDS-Related Complex (ARC), if they are designed to establish the existence of the condition, but are not used as a proxy to establish sexual orientation of the applicant.

Ensure the regulated entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation to be a factor in the determination of insurability.

A sample of underwriting files for denied applications should be reviewed to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the regulated entity's guidelines (e.g., based on the amount of insurance).

Neither the marital status, living arrangements, occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards and the standards set forth below.

STANDARDS
CLAIMS

Standard 1
The regulated entity provides the required disclosure material to policyholders at the time an accelerated benefit payment is requested.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim procedure manuals

_____ Claim files

_____ Claim complaint records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Disclosure of possible tax consequences and advice that the claimant seek assistance from a tax advisor;
- A written statement to the policyowner and to the irrevocable beneficiary explaining any effect the payment will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens;
- A statement warning that receipt of accelerated benefits may adversely affect claimant eligibility for government benefits or entitlements;
- Administrative expense charges, if any, applicable to the payment of accelerated benefits;
- Any continuing premium requirement to keep the policy in force;
- Lump sum settlement options are required; and
- Any accidental death benefits remain intact.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from policyowners not receiving required disclosure material.

Accelerated benefits are available on the effective date of the policy or rider for accidents and no more than 30 days following the effective date for illness.

No restrictions are permitted on use of accelerated benefit proceeds.

STANDARDS
CLAIMS

Standard 2
The regulated entity does not discriminate among insureds with differing qualifying events covered under the policy or among insureds with similar qualifying events covered under the policy.

Apply to: All life insurance products that contain a benefit provision or benefit rider for the payment of accelerated benefits

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Regulated entity's claim procedures manual and claim bulletins

_____ Claims training manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accelerated Benefits Model Regulation (#620)

Review Procedures and Criteria

Review procedure manuals, training manuals and the regulated entity's internal claim bulletins to determine if regulated entity standards exist for consistent evaluation of criteria for approval of accelerated benefits payments.

Review claim files to verify that the regulated entity does not apply further conditions on the payment of accelerated benefits beyond those conditions specified in the policy or benefit rider.

Standard 3
The regulated entity provides the beneficiary, at the time a claim is made, written information describing the settlement options available under the policy and how to obtain specific details relevant to the settlement options.

Apply to: All life insurance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Claim procedure manuals/claim training manuals/claim bulletins

_____ Claim files

_____ Claim complaint records

_____ Disclosures provided to beneficiaries

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Retained Asset Accounts Sample Bulletin (#573)

Review Procedures and Criteria

Review the regulated entity's procedures, training manuals and claim bulletins to determine if claim procedures meet the requirements for disclosure at the time benefits are requested. Required disclosures include:

- Written information provided to the beneficiary describing available settlement options under the policy; and
- Written information provided to the beneficiary informing the beneficiary how to obtain specific details regarding available settlement options;

A "retained asset account" as defined in the *Retained Asset Accounts Sample Bulletin* (#573) means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

If the regulated entity settles benefits through a retained asset account, examiners should review and verify in accordance with the applicable state's record retention requirements that the regulated entity has established and implemented procedures to ensure that the regulated entity has:

a) Provided the following written disclosures to the beneficiary before the account is selected, if optional, or established, if not:
    - Payment of the full benefit amount is accomplished by delivery of the "draft book"/"check book";
    - One draft or check may be written to access the entire amount, including interest, of the retained asset account at any time;
    - Whether other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the regulated entity's minimum balance requirements;
    - A statement identifying the account as either a checking or draft account and an explanation of how the account works;
    - Information about the account services provided and contact information where the beneficiary may request and obtain more details about such services;
    - A description of fees charged, if applicable;
    - The frequency of statements showing the current account balance, the interest credited, drafts/checks written and any other account activity;
    - The minimum interest rate to be credited to the account and how the actual interest rate will be determined;
    - The interest earned on the account may be taxable;
    - Retained asset account funds held by regulated entities are not guaranteed by the Federal Deposit Insurance Corporation (FDIC) but are guaranteed by the state guaranty associations (where permitted by state law). The beneficiary should be advised to contact the National Organization of Life and Health Insurance Guaranty Associations *(www.nolhga.com*) to learn more about the coverage limitations to his or her account;
    - A description of the regulated entity's policy regarding retained asset accounts that may become inactive; and

b) Provided the beneficiary with a supplemental contract that clearly discloses the rights of the beneficiary and obligations of the regulated entity under the contract.

Review claim files for documentation that required disclosure notices were issued in a timely manner.

Review claim-related complaint files for complaints from beneficiaries not receiving required disclosure material.

H. Supplemental Checklist for Marketing and Sales Standard #1

Yes	No	Requirement
For companies that use enrollment periods:		
		Advertisements should specify the date by which the applicant must mail the application, which should be not less than 10 days and not more than 40 days from the date the enrollment period is advertised for the first time.
For direct response policies:		
		The advertisement should not state or imply there is a cost savings because there is no insurance producer or commission, unless true.
		The advertisement should not use the terms "inexpensive," "low cost" or other similar language when the policies are being marketed to persons who are 50 years of age or older when the policy is guaranteed issue.
For graded or modified benefit policies:		
		The advertisement must prominently display any limitation of benefits.
		If the premium is level and coverage decreases or increases with age or duration, that fact must be prominently disclosed.
		If the death benefit varies with the length of time the policy has been in force, the advertisement should accurately describe and clearly call attention to the amount of minimum death benefit under the policy.
		The advertisement should not use the terms "inexpensive," "low cost" or other similar language when the policies are being marketed to persons who are 50 years of age or older, when the policy is guaranteed issue.
For policies with premium changes:		
		The advertisement for a policy with non-level premiums should prominently describe the premium changes.
		An advertisement in which the insurer describes a policy where it reserves the right to change the amount of the premium during the policy term, but which does not prominently describe this feature, is deemed to be deceptive and misleading and is prohibited.
For policies with non-guaranteed policy elements:		
		An advertisement should not utilize or describe non-guaranteed policy elements in a manner that is misleading or has the capacity or tendency to mislead.
		An advertisement should not state or imply that the payment or amount of non-guaranteed policy elements is guaranteed. If non-guaranteed policy elements are illustrated, they must be based on the insurer's current scale, and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		An advertisement that includes any illustrations or statements containing or based upon non-guaranteed elements should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed elements.
		If an advertisement refers to any non-guaranteed policy element, it should indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way—such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience—the advertisement may indicate any such limitation on the insurer's right.
		An advertisement should not refer to dividends as "tax free" or use words of similar import, unless the tax treatment of dividends is fully explained, and the nature of the dividend as a return of premium is indicated clearly.
For policies sold to students:		
		The envelope in which insurance solicitation material is contained may be addressed to the parent(s) of students. The address may not include any combination of words which imply that the correspondence is from a school, college, university or other education or training institution, nor may it imply that the institution has endorsed the material or supplied the insurer with information about the student, unless such is a correct and truthful statement.
		All advertisements including, but not limited to, informational flyers used in the solicitation of insurance must be identified clearly as coming from an insurer or insurance producer, if such is the case, and these entities must be clearly identified as such.
		The return address on the envelope may not imply that the soliciting insurer or insurance producer is affiliated with a university, college, school or other educational or training institution, unless true.
For individual deferred annuity products or deposit funds:		
		Any illustrations or statements containing or based upon interest rates higher than the guaranteed accumulation interest rates should set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed accumulation interest rates. The higher interest rates should not be greater than those currently being credited by the company, unless the higher rates have been publicly declared by the company with an effective date for new issues not more than 3 months subsequent to the date of declaration.

H. Supplemental Checklist for Marketing and Sales Standard #1 (cont'd)

		If an advertisement states the net premium accumulation interest rate, whether guaranteed or not, it should also disclose in close proximity thereto and with equal prominence, the actual relationship between the gross and the net premiums.
		If a contract does not provide a cash surrender benefit prior to commencement of payment of annuity benefits, an illustration or statement concerning such contract should prominently state that cash surrender benefits are not provided.
For combination life insurance and annuity products:		
		An advertisement of a life insurance product and an annuity as a single policy or life insurance policy with an annuity rider should include a disclosure before the application is taken (if the policy contains an unconditional refund provision of at least 10 days, the disclosure statement can be delivered with the policy, or upon the applicant's request, whichever occurs sooner). The disclosure defines the gross annual life and premium annuity percentages and guaranteed cash value of the annuity and should include the first 5 policy years, the tenth and twentieth policy years, at least one age from 60 to 70 and the scheduled commencement of annuity payments.

I. Supplemental Checklist for Marketing and Sales Standard #4

For all illustrations: Determine if the illustration contains the following:

Yes	No	Requirement
		The illustration should be clearly labeled "life insurance illustration."
		Name of insurer.
		Name and business address of producer or insurer's authorized representative, if any.
		Name, age and gender of proposed insured except where a composite illustration is permitted.
		Underwriting or rating classification upon which the illustration is based.
		Generic name of the policy, the company product name, if different, and the policy form number.
		Initial death benefit.
		Dividend option election or application of non-guaranteed elements, if applicable.

(*Life Insurance Illustrations Model Regulation* (#582), Section 6A)

Note: "Generic name" means a short title descriptive of the policy being illustrated, such as "whole life," "term life" or "flexible premium adjustable life."

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine if the *basic* illustration contains or complies with the following:

Yes	No	Requirement
		Date illustration prepared.
		Page numbers for entire illustration and explanatory notes.
		Assumed dates of payment receipt and benefit payout within a policy year.
		The issue age plus the number of years the policy is assumed to have been in force, if the age is shown as a component of tabular detail.
		Assumed payments on which the illustrated benefits and values are based are identified as premium outlay or contract premium. For policies that do not require a specific contract premium, the illustrated payments should be identified as premium outlay.
		Guaranteed death benefits and values available upon surrender, if any, for the illustrated premium outlay or contract premium should be shown and clearly labeled guaranteed.
		Non-guaranteed elements should not be based on a scale more favorable to the policyowner than the insurer's illustrated scale at any duration. These elements should be clearly labeled non-guaranteed.
		Guaranteed elements, if any, should be shown before corresponding non-guaranteed elements, and should be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements.
		Account or accumulation value of a policy, if shown, should be identified by the name this value is given in the policy being illustrated and shown in close proximity to the corresponding value available upon surrender.
		Value available upon surrender should be identified by the name this value is given in the policy being illustrated and should be the amount available to the policyowner in a lump sum after deduction of surrender charges, policy loans and policy interest, as applicable.
		Illustration may show policy benefits and values in graphic or chart form in addition to tabular form.
		Non-guaranteed elements should be accompanied by a statement indicating that, "The benefits and values are not guaranteed; the assumptions on which they are based are subject to change by the insurer, and actual results may be more or less favorable."

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		If the illustration shows that the premium payor may have the option to allow policy charges to be paid using non-guaranteed values, the illustration must clearly disclose that a charge continues to be required and that, depending on the actual results, the premium payor may need to continue or resume premium outlays. Similar disclosure should be made for premium outlay of lesser amounts or shorter duration than the contract premium. If a contract premium is due, the premium outlay should not be left blank or show zero unless accompanied by an asterisk or similar mark to draw attention to the fact that the policy is not paid.
		If the applicant plans to use dividends or policy values, guaranteed or non-guaranteed, to pay all or a portion of the contract premium policy charges, or for any other purpose, the illustration may reflect those plans and the effect on future policy benefits and values.
		A brief description of the policy being illustrated, including a statement that it is a life insurance policy.
		A brief description of the premium outlay or contract premium, as applicable, for the policy. For a policy that does not require payment of a specific contract premium, the illustration should show the premium outlay that must be paid to guarantee coverage for the term of the policy, subject to maximum premiums allowable to qualify as a life insurance policy under the applicable provisions of the Internal Revenue Code.
		A brief description of any policy features, riders or options, guaranteed or non-guaranteed, shown in the basic illustration, and the effect they may have on the benefits and values of the policy.
		Identification and a brief definition of column headings and key terms used in the illustration.
		The following statement, "This illustration assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur. Actual results may be more or less favorable than those shown."
		Following the narrative summary, a basic illustration should include a numeric summary of the death benefits and values and the premium outlay and contract premium as applicable. For a policy that provides for a contract premium, the guaranteed death benefits and values should be based on the contract premium. This summary should be shown for at least policy years 5, 10, 20 and at age 70, if applicable, on the three bases shown below. For multiple life policies the summary should show policy years 5, 10, 20 and 30.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

		The columns of the numeric summary should include: Bases 1: Policy guarantees Bases 2: Insurer's illustrated scale Bases 3: Insurer's illustrated scale used, but with the non-guaranteed elements reduced as follows: • Dividends at 50 percent of the dividends contained in the illustrated scale used; • Non-guaranteed credited interest at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used; and • All non-guaranteed charges, including, but not limited to, term insurance charges and mortality and expense charges, at rates that are the average of the guaranteed rates and the rates contained in the illustrated scale used.
		If coverage would cease before policy maturity or age 100, the year in which coverage ceases should be identified for each of the three bases.
		The following statement signed and dated by the applicant or policyowner: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed."
		The following statement signed and dated by the insurance producer or other authorized representative of the insurer: "I certify that this illustration has been presented to the applicant, and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration."
		A basic illustration must include the following for at least each policy year from one to 10 and for every fifth policy year thereafter, ending at age 100, policy maturity or final expiration, and except for term insurance beyond the 20th year, for any year in which the premium outlay and contract premium, if applicable, is to change: • Premium outlay and mode the applicant plans to pay and the contract premium as applicable; • The corresponding guaranteed death benefit, as provided in the policy; • Corresponding guaranteed value available upon surrender, as provided in the policy; • Non-guaranteed elements may be shown if described in the contract. In the case of an illustration for a policy on which the insurer intends to credit terminal dividends, they may be shown if the insurer's current practice is to pay terminal dividends. If any non-guaranteed elements are shown, they must be shown at the same durations as the corresponding guaranteed elements, if any; and • If no guaranteed benefit value is available at any duration for which a non-guaranteed benefit or value is shown, a zero should be displayed in the guaranteed column.

"Basic illustration" means a ledger or proposal used in the sale of a life insurance policy that shows both guaranteed and non-guaranteed elements.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

A *supplemental* illustration may be provided as long as:

Yes	No	Requirement
		It is appended to, accompanied by, or preceded by a basic illustration.
		The non-guaranteed elements shown are not more favorable to the policyowner than the corresponding elements in the basic illustration.
		It contains the same statement required of a basic illustration that non-guaranteed elements are not guaranteed.
		The premium outlay/contract premium must be equal to the premium outlay/contract premium shown in the basic illustration.
		A notice is included referring to the basic illustration for guaranteed elements and other important information.

"Supplemental illustration" means an illustration furnished in addition to a basic illustration that meets the applicable requirements of [*Life Insurance Illustrations Model Regulation* (#582)], and that may be presented in a format differing from the basic illustration, but may only depict a scale of non-guaranteed elements that is permitted in a basic illustration.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine if the *universal life* illustration has the following:

Yes	No	Requirement
		Any statement of policy cost factors or benefits shall contain: • The corresponding guaranteed policy cost factors or benefits, clearly identified; • A statement explaining the non-guaranteed nature of any current interest rates, charges or other fees applied to the policy, including the insurer's rights to alter any of these factors; • Any limitations on the crediting of interest, including identification of those portions of the policy to which a specified interest rate shall be credited; • Any illustration of the policy value shall be accompanied by the corresponding net cash surrender value; • Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined; • If any statement refers to the policy being interest-indexed, the index shall be described. In addition, a description shall be given of the frequency and timing of determining the interest rate and of any adjustments made to the index in arriving at the interest rate credited under the policy; • Any illustrated benefits based upon non-guaranteed interest, mortality or expense factors shall be accompanied by a statement indicating that these benefits are not guaranteed; and • If the guaranteed cost factors or initial policy cost factor assumptions would result in policy values becoming exhausted prior to the policy's maturity date, such fact shall be disclosed, including notice that coverage will terminate under such circumstances.

(*Universal Life Insurance Model Regulation* (#585), Section 8A)

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Determine whether, in addition to all other illustration requirements, indexed universal life (IUL) illustrations contain or comply with the following requirements specified in *Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index Based Interest* (AG 49). (Section 4 and Section 5 apply to new business and in force illustrations for policies sold on or after Sept. 1, 2015, and Section 6 and Section 7 apply to new business and in force illustrations for policies sold on or after March 1, 2016.)

Yes	No	N/A	Requirement
			The illustration actuary uses the current annual cap for the Benchmark Index Account offered with the illustrated policy (AG 49, Section 4.A.i.).
			The illustration actuary uses a hypothetical, supportable current annual cap for a hypothetical, supportable Index Account that meets the definition of a Benchmark Index Account (AG 49, Section 4.A.ii.). Note: Actuarial judgment may be used by the illustration actuary. Support for the determination of the hypothetical cap may be requested of the illustration actuary by the examiner. The examiner may refer this support to an actuarial or investment specialist for review as necessary.
			The maximum credited rate used for the Illustrated Scale is the arithmetic mean of the geometric average annual credited rates calculated in 4.A. (per AG 49, Section 4.B.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			Where other Index Accounts are used in illustrations, the illustration actuary determined the Illustrated Scale (according to AG 49, Section 4.C.). Note: Review may be referred by the examiner to an actuarial or investment specialist as necessary.
			The insurer updated the credited rate for each Index Account (in accordance with AG 49 Section 4.B. and Section 4.C.) within three months of the beginning of the calendar year of the illustration (AG 49, Section 4.D.).
			The illustrated rate credited to the loan balance shall not exceed the illustrated loan charge by more than 100 basis points (AG 49, Section 6).
			The basic illustration includes a ledger using the Alternate Scale shown alongside the ledger using the Illustrated Scale with equal prominence (AG 49, Section 7.A.).
			The basic illustration includes a table showing the minimum and maximum of the geometric average annual credited rates calculated in AG 49, Section 4.A. (AG 49, Section 7.B.).
			The basic illustration includes a table showing actual historical index changes and corresponding hypothetical interest rates using current index parameters for the most recent 20-year period for each Index Account illustrated (AG 49, Section 7.C.).

(*Actuarial Guideline XLIX— The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest*)

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

Ensure *variable life* illustrations contain or comply with the following:

Yes	No	Requirement
		The hypothetical interest rates used to illustrate accumulated policy values must be an annual effective gross rate after brokerage expenses and prior to any deduction for taxes, expenses and contract charges.
		If illustrations of accumulated policy values are shown, then for the highest interest rate used, one illustration must be based solely upon guarantees contained in the policy contract being illustrated.
		Except for illustrations contained in the prospectus, the pattern of premium payments used in an illustration should be the initial pattern requested by the proposed policyholder at inception or upon changes in face amount requested by the policyholder.
		If the illustrated policy contract provides for a variety of investment options, the illustration may either use an asset charge, which is reasonably representative, or use the asset charge of a particular option. The illustration should clearly identify the asset charge and either label it "hypothetical" or identify the fund.
		The illustration must disclose the transaction charges that will be levied against the contract because of transactions requested in accordance with rights and privileges specified in the policy contract. Any charge for the exercise of a right or privilege upon which the illustration is based must be reflected in the illustrated values. The nature of any other such charges must be disclosed in a clear statement accompanying such illustrations.
		A clear statement must be made following the table of illustrated accumulated policy values that use of hypothetical investment results does not in any way represent actual results or suggest that such results will be achieved and must indicate that the policy values which actually arise will differ from those shown, whenever the actual investment results differ from the hypothetical rates illustrated. Assumptions upon which illustrations are based must be clearly disclosed.
		Any sales illustration to a prospective policyholder must reflect the policy being presented accurately. Misleading statements or captions or other misrepresentations are prohibited.
		The requested sales illustration must be printed clearly and legibly on hard paper copy. An illustration displayed on a computer screen may be used in addition to, but not as a substitute for, hard paper copy.

I. Supplemental Checklist for Marketing and Sales Standard #4 (cont'd)

	In connection with variable life insurance contracts offering both fixed and variable funding options: • An illustration of the variable funding option must comply with these guidelines; • If an illustration of the fixed funding option is shown, accumulated policy values must be shown on the basis of guaranteed rates. One or more additional rates may also be shown, but such rates may not exceed current rates; and • A summary illustration may be given in which results from comparable illustrated and hypothetical interest rates are combined. Such summary must cross-reference to the accompanying separate illustrations of the fixed and variable funding options.

(*Life Insurance Illustrations Model Regulation* (#582))

J. Supplemental Checklist for Marketing and Sales Standard #8

Yes	No	Requirement
Ensure the disclosures include:		
		The fact that a life insurance policy is involved or being used to fund a prearrangement.
		The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.
		The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement.
		The impact on the prearrangement of the following: • Any changes in the life insurance policy including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds; • Any penalties to be incurred by the policyholder as a result of failure to make premium payments; • Any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy; • A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need; • All relevant information concerning what occurs and whether any entitlements or obligations arise, if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement; • Any penalties or restrictions, including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and • The fact that a sales commission or other form of compensation is being paid and, if so, the identity of such individuals or entities to whom it is paid.

Chapter 24—Conducting the Health Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

Introduction
The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health plans that may or may not include Minimum Essential Coverage (MEC), as defined by the Affordable Care Act (ACA), whereas Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination applies only to Qualified Health Plans (QHPs); NAIC models related to the ACA are set forth separately under each examination standard in Chapter 24A. The health insurance market is always evolving, and new products, such as supplemental, short-term, limited duration insurance, may not fall completely under Chapter 24 or Chapter 24A. When developing an examination or review plan related to MEC or ACA compliance, it is important to consider examination standards as applicable from both Chapter 24 and Chapter 24A. In the event of duplication or conflict of examination standards between the chapters, the examination standards and review criteria located in Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination will generally take precedence for QHP and ACA-related compliance, barring applicable state or federal laws to the contrary.

The intent of Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies that are intended to serve as Qualified Health Plans as defined by the ACA. In its current form, Chapter 24A is not intended to fully provide guidance on which standards are applicable to MEC policies that are not designated as QHPs. Where possible, reference to the applicability of the standards to MEC policies has been included.

Regardless of which chapter is used in the *Market Regulation Handbook,* the examiner will also need to reference Chapter 20—General Examination Standards for general examination standards that apply to all insurers.

This chapter provides a format for conducting health insurance company examinations. Procedures for conducting other types of specialized examinations—such as third-party administrators and surplus lines brokers—may be found in separate chapters.

The examination of health insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Grievance Procedures
I. Network Adequacy
J. Provider Credentialing
K. Quality Assessment and Improvement

L. Utilization Review
M. External Review
N. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

Examiners should note that some of the following market conduct standards may apply to all health carriers, while others may apply only to health carriers with network plans. The manner in which a state may define or distinguish a network plan from indemnity plans or other types of health benefit plans in relation to the NAIC's model definitions of those plans should be taken into account when determining the extent to which each of these market conduct standards apply to health carriers with network plans. For instance, the NAIC definition of network plans is broad; i.e., "network plan" is defined as a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. States may have a narrower definition of "network plan" that may impact how the standards are applied. Standards that apply to disability income insurance are so noted. Review procedures and criteria relating to HIPAA and small group requirements are generally not applicable to disability income insurance.

Examiners also should note that states may require, by law or regulation, that health plans receive certification by specific private accreditation organizations in order to obtain licensing. Other states may recognize accreditation as meeting specific state requirements. To the extent an examiner may take into account accreditation for specific operational areas (such as quality assessment and improvement, credential verification, utilization review, grievance processes or utilization management), when planning the examination and setting review priorities, the examiner should become familiar with the standards applied by the accrediting entity. Individual jurisdictions may have procedures in place for communicating deviations from such standards to the applicable accrediting entity in addition to administrative procedures.

A supplemental checklist is available at the end of this chapter to verify compliance with the *Advertisements of Accident and Sickness Insurance Model Regulation* (#40).

Exempt Benefit Plans

Examiners may encounter documents in the course of a health plan examination that refer to "ERISA plans." Many health carriers perform administrative functions on behalf of self-funded employers, union trusts and other collectively bargained groups (under ERISA Section 3(40)) that are not subject to state insurance regulation.

A Multiple Employer Welfare Arrangement (MEWA) is a welfare benefit plan set up to benefit the employees of two or more employers. This can be a cost-effective way for several small employers to band together to purchase health insurance for their employees. If the group is not a collectively bargained group, a Taft-Hartley trust or a self-funded employer group, then the benefit plan should comply with state insurance regulations and the ERISA exemption does not apply.

According to advisory opinions from the U.S. Department of Labor, there are plans operating that may claim ERISA exemptions from state regulation that do not qualify for that exemption. Examiners may need to consult others in the insurance department or other regulatory agencies to correctly determine jurisdiction. Some states have enacted the NAIC Jurisdiction to determine Jurisdiction of Providers of Health Care Benefits Model Act which also provides guidance. Examiners may reference the NAIC Health and Welfare Plans Under the Employee Retirement Income Security Act (ERISA): Guidelines for State and Federal Regulation for more information about determining whether a state law is preempted by ERISA.

HIPAA—Federal Minimum Requirements

Examiners should be aware that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes minimum requirements for health insurance coverage in certain areas and prohibits the application of any state law to the extent that it prevents the application of a HIPAA requirement. However, states that have laws in these areas that extend beyond HIPAA's minimum requirements may enforce those laws. Group and individual health insurance issues affected by HIPAA include:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed-issue for small groups of 2 to 50;
- Guaranteed renewability for all policies, with certain exceptions;
- Expansion of COBRA entitlement;
- Portability for eligible individuals leaving group coverage, with certain exceptions;
- Minimum maternity benefits when maternity is covered by the plan;
- Minimum standards for tax-qualified long-term care (LTC) policies;
- Mental health parity; and
- Standards for association group coverage.

Many states have requirements that impose more consumer protection requirements on carriers than HIPAA, in which case the state's requirements should be enforced. (For example, a state may include a group of one in its definition of "group" or "small group.")

Federally Mandated Benefits

Examiners should also be aware of benefits mandated under federal law and if state laws or regulations meet the minimum requirements established under federal law.

Federally mandated benefits include:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986;
- The Mental Health Parity Act (MHPA) of 1996;
- Newborns' and Mothers' Health Protection Act (NMHPA) of 1996;
- Women's Health and Cancer Rights Act of 1998;
- Genetic Information Nondiscrimination Act (GINA) of 2008; and
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

IIPRC-Approved Products

When conducting an exam that includes products approved by the Interstate Insurance Product Regulation Commission (Compact) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The Compact website is *www.insurancecompact.org* and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rates and Forms Filing (SERFF) to product filings submitted to the Compact for approval and use in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information. Each Compact-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The Compact office should be included when a compacting state(s) is concerned that a Compact-approved product constitutes a violation of the provisions, standards or requirements of the Compact (including the uniform standards).

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
Regulated entity rules on replacement are in compliance with applicable statutes, rules and regulations.

Apply to: Individual accident and health products in jurisdictions where the NAIC *Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act* (#171) has been adopted

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Underwriting file

_____ Replacement comparison form (if external replacement)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act (#171), Sections 9A and 9B

Review Procedures and Criteria

Review replacement register to see if it is cross-indexed by producer and regulated entity. This is to determine if a regulated entity has been targeted for replacements by a producer (internal and external).

Determine if the existing insurer has been notified of replacement as required by applicable statutes, rules and regulations.

Review replacement forms for compliance.

Ensure individual health applications include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force.

Determine that the insurer or its producer provides applicable notices of replacement to applicants upon determining that a sale of individual health insurance will involve replacement.

Standard 2
Outline of coverages is in compliance with all applicable statutes, rules and regulations.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial records

_____ Underwriting file

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Employer and Individual Health Insurance Availability Model Act (#35)
Individual Health Insurance Portability Model Act (#37), Section 5
Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)

Review Procedures and Criteria

Determine if all outlines of coverages used are authorized by the regulated entity.

Look for verification that outlines of coverages used have been approved by appropriate persons within the regulated entity.

Determine that health policy mandated benefits and benefit limitations are completely and accurately described.

Determine that the following information has been disclosed in all solicitation and sales materials:

- The extent to which premium rates for an individual and dependents are established or adjusted based on rating characteristics;
- The carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;
- The provisions relating to renewability of policies and contracts;
- Any provisions relating to any preexisting condition provision; and
- All individual health benefit plans offered by the carrier, the prices of the plans, if available to the eligible person and the availability of the plans to the individual.

Ensure the outlines of coverage accurately represent the applicable consumer protections and minimum standards required by HIPAA, which may include:

- Limits on preexisting condition exclusions;
- Prohibitions on discrimination based on health status and related factors;
- Guaranteed-issue for small groups of 2 to 50;
- Guaranteed renewability for all policies, with certain exceptions;
- Expansion of COBRA entitlement;
- Portability for eligible individuals leaving group coverage, with certain exceptions;
- Minimum maternity benefits when maternity is covered by the plan;
- Minimum standards for tax-qualified LTC policies;
- Mental health parity requirements;
- Limits on the factors that can be used to establish and change premium rates; and
- Descriptive information about all available health benefit plans.

Ensure the regulated entity maintains complete and detailed descriptions of its rating and underwriting practices for individuals and small groups at its principal place of business.

STANDARDS
MARKETING AND SALES

Standard 3
The regulated entity has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All health products

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References
Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)

Review Procedures and Criteria

Determine whether the regulated entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have regulated entity run a policyholder history to identify the number of policies sold to those individuals. Particular attention should be given to LTC and Medicare products.

Determine if underwriting guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the regulated entity has a system to discourage "over-insurance" of policyholders as defined by regulated entity underwriting requirements.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Reinstatement is applied consistently and in accordance with policy provisions.

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Notice of reinstatement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine that notice was sent in a timely manner.

Verify that reinstatement provisions were applied consistently and in a non-discriminatory manner.

Verify that reinstatement was applied per policy provisions.

STANDARDS
POLICYHOLDER SERVICE

Standard 2
Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or applicable statutes, rules and regulations.

Apply to: All health plans

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy history file

_____ Regulated entity procedures manual

Others Reviewed

Examiners are encouraged to reference the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 7

Review Procedures and Criteria

"Creditable coverage" includes most health coverage, including prior coverage under:

- Group health plan (including a governmental or church plan);
- Health insurance coverage (either group or individual);
- Medicare;
- Medicaid;
- Military-sponsored health care program such as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services);
- Program of the Indian Health Service or tribal organization;
- Qualified state health benefits risk pool;
- Federal Employees Health Benefit Program;
- Public health plan established or maintained by a state or local government;
- COBRA (Consolidated Omnibus Budget Reconciliation Act); or
- Health benefit plan provided for Peace Corps members.

Documents that may establish creditable coverage include a certificate of coverage or, in the absence of a certificate of coverage, any of the following:

- Explanations of benefits or other correspondence from a plan or issuer indicating coverage;
- Pay stubs showing a payroll deduction for health coverage;
- Health insurance identification card;

- Certificate of coverage under a group health policy;
- Records from medical care providers indicating health coverage;
- Third-party statements verifying periods of coverage;
- Benefit termination notice from Medicare or Medicaid; or
- Other relevant documents that evidence periods of health coverage.

Determine if the health carrier issues creditable coverage certificates as required.

The carrier must issue certificates automatically and upon request. "Upon request" allows a policy or certificateholder to request a certificate within 24 months of ceasing coverage or before coverage ends. Certificates must be issued within a reasonable time and at no charge.

Certificates should automatically be issued to:

- An individual entitled to elect COBRA, at a time no later than when a notice is required to be provided for a qualifying event under COBRA;
- An individual who loses coverage under the plan and who is not entitled to elect COBRA, within a reasonable time after coverage ceases; or
- An individual who leaves COBRA, within a reasonable time after COBRA coverage terminates.

Creditable coverage certificates should include:

- An indication whether an individual has at least 18 months of creditable coverage;
- For individuals with less than 18 months of creditable coverage, an indication of the dates when coverage began and ended and the dates any waiting or affiliation period began;
- A contact phone number; and either
    - When provided upon request, each period of continuous coverage ending within the 24 months prior to the date of the request; or
    - When automatically issued, the most recent period of coverage.

The carrier should have started issuing certificates June 1, 1997, or within the following guidelines:

- By June 1, 1997, certificates should have been delivered to all persons who lost coverage or began or ended COBRA coverage between October 1, 1996 and May 31, 1997 (notices are allowed in lieu of completed certificates as long as a certificate is issued upon request); or
- Certificates after July 1, 1998 must be issued with names and individual dates of coverage for all dependents. (Use of terms "spousal" or "family" allowed until July 1, 1998.)

Duplicate certificates should be provided free of charge.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
UNDERWRITING AND RATING

Standard 1
Cancellation practices comply with policy provisions, HIPAA and state laws.

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy contract

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Regulated entity cancellation/nonrenewal guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Employer and Individual Health Insurance Availability Model Act (#35)
Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria

For the group and individual markets, nonrenewal or discontinuance is allowed for:

- Nonpayment of premiums;
- Fraud;
- Insured's request;
- The insured moving outside of service area; or
- The insured terminating membership in an association.

Group coverage may also be terminated for violation of applicable participation/contribution rules. Individuals within groups may be required to select another coverage option for certain misconduct and may lose coverage when they become eligible for Medicare.

An insurer may nonrenew if they discontinue coverage, but they must sit out of the market for 5 years. There are exceptions to this general rule. Refer to HIPAA and state statutes, rules and regulations for the examination of specific situations.

Ensure the regulated entity complies with the provisions of COBRA and HIPAA with respect to continuation of coverage, including required notice periods for withdrawing products from the marketplace.

Note: Many states have specific rules for associations that will provide additional protections. HIPAA addresses the issue of bona fide associations in the individual and group markets in a manner that may also provide additional protections to consumers.

Standard 2
Pertinent information on applications that form a part of the policy is complete and accurate.

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria

Determine if the coverage is issued as applied for.

Determine if the regulated entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and dividend options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Standard 3
The regulated entity complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms

_____ Regulated entity guidelines

_____ Regulated entity marketing materials dealing with continuation of benefits

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 10
Group Health Insurance Mandatory Conversion Privilege Model Act (#105)

Review Procedures and Criteria

Review the regulated entity's procedures for providing information pertaining to continuation of benefits, for processing applications for continuation of benefits, for notification to insureds of the beginning and the termination of continuation of benefit periods and for premium notices.

Review continuation of benefit files.

Review declinations/cancellations of continuation of benefits insureds.

Review regulated entity procedures for compliance with COBRA, which allows individuals to continue their group coverage for specified periods of time. In accordance with the provisions of HIPAA:

- An individual may have 29 months of coverage under COBRA if they become disabled during the first 60 days of COBRA coverage. The 29-month extension must also apply to non-disabled family members who were entitled to COBRA coverage;
- COBRA continuation coverage generally can be terminated when an individual becomes covered under another group health plan, which could include a state continuation or risk pool program. COBRA cannot be terminated because of other coverage where the plan limits or excludes coverage for any preexisting condition of the individual. HIPAA limits the circumstances under which a plan may impose a preexisting exclusion period on individuals. If a plan is precluded under HIPAA from imposing an exclusion period on any individual (i.e., it must cover the individual's preexisting condition), COBRA continuation coverage may be terminated;

- Children who are born, adopted or placed for adoption are "qualified beneficiaries" and are thus eligible for COBRA. There is no restriction that they be covered prior to the COBRA qualifying event to be considered a "qualified beneficiary";
- Guaranteed access requirements to individual insurance must be provided when COBRA benefits are exhausted; and
- If an individual declines coverage due to "other coverage," COBRA benefits may be required to be exhausted before a "special enrollment" period is allowed due to non-coverage. Note that rules on special enrollment are complex.

Standard 4
The regulated entity complies with the Genetic Information Nondiscrimination Act of 2008.

Apply to: All group health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting guidelines and producer guidelines related to group health insurance

_____ Rating guidelines related to group health insurance

Others Reviewed

Genetic Information Nondiscrimination Act of 2008 (GINA)

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

For group coverage, GINA prohibits group health plans and health insurance issuers offering health coverage in connection with such a plan from:

- Requesting or requiring genetic testing. Plans that incidentally acquire genetic information will not violate the law;
- Increasing group premiums or denying enrollment based on genetic information;
- Requesting, requiring, or purchasing genetic information for underwriting purposes or with respect to any individual prior to enrollment and in connection with enrollment; and
- Using or disclosing genetic information about an individual for underwriting purposes.

Standard 5
The regulated entity complies with proper use and protection of health information in accordance with statutes, rules and regulations.

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written policies, standards and procedures

_____ Regulated entity guidelines

_____ Rights of individual applicant to access and amend health information

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Information Privacy Model Act (#55)
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Review the regulated entity's procedures for proper use of protected health information.

Review medical/lifestyle questions and underwriting guidelines for AIDS.

Review guidelines for use of notice and consent form for AIDS.

Standard 6
The regulated entity complies with the provisions of HIPAA and state laws regarding limits on the use of preexisting exclusions.

Apply to: All group health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Policy forms and endorsements

_____ Regulated entity guidelines

_____ Regulated entity materials dealing with HIPAA

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 7
Newborn and Adopted Children Coverage Model Act (#155)
Group Health Insurance Standards Model Act (#100)
Small Employer and Individual Health Insurance Availability Model Act (#35)

Review Procedures and Criteria

Determine appropriate handling of preexisting conditions in accordance with the requirements of HIPAA and state law. Ensure creditable coverage is properly applied. The time constraints are:

- Preexisting conditions should be limited to a "physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date in a plan or policy;"
- The "enrollment date" is the first day of coverage or, if earlier, the first day of the waiting period; and
- Preexisting condition exclusion periods may be applied for a maximum of 12 months or 18 months for late enrollment. The preexisting condition exclusion period should be reduced by any prior creditable coverage. Preexisting condition exclusions cannot be applied to conditions identified as a result of genetic testing, pregnancy, newborns, newly adopted children or children newly placed for adoption within 30 days.

Continuous coverage is required as follows:

- Issuers are not required to count coverage as creditable if it existed before a 63 day break in coverage (NAIC model allows a 90 day break); and
- Creditable coverage must be in effect for 12 months or 18 months for a late enrollee to fully preempt preexisting conditions. (NAIC model allows 6 months or 12 months for late enrollees);
- "Creditable coverage" includes most health coverage, including:
    - Prior coverage under a group health plan (including a governmental or church plan);
    - Health insurance coverage (either group or individual);
    - Medicare;
    - Medicaid;
    - Military-sponsored health care program such as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services);
    - Program of the Indian Health Service or tribal organization;
    - Qualified state health benefits risk pool;
    - Federal Employees Health Benefit Program;
    - Public health plan established or maintained by a state or local government;
    - COBRA (Consolidated Omnibus Budget Reconciliation Act); or
    - Health benefit plan provided for Peace Corps members.

Waiting periods:

- Generally do not count as creditable coverage unless the individual has other coverage during the waiting period;
- Are not taken into account when determining whether a break of 63 days has occurred; and
- Run concurrently with a preexisting condition exclusion period.

If a carrier imposes a preexisting condition period, the carrier must provide notice that a preexisting condition period will be imposed. If an individual provides evidence of creditable coverage and there would still be a preexisting condition exclusion period remaining, the carrier must notify the individual that a preexisting condition exclusion period will be imposed and for what period of time.

Individual Market

HIPAA limitations on preexisting condition exclusions only apply to the group market. The NAIC model outlines limitations for the individual market similar to the group market.

STANDARDS
UNDERWRITING AND RATING

Standard 7
The regulated entity does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA or state law.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Section 7
Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)
Group Health Insurance Standards Model Act (#100)
Small Employer and Individual Health Insurance Availability Model Act (#35)

Review Procedures and Criteria

For group coverage:

- No individual eligibility determination may be made using health status, physical or mental medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability;
- A special enrollment period must be allowed for changes in family status, including a spouse that declined coverage at open enrollment due to "other coverage" and subsequently lost coverage; and
- Similarly situated individuals cannot be charged a higher premium, pay higher contribution amounts or have limitations or restrictions on their benefits or coverage.

For individual coverage:

- No individual may be denied on the basis of health status if they are an "eligible individual;"
- HIPAA does not preclude states from limiting health status denials for individuals that are not eligible; and
- HIPAA does not preclude states from limiting the ability of an insurer to charge a higher rate to individuals in poor health.

"Eligible individual" includes a person that:

- Has portability because of 18 months of previous coverage most recently under a group plan (including ERISA self-funded plans);
- Has exhausted COBRA benefits or a similar state program;
- Is not eligible for Medicare, Medicaid or a group health plan;
- Is not covered under other health insurance;
- Has had no gaps in coverage exceeding 63 days; and
- Has not been terminated for nonpayment of premiums or fraud.

Note: Under HIPAA's 45 CFR 148.120, it is the carrier's responsibility in federal fallback states to offer all federally defined eligible individuals a choice of at least two policies that meet certain requirements and to guarantee issue any of those products to all such individuals that apply for coverage. Furthermore, under 45 CFR 148.126, all carriers in the individual market in federal fallback states are responsible for determining whether an applicant for coverage is an eligible individual, as defined in 45 CFR 148.103. Carriers must exercise reasonable diligence in making this determination.

In a HCFA bulletin issued April 15, 1998 in Missouri, this was interpreted to mean that a carrier has an affirmative responsibility to determine whether an individual is a federally defined eligible individual, whether or not the applicant is aware of his or her status. Compliance by a carrier is also not conditioned upon the type of plan for which the applicant applied. Therefore, a carrier that fails to identify all federally defined eligible individuals and treat them accordingly could potentially be subject to penalties.

For association group coverage in the group or individual market, determine:

- Whether the regulated entity has an arm's-length relationship with the association;
- If the regulated entity or its affiliates have any control over the association;
- If the association had a 100-person membership at the outset, and if the association has a shared or common purpose;
- If the association has been organized and maintained in good faith primarily for purposes other than obtaining insurance;
- If the association has been in active existence for at least one year and has a constitution and by-laws that require the association to hold regular meetings (at least annually);
- How the association solicits dues or contributions from its members;
- If the association allows its members to have voting privileges and representation on the board and committees;
- If the policy provides the applicable coverage to all members of the association;
- How the premium for the policy is paid; and
- How the association obtains new members.

Standard 8
The regulated entity issues coverage that complies with guaranteed-issue requirements of HIPAA and related state laws for groups of 2 to 50.

Apply to: All small group health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Employer and Individual Health Insurance Availability Model Act (#35)

Review Procedures and Criteria

Small group coverage must be issued on a guaranteed-issue basis for all products, subject to participation and contribution requirements. No eligible employee or dependent can be excluded on the basis of health status or related factors. The NAIC model requires regulated entities to include a basic and standard plan in offerings.

HIPAA defines a small group as 2 to 50, but allows states to add groups of 1 and/or groups of more than 50 employees.

Under the NAIC model, individual coverage must be issued on a guaranteed-issue basis for all products, including basic and standard plans, with exceptions for individuals eligible for other coverages. The alternative version limits guaranteed-issue to annual open enrollment periods.

STANDARDS
UNDERWRITING AND RATING

Standard 9
The regulated entity issues individual insurance coverage to eligible individuals entitled to portability under the provisions of HIPAA and in compliance with applicable statutes, rules and regulations.

Apply to: All health products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files of denied policies

_____ Regulated entity guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Health Insurance Portability Model Act (#37), Sections 7 and 10

Review Procedures and Criteria

This standard is designed to ensure portability requirements from HIPAA and/or state rules are followed. States are given broad latitude to develop alternatives to federal requirements. For federal fallback option states, a regulated entity:

- May limit coverage if it offers two different policy forms. ("Policy form" does not mean separate riders or cost-sharing mechanisms; it can, however, mean out-of-pocket and deductible differences that are "significantly different.");
- May offer two largest premium volume policy forms of previous reporting year. (State reporting year or October 1 to September 30, if state reporting year is not defined.);
- Alternatively, may offer low-level or high-level coverage policy forms that meet benefits substantially similar to other health insurance coverage offered by the issuer in the state; and
- May deny coverage by a network plan if individual does not live, reside or work in the network area. States may approve denial if the insurer demonstrates inability to deliver services adequately (due to volume of current group contractholders, etc.) and it uniformly denies the individual coverage. If denial is approved by the state, the issuer may not offer coverage in the individual market for 180 days. (Financial impairment may also be demonstrated to the state to allow denial.)

Standard 10
The regulated entity does not administer self-funded benefit plans for entities subject to state regulation (e.g., MEWAs) or provide insurance coverage to entities not entitled to such coverage under state or federal law.

Apply to: All group health plans

Priority: Essential

Documents to be Reviewed—Multiple employer groups NOT claiming exemption from state regulation

_____ Applicable statutes, rules and regulations

_____ Listing of multiple employer groups (including associations) provided insurance coverage

_____ Organizational documents or such other information, indicating these entities meet state or federal laws to purchase group coverage

_____ Forms and endorsements issued to such groups and copy of insurance department approval (if applicable)

_____ Rates charged such groups and insurance department approval of same (if applicable)

Documents to be Reviewed—Multiple employer groups claiming exemption from state regulation

_____ Applicable statutes, rules and regulations

_____ Listing of multiple employer groups for whom self-funded benefits are administered

_____ Organizational documents or such other information indicating these entities meet state or federal laws to provide self-funded benefits exempt from state regulation

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220)
Group Health Insurance Standards Model Act (#100)

Review Procedures and Criteria—Multiple Employer Groups NOT claiming exemption from state regulation

Determine if the multiple employer group satisfies appropriate state or federal law to be qualified as either an association, MEWA or other arrangement permitted by law.

Determine if regulated entity forms and rates meet state requirements for filing and approval (if any).

Review Procedures and Criteria—Multiple Employer entities claiming exemption from state regulation

Determine if the multiple employer group satisfies appropriate federal law to be qualified as an entity not subject to state regulation.

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
CLAIMS

Standard 1
Claim files are handled in accordance with policy provisions, HIPAA and state law.

Apply to: All health products
Disability income products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, including the Unfair Trade Practices Act, the Unfair Claims Settlement Practices Act and the Unfair Life, Accident and Health Claims Settlement Discrimination Act

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins, UCR guidelines and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Accident and Sickness Insurance Minimum Standards Model Act (#170)
Consumer Credit Insurance Model Act (#360)
Consumer Credit Insurance Model Regulation (#370)
Coordination of Benefits Model Regulation (#120)
Health Maintenance Organization Model Act (#430)
Insurance Fraud Prevention Model Act (#680)
Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)
Off-Label Drug Use Model Act (#148), Section 4
Unfair Claims Settlement Practices Act (#900)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Unfair Trade Practices Act (#800)

Review Procedures and Criteria

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether such standards comply with state laws.

Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the commissioner.
Determine if claim handling meets any applicable state laws, including:

- Usual, customary and reasonable (UCR);
- Coordination of benefits (COB), including, but not limited to, the determination of primary and secondary coverage responsibilities, the timely determination of those responsibilities and the proper handling of savings provisions;
- Deductibles and coinsurance;
- Correct payees;
- Accelerated payments; and
- Unfair trade practices and unfair discrimination acts.

Review handling of cash or advance settlements of first-party long-term disability claims to ascertain whether the claimant was provided adequate information regarding future benefits.

Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

Determine if any required explanation of benefit statements are provided to claimants.

Determine if claim handling includes proper referral of suspicious claims.

Determine that health benefit plans that cover drugs also provide benefits for any drug prescribed to treat a covered indication, so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for the treatment of the covered indication in one or more of the standard reference compendia or peer-reviewed medical literature. Exceptions—drugs determined to be contra-indicated for treatment of the current indication and drugs used in certain research trials.

Determine appropriate handling of claims in accordance with the requirements of HIPAA. The company should have procedures, which assure that no exclusions of coverage are imposed for a preexisting condition where HIPAA preexisting condition exclusion maximums have been reached, or claims denied where an individual has periods of creditable coverage, which should be credited from prior coverage.

For disability income insurance claims:

- If the minimum benefit is payable, confirm the correct minimum benefit is being used;
- If the policy provides for a pension supplement and the claimant is entitled to it, confirm that benefit is being paid to the pension plan administrator; and
- Ascertain that investigations to determine initial liability are fair and reasonable; i.e., if medical records do not objectively support disability, despite certification of disability by the physician, are independent medical evaluations being conducted and/or are insurers obtaining clarification of medical information from the insured's physician(s)?
- Review policy provisions relating to benefits:
    - Are the policy's offset provisions correctly applied to the benefit determination?
    - Are applicable cost of living adjustment (COLA) benefits correctly applied to the benefit payment?
    - Are benefits administered in accordance with provisions relating to changes in age or maximum benefit periods?
    - Are number of days calculated consistently and according to the policy provisions?
    - Are elimination periods, such as retroactive benefits, determined correctly?
- Verify the claimant met the policy's definition of gainfully employed and disabled;

- Verify the company disclosed to the claimant, when benefits are initially paid, that overpayment of benefits, because of other income benefits not being deducted, can be recovered from the claimant;
- Where applicable, verify that Social Security benefit increases for inflation are not used to adjust the benefit amount. Likewise, if the Social Security benefit decreases, the offset must also decrease where required by ERISA;
- Verify that cash settlement offers are fair, reasonable and documented; and
- Ensure that overpayment recoveries due to workers' compensation lump sum awards are from only the income protection portion, and not from the medical or other expenses portion of the award.

It is an unfair practice to attempt to settle or settle a claim on the basis of an application that was materially altered without the consent of the insured.

For credit insurance, a provision in the individual policy or certificate that sets a maximum limit on total claim payments must apply only to that individual policy or certificate.

Standard 2
The company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996.

Apply to: All health lines offering maternity coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

Others Reviewed

Newborns' and Mothers' Health Protection Act of 1996

_____ _____

NAIC Model References

Unfair Claims Settlement Practices Act (#900)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Determine if state statutes, rules or regulations impose different and/or more restrictive requirements on carriers than federal law. If so, ensure the company is in compliance with those statutes, rules or regulations.

Unless the state has a specific exemption because of an alternative law, HIPAA requires that all group health plans, insurance companies and HMOs offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum of 48 hours for a normal vaginal delivery and 96 hours for a cesarean section. (Coverage is required for both the mother and the newborn.) Deductibles, coinsurance and other cost-sharing methods may be applied.

Ensure the company does not engage in incentive arrangements to circumvent the requirements of the law. Such incentive requirements could include: making monetary payments or rebates to mothers to encourage them to accept a shorter length of stay; penalizing or reducing or limiting reimbursement of an attending provider because they provided care to an individual for the above minimum time frames; or providing incentives to induce a provider to provide care in a manner inconsistent with the law.

Standard 3
The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.

Apply to: Certain group health plans offering mental health coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins, UCR guidelines and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

Mental Health Parity Act of 1996

Mental Health Parity and Addiction Equity Act of 2008

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if state statutes, rules or regulations impose different and/or more restrictive requirements on carriers than federal law, and, if so, ensure the company is in compliance with those statutes, rules or regulations.

Mental Health Parity Act (MHPA) requirements do not apply to 1) small employer groups of two to 50 employees; or 2) any group health plan where the required federal notice has been filed, documenting that actual costs increased two percent or more due to the application of the MHPA requirements during the first year and at least one percent of the actual cost in each subsequent year. The 1996 MHPA does not allow carriers to set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. The 2008 revisions include substance abuse parity, and the law affects items such as cost-sharing features and utilization restrictions of the substance abuse/mental health benefits when compared to the medical/surgical benefits under the policy.

Note: MHPA does not apply to policies sold in the individual market or small group marketplace.

Standard 4
The group health plan complies with the requirements of the federal Women's Health and Cancer Rights Act of 1998.

Apply to: Certain group health plans offering mastectomy coverage

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

Women's Health and Cancer Rights Act of 1998

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if state statutes, rules or regulations impose different and/or more restrictive requirements on carriers than federal law. If so, ensure the company is in compliance with those statutes, rules or regulations.

The Women's Health and Cancer Rights Act of 1998 applies to group health plans offering mastectomy coverage. Written notice about the availability of these benefits must be delivered to plan participants upon enrollment and each year afterwards. Deductibles and coinsurance must have parity with other medical/surgical benefits.

Note: The mandate applies to the large and small group marketplace.

STANDARDS
CLAIMS

Standard 5
The company complies with applicable statutes, rules and regulations for group coverage replacements.

Apply to: Replacement or replaced group health plans

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company claim procedure manuals

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Group Coverage Discontinuance and Replacement Model Regulation (#110)

Review Procedures and Criteria

Ensure the discontinued or replaced group policy provides an extension of benefits to qualified individuals that are totally disabled or confined in a hospital on the date a group contract is discontinued.

Ensure the prior carrier provides a statement of benefits upon a succeeding carrier's request. The statement should include available or pertinent information to permit verification of benefit determinations.

Ensure the succeeding carrier credits deductibles and waiting periods satisfied under the prior carrier's contract, when required.

Ensure the succeeding carrier complies with preexisting condition requirements. The limitation should be the lesser of 1) the benefits of the new plan determined without application of the preexisting condition limitation; or 2) the benefits of the prior plan.

H. Grievance Procedures

1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the company handles grievances. The NAIC definition of a grievance is a written complaint, or an oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding the:

a. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
b. Claims payment, handling or reimbursement for health care services; or
c. Matters pertaining to the contractual relationship between a covered person and a health carrier.

Note: This definition may not include all written communications that the company tracks as "complaints" under the NAIC definition of complaint.

The examiner should review the company procedures for processing grievances. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

2. Techniques

A review of grievance procedures should incorporate consumer and provider appeals, consumer direct grievances to the company and those grievances filed with the insurance department. The examiner should reconcile the company grievance register with a list of grievances from the insurance department. A random sample of appeals and each level of grievance should be selected for review from the company's grievance register.

The company's written grievance procedures should be reviewed. Determine how those procedures are communicated to plan members within membership materials and upon receipt of appeals and grievances.

The examiner should review the frequency of similar grievances and be aware of any pattern of specific type of grievance. Should the type of grievances noted be cause for concern, specific measures should be instituted to investigate other areas of the company's operation? This may include modifying the scope of examination to examine specific company behavior.

3. Tests and Standards

The grievance handling review includes, but is not limited to, the following standards addressing various aspects of a company's operations. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
GRIEVANCE PROCEDURES

Standard 1
The health carrier treats as a grievance any written complaint, or any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample documents and files (including electronic correspondence)

_____ Member evidence of coverage

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 3R

Review Procedures and Criteria

As grievances are detected during the examination, verify they have been properly handled and recorded.

STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company's grievance handling policies and procedures

_____ Sample of grievances

_____ Member evidence of coverage

_____ Company's grievance register

_____ Company's annual grievance report to the insurance department

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 5

Review Procedures and Criteria

Verify that the health carrier maintains a grievance register consisting of written records to document all grievances received during a calendar year (the register).

Verify that the health carrier includes requests for first level review of grievances involving an adverse determination in the grievance register.

Verify that the health carrier includes requests for additional voluntary review of grievances involving an adverse determination in the grievance register.

Verify that the health carrier's grievance register contains, at a minimum, the following information:

- A general description of the reason for the grievance;
- The date the grievance was received;
- The date of each review or, if applicable, review meeting;
- The resolution at each level of the grievance, if applicable;
- The date of resolution at each level, if applicable; and
- The name of the covered person for whom the grievance was filed.

Verify that the health carrier's grievance register is maintained in a manner that is reasonably clear and accessible to the insurance commissioner.

Verify that the health carrier retains the grievance register compiled for a calendar year for the longer of three years or until the insurance commissioner has adopted a final report of an examination that contains a review of the grievance register for that calendar year.

Verify that the health carrier submits to the insurance commissioner, at least annually, a report in the format specified by the insurance commissioner.

Verify that the health carrier's grievance report includes, for each type of health benefit plan offered by the health carrier:

- The certificate of compliance as required by applicable state statutes, rules and regulations;
- The number of covered lives;
- The total number of grievances;
- The number of grievances for which a covered person, or, if applicable, the covered person's authorized representative, requested an additional voluntary grievance review pursuant to applicable state statutes, rules and regulations;
- The number of grievances resolved at each level, if applicable, and their resolution;
- The number of grievances appealed to the insurance commissioner that the health carrier has been informed of;
- The number of grievances referred to in alternative dispute resolution procedures or resulting in litigation; and
- A synopsis of actions being taken to correct problems identified.

The health carrier shall comply with all applicable state provisions equivalent to the *Health Carrier Grievance Procedure Model Act* and accompanying regulations not expressly covered by any other of these standards.

STANDARDS
GRIEVANCE PROCEDURES

Standard 3
A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Grievance procedures

_____ All forms used to process a grievance

_____ Company approval register

_____ Grievance procedure filings filed with the insurance department

_____ Certificates of compliance filed with the insurance department

_____ Sample of grievance procedure disclosures provided to covered persons (e.g., policies, certificates, membership booklets, outlines of coverage or other evidence of coverage)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 6

Review Procedures and Criteria

Verify that the health carrier utilizes written procedures for receiving and resolving first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination; and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, pursuant to applicable state statutes, rules and regulations.

Verify that the health carrier files with the insurance commissioner a copy of its grievance procedures required by applicable state statutes, rules and regulations regarding first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination, and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, including all forms used to process grievance requests. Verify that the health carrier also files any subsequent material modifications to the documents.

Verify that the health carrier files annually with the insurance commissioner, as part of its annual grievance report required by applicable state statutes, rules and regulations, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with applicable state statutes, rules and regulations.

Verify that the health carrier includes a description of its grievance procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons, or, if applicable, the covered person's authorized representative.

Verify that the health carrier's grievance procedure documents include a statement of a covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time. Verify that the statement includes the telephone number and address of the insurance commissioner's office.

STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The health carrier has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of first level reviews of grievances involving an adverse determination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 7

Review Procedures and Criteria

Verify that the health carrier provides a covered person, or, if applicable, the covered person's authorized representative, with the name, address and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier.

In the case of an adverse determination involving utilization review, verify that the health carrier designates an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. Verify that the clinical peer appointed by the health carrier was not involved in the initial adverse determination.

Verify that the health carrier, in designating an appropriate clinical peer or peers ensures that, if more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

Verify that the reviewer or reviewers appointed by the health carrier, in conducting a review of an adverse determination involving utilization review, take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person, or, if applicable, the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

Verify that the health carrier, within three working days of the date of receipt of a first level grievance, informs the covered person, or if applicable, the covered person's authorized representative, of his or her right to submit written comments, documents, records and other material relating to the request for benefits for reviewer consideration when conducting the review.

Verify that the health carrier, within three working days of the date of receipt of a first level grievance, informs the covered person, or, if applicable, the covered person's authorized representative, of his or her right to receive from the health carrier, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the covered person's request for benefits.

With regard to the covered person's, or, if applicable, the covered person's authorized representative's, right to have reasonable access to and to receive "relevant" documents, records and other information, verify that the health carrier considers a document, record or other information "relevant" to a covered person's, or, if applicable, the covered person's authorized representative's, request for benefits when the document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;
- Demonstrates that, in making the benefit determination, the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or
- Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

Verify that the health carrier calculates the time period, within which a determination is required to be made and notice provided pursuant to applicable state statutes, rules and regulations, to begin on the date the grievance requesting the review is received by the health carrier in accordance with the health carrier's procedures for filing a request, established pursuant to applicable state statutes, rules and regulations, for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Verify that the health carrier notifies and issues a decision in writing or electronically to the covered person, or, if applicable, the covered person's authorized representative, within the time frames set forth in applicable state statutes, rules and regulations regarding the following types of grievances:

- With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, verify the health carrier notifies and issues a decision within a reasonable period of time that is appropriate, given the covered person's medical condition, but no later than thirty days after the date of the health carrier's receipt of the grievance requesting the first level review; or
- With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, verify the health carrier notifies and issues a decision within a reasonable period of time, but no later than sixty days after the date of the health carrier's receipt of the grievance requesting the first level review.

Verify that the health carrier's decision of a first level review of a grievance involving an adverse determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
- A statement of the reviewers' understanding of the covered person's, or, if applicable, the covered person's authorized representative's, grievance;
- The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person, or, if applicable, the covered person's authorized representative, to respond further to the health carrier's position;
- A reference to the evidence or documentation used as the basis for the decision; and

- For a first level review decision that upholds the grievance:
    - The specific reason or reasons for the final adverse determination;
    - The reference to the specific plan provisions on which the determination is based;
    - A statement that the covered person, or, if applicable, the covered person's authorized representative, is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in applicable state statutes, rules and regulations, to the covered person's, or, if applicable, the covered person's authorized representative's, benefit request;
    - If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
    - If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances, or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request; and
    - If applicable, instructions for requesting:
        - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination, as set forth in applicable state statutes, rules and regulations; and
        - The written statement of the scientific or clinical rationale for the determination, as set forth in applicable state statutes, rules and regulations;
- If applicable, a statement indicating:
    - A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person, or, if applicable, the covered person's authorized representative, wishes to request a voluntary review;
    - The written procedures governing the voluntary review, including any required time frame for the review;
    - A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75) if the covered person, or, if applicable, the covered person's authorized representative, decides not to file for an additional voluntary review of the first level review decision involving an adverse determination; and
    - The covered person's, or, if applicable, the covered person's authorized representative's, right to bring a civil action in a court of competent jurisdiction;
- If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner"; and
- Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time, including the telephone number and address of the insurance commissioner's office.

STANDARDS
GRIEVANCE PROCEDURES

Standard 5
The health carrier has procedures for and conducts standard reviews of grievances not involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 8

Review Procedures and Criteria

Verify that the health carrier has established written procedures for standard review of grievances that do not involve an adverse determination.

Verify that the health carrier's procedures permit a covered person, or, if applicable, the covered person's authorized representative, to file a grievance that does not involve an adverse determination with the health carrier.

Verify that the health carrier, within three working days of receiving a grievance not involving an adverse determination, informs the covered person, or if applicable, the covered person's authorized representative, of his or her right to submit written material for the person or persons designated by the health carrier to consider when conducting the review.

Verify that the health carrier, upon receipt of the grievance that does not involve an adverse determination, designates a person or persons to conduct the standard review of the grievance.

Verify that the health carrier does not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

Verify that the health carrier provides the covered person, or, if applicable, the covered person's authorized representative, with the name, address and telephone number of a person designated to coordinate the standard review of the grievance on behalf of the health carrier.

Verify that the health carrier notifies in writing the covered person, or, if applicable, the covered person's authorized representative, of the decision within 20 working days after the date of receipt of the request for a standard review of a grievance.

If circumstances beyond the health carrier's control prevent the health carrier from making a decision and notifying the covered person, or, if applicable, the covered person's authorized representative, of that decision within 20 working days, verify that the health carrier takes no longer than an additional 10 working days to issue a written decision, provided that the health carrier provides written notice to the covered person, or, if applicable, the covered person's authorized representative, of the extension and the reasons for the delay on or before the 20th working day after the request for standard review of the grievance.

Verify that the health carrier's written decision issued pursuant to a standard review of a grievance not involving an adverse determination contains all of the following:

- The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);
- A statement of the reviewers' understanding of the covered person's grievance;
- The reviewers' decision in clear terms, and the contract basis in sufficient detail for the covered person, or, if applicable, the covered person's authorized representative, to respond further to the health carrier's position;
- A reference to the evidence or documentation used as the basis for the decision;
- If applicable, a statement containing:
    - A description of the process to obtain an additional review of the standard review decision if the covered person, or, if applicable, the covered person's authorized representative, wishes to request a voluntary review pursuant to applicable state statutes, rules and regulations; and
    - The written procedures governing the voluntary review, including any required time frame for the review; and
- Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right, at any time, to contact the insurance commissioner's office, including the telephone number and address of the insurance commissioner's office.

STANDARDS
GRIEVANCE PROCEDURES

Standard 6
The health carrier has procedures for voluntary reviews of grievances and conducts voluntary reviews of grievances in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan. The provisions in this examination standard do not apply to health indemnity plans.

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of voluntary review grievances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 9

Review Procedures and Criteria

Note: Although this examination standard requires a health carrier that offers managed care plans to establish an additional voluntary review process for its managed care plans, the decision to file a request for an additional voluntary review of a grievance involving an adverse determination rests solely within the discretion of the covered person, or, if applicable, the covered person's authorized representative. This examination standard addresses an optional additional level of review that the covered person, or, if applicable, the covered person's authorized representative, may voluntarily use to resolve the issue in dispute after receiving an adverse determination upon a health carrier's completion of a first level review of a grievance. The provisions of applicable state statutes, rules and regulations regarding this examination standard are not intended to be, and should not be considered to be, part of the requirements for the "full and fair review" of claim denials (known as adverse benefit determinations) under Section 503 of ERISA, as specified in the Department of Labor (DOL) final rule. As such, this section is not required to be included in any health carrier's internal claims and appeals process for purposes of complying with the DOL final rule published in the Federal Register, Nov. 21, 2000, or the interim final rules on internal claims and appeals and external review processes published in the Federal Register, July 23, 2010.

Verify that the health carrier has established an additional voluntary grievance review process for its managed care plans to give those covered persons who are dissatisfied with a first level grievance review decision involving an adverse determination, or who are dissatisfied with the standard review of grievances not involving an adverse determination, the option to request an additional voluntary review, at which the covered person, or, if applicable, the covered person's authorized representative, has the right to appear in person at the review meeting before designated representatives of the health carrier.

Verify that a health carrier required by applicable state statutes, rules and regulations to establish a voluntary review process provides covered persons, or, if applicable, the covered person's authorized representatives, with notice, pursuant to applicable state statutes, rules and regulations, of the option to file a request with the health carrier for an additional voluntary review of a first level review decision or a standard review decision.

Verify that, upon receipt of a request for an additional voluntary review, the health carrier sends notice to the covered person, or, if applicable, the covered person's authorized representative, of the covered person's right to:

- Request, within the time frame set forth in applicable state statutes, rules and regulations, the opportunity to appear in person before a review panel of designated representatives of the health carrier;
- Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's, or, if applicable, the covered person's authorized representative's, request for benefits;
- Present the covered person's case to the review panel;
- Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;
- If applicable, ask questions of any representative of the health carrier on the review panel; and
- Be assisted or represented by an individual of the covered person's choice.

Verify that the health carrier has procedures in place to ensure that a covered person's, or, if applicable, the covered person's authorized representative's, right to a fair review is not made conditional on the covered person's, or, if applicable, the covered person's authorized representative's, appearance at the review.

Verify that the health carrier appoints a review panel to review requests for voluntary review of a first level review decision involving an adverse determination.

Verify that the review panel appointed by the health carrier takes into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person, or, if applicable, the covered person's authorized representative, without regard to whether the information was submitted or considered in reaching the first level review decision.

Verify that the health carrier review panel has the legal authority to bind the health carrier to the panel's decision.

Verify that a majority of the health carrier's review panel is composed of individuals who were not involved in the first level review decision. This provision does not apply to an individual involved with the first level review decision who may be a member of the panel or who may appear before the panel to present information or answer questions.

Verify that the health carrier ensures that a majority of the individuals conducting the additional voluntary review of the first level review decision involving an adverse determination are health care professionals who have appropriate expertise.

Except, when such a reviewing health care professional is not reasonably available, in cases where there has been a denial of a health care service, verify that the health carrier has procedures in place to ensure that the reviewing health care professional:

- Is not a provider in the covered person's health benefit plan; and
- Does not have a financial interest in the outcome of the review.

Verify that the health carrier appoints a review panel to review requests for voluntary review of a standard review decision.

Verify that the health carrier review panel has the legal authority to bind the health carrier to the panel's decision.

Verify that a majority of the health carrier's review panel is composed of employees or representatives of the health carrier who were not involved in the standard review decision. This provision does not apply to an employee or representative of the health carrier who was involved with the standard review decision, who may be a member of the panel or who may appear before the panel to present information or answer questions.

Whenever a covered person, or, if applicable, the covered person's authorized representative, requests, within the time frame specified in applicable state statutes, rules and regulations, the opportunity to appear in person before an appointed review panel, verify that the health carrier's procedures for conducting the review include the provisions set forth in applicable state statutes, rules and regulations.

Verify that the health carrier review panel schedules and holds a review meeting within 45 working days after the date of receipt of the request.

Verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, in writing at least 15 working days in advance of the date of the review meeting.

Verify that the health carrier does not unreasonably deny a request for postponement of the review made by the covered person, or, if applicable, the covered person's authorized representative.

Verify that the health carrier holds review meetings during regular business hours at a location reasonably accessible to the covered person, or, if applicable, the covered person's authorized representative.

In cases where a face-to-face meeting is not practical for geographic reasons, verify that the health carrier offers the covered person, or, if applicable, the covered person's authorized representative, the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology.

If the health carrier desires to have an attorney present to represent the interests of the health carrier, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, at least 15 working days in advance of the date of the review meeting that an attorney will be present and that the covered person, or, if applicable, the covered person's authorized representative, may wish to obtain legal representation of his or her own.

Verify that the health carrier review panel issues a written decision to the covered person, or, if applicable, the covered person's authorized representative, within five working days of completing the review meeting.

Whenever the covered person, or, if applicable, the covered person's authorized representative, does not request the opportunity to appear in person before the review panel within the specified time frame set forth in applicable state statutes, rules and regulations, verify that the health carrier review panel issues a decision and notifies the covered person, or, if applicable, the covered person's authorized representative, of the decision, in writing or electronically, within 45 working days after the earlier of:

- The date the covered person, or, the covered person's authorized representative, notifies the health carrier of the covered person's, or, if applicable, the covered person's authorized representative's, decision not to request the opportunity to appear in person before the review panel; or
- The date on which the covered person's, or, if applicable, the covered person's authorized representative's, opportunity to request to appear in person before the review panel expires pursuant to applicable state statutes, rules and regulations.

Verify that the health carrier calculates the time period, within which a decision is required to be made and notice provided pursuant to applicable state statutes, rules and regulations, to begin on the date the request for an additional voluntary review is filed with the health carrier in accordance with the health carrier's procedures as established pursuant to applicable state statutes, rules and regulations for filing a request, without regard to whether all of the information necessary to make the determination accompanies the filing.

Verify that the health carrier's written decision contains all of the following:

- The titles and qualifying credentials of the members of the review panel;
- A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
- The rationale for the review panel's decision;
- A reference to evidence or documentation considered by the review panel in making that decision;
- In cases concerning a grievance involving an adverse determination:
    - The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and
    - If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75);
- Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time, including the telephone number and address of the insurance commissioner's office.

STANDARDS
GRIEVANCE PROCEDURES

Standard 7
The health carrier has procedures for and conducts expedited reviews of urgent care requests of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers offering a health benefit plan

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of expedited appeals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72), Section 10

Review Procedures and Criteria

Verify that the health carrier has established written procedures for the expedited review of urgent care requests of grievances involving an adverse determination. involving a situation where the time frame of standard grievance procedures:

- Would seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the urgent care request.

Verify that a health carrier also provides expedited review of urgent care requests of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

Verify that the health carrier's procedures allow a covered person, or, if applicable, the covered person's authorized representative, to request an expedited review either orally or in writing.

Verify that the health carrier appoints an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. Verify that a clinical peer or peers are not involved in making the initial adverse determination.

Verify that in an expedited review, the health carrier transmits all necessary information, including the health carrier's decision, between the health carrier and the covered person, or, if applicable, the covered person's authorized representative, by telephone, fax or the most expeditious method available.

In an expedited review, verify that the health carrier makes a decision and notifies the covered person, or, if applicable, the covered person's authorized representative, of the decision in accordance with applicable state statutes, rules and regulations as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the receipt of the request for the expedited review.

If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, verify that the health carrier continues service without liability to the covered person until the covered person, or, if applicable, the covered person's authorized representative, has been notified of the determination.

Verify that the health carrier calculates the time period, within which a decision is required to be made pursuant to applicable state statutes, rules and regulations, to begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to applicable state statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Verify that the health carrier's decision issued pursuant to an expedited review of urgent care requests of a grievance involving an adverse determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- The titles and qualifying credentials of each reviewer participating in the expedited review process (the reviewers);
- A statement of the reviewers' understanding of the covered person's, or, if applicable, the covered person's authorized representative's, grievance;
- The reviewers' decision in clear terms, and the contract basis or medical rationale in sufficient detail for the covered person, or, if applicable, the covered person's authorized representative, to respond further to the health carrier's position;
- A reference to the evidence or documentation used as the basis for the decision; and
- If the decision involves a final adverse determination, the notice shall provide:
    - The specific reason or reasons for the final adverse determination
    - Reference to the specific plan provisions on which the determination is based;
    - A description of any additional materials or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to complete the request, including an explanation of why the material or information is necessary to complete the request;
    - If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
    - If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
    - If applicable, instructions for requesting:
        - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; or
        - The written statement of the scientific or clinical rationale for the adverse determination;
    - A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75);

- A statement indicating the covered person's, or, if applicable, the covered person's authorized representative's, right to bring a civil action in a court of competent jurisdiction;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance commissioner"; and
- A notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office for assistance at any time, including the telephone number and address of the insurance commissioner's office.

Verify that the health carrier provides the notice orally, in writing or electronically.

If notice of the adverse determination is provided orally, verify that the health carrier provides written or electronic notice of the adverse determination within three days following the oral notification.

I. Network Adequacy

1. Purpose

The network adequacy portion of the examination is designed to ensure that companies offering network plans maintain service networks that are sufficient to ensure that all services are accessible without unreasonable delay. The standards require companies to ensure the adequacy, accessibility and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include company access plans and other measures used by the company to analyze network sufficiency, contracts with participating providers and intermediaries, and ongoing oversight and assessment of access issues.

2. Techniques

To evaluate network adequacy standards, it is necessary for examiners to request a statement or map from the insurer that reasonably describes the service area. Additional items for review should include a roster of network providers and facilities. The examiner should determine whether the plan has conducted studies to measure waiting times for appointments and other studies that measure the sufficiency and adequacy of the network. The examiner should also determine how the health plan arranges for covered services that cannot be provided within the network. Examiners should request the health plan's written selection standards for providers. Access plans, where required, should also be obtained. Using the roster of providers and facilities, examiners should request a sample of specific provider contracts. The review of provider contracts should include an evaluation of compliance with filing requirements and adherence to patient protection requirements. In addition to direct contracts with providers and facilities, examiners should review the written guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Also, examiners should obtain verification that accurate provider directories are provided upon enrollment and are updated and dispersed periodically. Another area for review includes grievances related to provider access issues.

3. Tests and Standards

The network adequacy review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider network. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
NETWORK ADEQUACY

Standard 1
The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Selection criteria

_____ Documents related to physician recruitment

_____ Provider directory

_____ Reports of out-of-network service denials

_____ Company policy for in-network/out-of-network coverage levels

_____ Provider/member location reports (e.g., by ZIP code)

_____ List of providers by specialty

_____ Any policies or incentives that restrict access to subsets of network specialists

_____ Computer tools used to assess the network's adequacy; e.g., GeoAccess®

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

- Ratios of providers, both primary care providers and specialty providers, to covered persons;
- Geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of covered persons;
- Waiting times for appointments;

- Hours of operation; and
- Volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

The health carrier shall develop and comply with written policies and procedures specifying when the carrier shall pay for out-of-area and out-of-network services that are required by a covered person and are covered by the network plan pursuant to the covered person's health benefit plan or as required by state laws. In any case where the health carrier is required to cover services, but it has an insufficient number or type of participating providers to provide the covered benefit, the health carrier shall 1) ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers; or 2) make other arrangements acceptable to the insurance commissioner.

The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

A health carrier shall demonstrate that it monitors its providers, provider groups and intermediaries with which it contracts on an ongoing basis to ensure their ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to covered persons. There are standards pertinent to provider licensing in Section J Provider Credentialing in this chapter.

The health carrier shall comply with all applicable state provisions equivalent to the *Health Benefit Plan Network Access and Adequacy Model Act* (#74) and accompanying regulations not expressly covered by any other of these standards.

STANDARDS
NETWORK ADEQUACY

Standard 2
The health carrier files an access plan with the insurance commissioner for each network plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing network plan. The carrier makes the access plans available: 1) on its business premises; 2) to regulators; and 3) to interested parties, absent proprietary information, upon request.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Copy of access plan filed in state and copy in use by company

_____ Member materials referencing access plans

_____ Provider manual

_____ Provider contract

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5F
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The access plan shall describe or contain the following:

- The health carrier's network;
- The health carrier's procedures for making referrals within and outside of its network;
- The health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its network plans;
- The health carrier's efforts to address the needs of covered persons with 1) limited English proficiency and illiteracy; 2) diverse cultural and ethnic backgrounds; and 3) physical and/or mental disabilities;
- The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
- The health carrier's method of informing covered persons of the plan's services and features, including, but not limited to 1) the plan's grievance procedures; 2) its process for choosing and changing providers; and 3) its procedures for providing and approving emergency and specialty care;
- The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals; and

- The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner.

STANDARDS
NETWORK ADEQUACY

Standard 3
The health carrier files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 11
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Determine if the forms and endorsements have been filed.

Review provider contracts to determine if the provider is listed in the directory and determine if credentialing is up-to-date.

STANDARDS
NETWORK ADEQUACY

Standard 4
The health carrier ensures covered persons have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for emergency services outside of its network, pursuant to the appropriate section of state law that corresponds to the *Utilization Review and Benefit Determination Model Act* (#73) and/or the *Health Benefit Plan Network Access and Adequacy Model Act* (#74).

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider manual

_____ Provider contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 5
Utilization Review and Benefit Determination Model Act (#73)
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Within the network, the health carrier shall operate or contract with facilities to provide covered persons with access to emergency services.

The health carrier shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services, if a prudent lay person acting reasonably would have believed that an emergency medical condition existed.

If care is obtained from a non-contracting provider within the service area of the network plan, the health carrier shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services, if a prudent lay person acting reasonably would have believed that the use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider.

STANDARDS
NETWORK ADEQUACY

Standard 5
The health carrier executes written agreements with each participating provider that are in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Sections 6B and 6C
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Every contract between a health carrier and a participating provider or provider group shall contain a "hold harmless" provision specifying protection for covered persons from being billed by providers. The language of the "hold harmless" provision shall be substantially similar to the language of the *Health Benefit Plan Network Access and Network Adequacy Model Act* (#74).

Every contract between a health carrier and a participating provider shall contain provisions ensuring that, in the event of the insolvency of the health carrier or an intermediary, covered services to covered persons will continue through the period for which a premium has been paid or until the covered person's discharge from an inpatient facility, whichever is greater. The language of the contract's provisions shall satisfy the requirements of state provisions equivalent to the *Health Benefit Plan Network Access and Network Adequacy Model Act* (#74).

Standard 6
The health carrier's contracts with intermediaries are in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Intermediary contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 10
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The contract between a health carrier and intermediary shall satisfy the following:

- Intermediaries and participating providers with whom they contract shall comply with all applicable requirements for health carriers and participating providers, as indicated in state provisions equivalent to the *Health Benefit Plan Network Access and Network Adequacy Model Act* (#74) and accompanying regulations;
- A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary;
- A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons;
- A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon 20 days' prior written notice from the health carrier;
- If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons;
- If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them according to applicable statutory duration, in a manner that facilitates regulatory review;
- An intermediary shall allow the insurance commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance; and

- A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Standard 7
The health carrier's arrangements with participating providers comply with applicable statutes, rules and regulations.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider contracts

_____ Provider manuals

_____ Complaints made by providers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 6
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

The health carrier shall develop selection standards for primary care professionals and each health care professional specialty in accordance with applicable state provisions equivalent to Section 6F of the *Health Benefit Plan Network Access and Network Adequacy Model Act* (#74). The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts.

The health carrier shall make its selection standards for participating providers available for review by the insurance commissioner.

The health carrier shall notify participating providers of the provider's responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

The health carrier shall not offer an inducement under the network plan to a provider to provide less than medically necessary services to a covered person.

The health carrier shall not prohibit a participating provider from 1) discussing treatment options with covered persons, regardless of the health carrier's position on the treatment options; or 2) advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

The health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

The health carrier and participating provider shall provide at least 60 days' written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of termination within 15 working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within 5 working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

The health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, and skill or licensing restrictions.

The health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

The health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

The health carrier shall establish a mechanism by which participating providers may determine in a timely manner whether a person is covered by the carrier.

The health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

Standard 8
The health carrier provides at enrollment a provider directory that lists all providers who participate in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

Apply to: Health carriers with network plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider directory and updates

_____ Provider contracts

_____ Credentialing documentation

_____ Internet directory

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 9
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Request information regarding the carrier's frequency of updates to the provider directory.

Review how provider data is maintained. If the provider directory is not produced from the same system(s) that handles the administration functions, determine if the data is maintained consistently between systems.

J. Provider Credentialing

1. Purpose

The provider credentialing portion of the examination is designed to ensure that companies offering managed care plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

The areas to be considered in this kind of review include the company's written credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy and the oversight of any delegated verification functions.

2. Techniques

Prior to reviewing records for specific providers, examiners should request all written credentialing procedures from the company. Examiners should determine the composition of the insurer's credentialing committee. Examiners should use the company's provider directory to select a sample of specific provider credential files, drawing from a variety of provider types and facilities. For each provider selected, the examiner should request:

- The provider application;
- Credentialing verification materials, including materials obtained through primary and secondary sources;
- Updates to credentialing information; and
- Copies of correspondence to providers that relates to the credentialing process.

Examiners should determine how the credentialing committee permits providers to correct information and provide additional information for reconsideration. In the event the credentialing process is subcontracted, examiners should determine whether the contracting entity is following applicable standards.

3. Tests and Standards

The provider credentialing review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider credentialing process. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PROVIDER CREDENTIALING

Standard 1
The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Credentialing plan

_____ Minutes of the credentialing committee

_____ Credentialing plan evaluation reports (if any)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5A
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall establish written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the health carrier contracts and shall apply those standards consistently.

The health carrier shall ensure that the carrier's medical director or other designated health care professional shall have responsibility for, and shall participate in, the health care professional credentialing verification.

The health carrier shall establish a credentialing verification committee, consisting of licensed physicians and other health care professionals, to review credentialing verification information and supporting documents, in order to make decisions regarding credentialing verification.

The health carrier shall make all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.
The health carrier shall keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

The health carrier shall retain all records and documents relating to a health care professional's credentialing verification process for a designated period of time, as determined by the applicable state record retention requirements.

The health carrier shall comply with all applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations not expressly covered by any other of these standards.

STANDARDS
PROVIDER CREDENTIALING

Standard 2
The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Provider directory

_____ Provider credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5A
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Ensure providers are properly credentialed prior to appearing in the provider directory.

STANDARDS
PROVIDER CREDENTIALING

Standard 3
The health carrier obtains primary verification of the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6A
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

- Current [license, certificate of authority or registration] to practice [health care profession] in [insert state] and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable);
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable);
- Graduation from [health care professional] school; and
- Completion of postgraduate training (if applicable).

STANDARDS
PROVIDER CREDENTIALING

Standard 4
The health carrier obtains, through either a primary or secondary credentialing verification process, the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6B
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

- The health care professional's license history in all states;
- The health care professional's malpractice history; and
- The health care professional's practice history.

STANDARDS
PROVIDER CREDENTIALING

Standard 5
The health carrier obtains, at least every 3 years, primary verification of the information required by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Checklist for credentialing

_____ Checklist and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6C
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

- Current [license, certificate of authority or registration] to practice [health care profession] in [insert state];
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable); and
- Specialty board certification status (if applicable).

STANDARDS
PROVIDER CREDENTIALING

Standard 6
The health carrier requires all participating providers to notify the health carrier's designated individual of changes in the status of any information that is required to be verified by the health carrier.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Provider contracts

_____ Credentialing files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6D
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall identify for participating providers the individual to whom they should report changes in the status of information required to be verified by the health carrier.

STANDARDS
PROVIDER CREDENTIALING

Standard 7
The health carrier provides a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Provider manual

_____ Listing of providers (active and terminated)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 7
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall make available to each health care professional that is subject to the credentialing verification process the information, and the source of the information obtained by the health carrier, to satisfy the carrier's credentialing process.

The health carrier shall notify a health care professional of any information obtained during the health carrier's credentialing verification process that does not meet the health carrier's credentialing verification standards, or that varies substantially from the information provided to the health carrier by the health care professional, if the information is required to be verified by applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations, unless such disclosure is prohibited by law.

The health carrier shall allow a health care professional to correct any erroneous information and request a reconsideration of the health care professional's credentialing verification application through a formal process by which the health care professional may submit supplemental or corrected information to the health carrier's credentialing verification committee.

STANDARDS
PROVIDER CREDENTIALING

Standard 8
The health carrier monitors the activities of the entity with which it contracts to perform credentialing functions and ensures the requirements of applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations are met.

Apply to: Health carriers with managed care plans that contract credentialing verification functions to intermediaries

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

_____ Reports of entity reviews and audits (if any) of credentialing activities by health carrier

_____ Minutes of the health carrier's credentialing committee

_____ Minutes of the health carrier's board of directors

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 8
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Whenever a health carrier contracts to have another entity perform credentialing functions, the health carrier shall be responsible for monitoring the activities of the entity with which it contracts and for ensuring that applicable state provisions equivalent to the *Health Care Professional Credentialing Verification Model Act* (#70) and accompanying regulations are met.

K. Quality Assessment and Improvement

1. Purpose

The quality assessment portion of the examination is designed to ensure that companies offering managed care plans have quality assessment programs in place that enable the company to evaluate, maintain and, when required by state law, improve the quality of health care services provided to covered persons. For managed care plans that limit covered persons to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals.

The areas to be considered in this kind of review include the company's written quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with members about the program and oversight of delegated quality-related functions.

2. Techniques

In some jurisdictions, the quality assessment and improvement function may be monitored jointly by the Department of Insurance and the Department of Health (or similar agency). To evaluate quality assessment and improvement activities, examiners should request information relative to the composition of the quality assessment and improvement committee. Determine the frequency of quality assessment and improvement meetings. To obtain an accurate assessment of an insurer's quality assessment and improvement program, it is advisable to review quality assessment and improvement committee meeting minutes for all meetings conducted during the examination period. Ascertain whether the quality assessment program reasonably encompasses all aspects of the covered health care services. Determine whether the insurer has obtained certification from a nationally recognized accreditation entity. Determine which standards will be met by virtue of the certification process. Examiners should evaluate the process by which quality assessment and improvement information and directives are communicated to network providers. Review procedures, such as peer review, for including network providers in the quality assessment and improvement process. Ascertain whether outcome-based goals and objectives are being monitored and met.

3. Tests and Standards

The quality assessment and improvement review includes, but is not limited to, the following standards related to the assessment and improvement activities conducted by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 1
The health carrier develops and maintains a quality assessment program in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment policies and procedures

_____ Quality assessment plan (if any)

_____ Minutes of the health carrier's quality assessment committee

_____ Minutes of the health carrier's board of directors

_____ Evaluations of the quality assessment program

_____ Job descriptions for the chief medical officer or clinical director

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Sections 5 and 7
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall develop a quality assessment program and procedures to ensure effective corporate oversight of this program.

The health carrier shall develop and maintain the infrastructure and disclosure systems necessary to measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier.

The health carrier shall establish a system designed to assess the quality of health care provided to covered persons. The system shall include systematic collection, analysis and reporting of relevant data, in accordance with statutory and regulatory requirements.

The health carrier shall communicate findings in a timely manner to applicable regulatory agencies, providers and consumers, as provided by applicable statutes, rules and regulations.

The health carrier shall appoint a chief medical officer or clinical director to have primary responsibility for the quality assessment activities carried out by, or on behalf of, the health carrier.

The chief medical officer or clinical director shall approve the written quality assessment program and shall periodically review and revise the program document and act to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director shall review reports of quality assessment activities.

The health carrier shall have an appropriate written policy to ensure the confidentiality of a covered person's health information used in the carrier's quality assessment programs.

The health carrier shall comply with all applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 2
The health carrier files a written description of the quality assessment program with the insurance commissioner in the prescribed format, which shall include a signed certification by a corporate officer of the health carrier that the filing meets applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written description of the quality assessment program

_____ Signed certification by a corporate officer

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5D
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Determine if the forms have been filed.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 3
The health carrier develops and maintains a quality improvement program, in compliance with applicable statutes, rules and regulations.

Apply to: All health carriers with closed plans or a combination plan with a closed component

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality improvement policies and procedures

_____ Quality improvement plan

_____ Minutes of the health carrier's quality improvement committee

_____ Minutes of the health carrier's board of directors

_____ Evaluations of the quality improvement program

_____ Job descriptions for the chief medical officer or clinical director

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Sections 6 and 7
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall develop a quality improvement program and procedures to ensure effective corporate oversight of this program.

The health carrier shall develop and maintain an organizational program for designing, measuring, assessing and improving the processes and outcomes of health care as identified in the health carrier's quality improvement program, in accordance with applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations.

The health carrier shall develop a written quality improvement plan. The written plan should include:

- A statement of the objectives, lines of authority and accountability, evaluation tools, data collection responsibilities, performance improvement activities and annual effectiveness review of the program;
- Intent to analyze processes and outcomes of care to discern the causes of variation;
- Identification of the targeted diagnoses and treatments to be reviewed each year;

- Methods to analyze quality, including collection and analysis of information on:
    - Over- or under-utilization of services;
    - Evaluation of courses of treatment and outcome of care; and
    - Collection and analysis of information specific to a covered person(s) or provider(s) gathered from multiple sources, and documentation of both the satisfaction and grievances of the covered person(s);
- A method to compare program findings with past performance, internal goals and external standards;
- Methods for:
    - Measuring the performance of participating providers and conducting peer review activities to identify practices that do not meet health carrier's standards, and taking action to correct deficiencies; and
    - Monitoring participating providers to determine whether they have implemented corrective action, and taking appropriate action when they have not;
- A plan to utilize treatment protocols and practice parameters developed with clinical input and using evaluations described above or acquired treatment protocols and providing participating providers with sufficient information about the protocols to meet the standards; and
- Evaluating access to care for covered persons according to the state's standards and a strategy for integrating public health goals with services offered under the managed care plans, including a description of good faith efforts to communicate with public health agencies.

The health carrier shall establish an internal system to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns and foster an environment of continuous quality improvement.

The health carrier shall ensure that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system.

The health carrier shall provide covered persons the opportunity to comment on the quality improvement process.

The health carrier shall use the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the health care delivered to covered persons.

The health carrier shall appoint a chief medical officer or clinical director to have primary responsibility for the quality improvement activities carried out by, or on behalf of, the health carrier.

The chief medical officer or clinical director shall approve the written quality improvement program, periodically review and revise the program document and act to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director shall review reports of quality assessment activities.

The health carrier shall have an appropriate written policy to ensure the confidentiality of a covered person's health information used in the health carrier's quality improvement programs.

The health carrier shall comply with all applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 4
The health carrier reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Reports made to the licensing authority

_____ Terminated and suspended provider contract files

_____ Quality of care complaints

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

Ascertain whether applicable terminated and suspended contract files reflect compliance with reporting requirements. Examiners should note that some terminated and suspended contracts will involve issues that are not necessary to report.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 5
The health carrier documents and communicates information about its quality assessment program and its quality improvement program to covered persons and providers.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Member materials (e.g., member newsletters, advertisements, etc.)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall include a summary of its quality assessment and quality improvement programs in marketing materials.

The health carrier shall include a description of its quality assessment and quality improvement programs and a statement of patient rights and responsibilities with respect to those programs in the certificate of coverage or handbook provided to newly enrolled covered persons.

The health carrier shall make available annually to providers and covered persons findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions may have affected the findings.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 6
The health carrier annually certifies to the insurance commissioner that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, meets applicable statutes, rules and regulations.

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certification filings

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier shall make the certified materials available for review by the public upon request, subject to a reasonable fee (except for those materials subject to confidentiality requirements and materials that are proprietary to the health plan).

The health carrier shall retain all certified materials for at least 3 years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 7
The health carrier monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable state provisions equivalent to the *Quality Assessment and Improvement Model Act* (#71) and accompanying regulations are met.

Apply to: All health carriers with managed care plans that contract to have another entity perform quality assessment or quality improvement activities

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Quality assessment and improvement policies and procedures

_____ Contracts with entities

_____ Reports of entity reviews and audits (if any) by health carrier

_____ Periodic reports from the entity

_____ Minutes from the health carrier's board of directors

_____ Minutes from the health carrier's quality assessment committee and quality improvement committee

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 10
Health Maintenance Organization Model Act (#430)

Review Procedures and Criteria

The health carrier has established, implemented and enforces a policy to address effective methods of accomplishing oversight of each delegated activity.

L. Utilization Review

1. Purpose

The utilization review portion of the examination is designed to verify that companies and their designees that provide or perform utilization review services comply with standards and criteria for the structure and operation of utilization review processes. In the *Utilization Review and Benefit Determination Model Act* (#73), the NAIC defines utilization review as a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

The areas to be considered in this kind of review include the company's written utilization review policies and procedures, annual summary reports, timeliness in making utilization review decisions and handling appeals, communications with members about the program and oversight of delegated utilization review functions.

2. Techniques

The review of utilization review activities should include an overview of the health plan's written utilization review policies, procedures and scripts, in addition to an overview of how utilization review activities are applied to individual cases. Utilization review issues may also surface during the examiners' review of claims, complaints and grievance procedures.

a. Examiners should request a written overview of the insurer's utilization review program. The overview should include the names and positions of individuals responsible for overseeing the program, along with the qualifications of the utilization review director and staff. Examiners may request an interview of appropriate personnel, to supplement information obtained in the written overview. During this process, examiners should also determine how the insurer maintains corporate oversight of the utilization review process. Where applicable, the examiner should obtain copies of any required utilization review licenses or certifications. Review the scope of the utilization review program. Utilization review functions for some specialized services are occasionally delegated to other entities. Examiners should request copies of applicable reports required for regulatory purposes.

b. Examiners should also obtain the program materials and scripts to ascertain the source of guidelines used, how frequently the materials are updated and whether they are supported by reliable sources of data and medical protocol. In addition, obtain standards used by applicable accreditation entities, if any. A review of the time guidelines for responding to utilization review and reconsideration requests should be conducted. An evaluation of the methods used to communicate utilization review decisions to medical providers, subscribers and other applicable divisions within the company should be completed.

c. Evaluate the availability of, and access to, the utilization review program to plan members or subscribers. Review adequacy of staffing and hours of operation.

d. Ascertain whether utilization review requirements are consistent with and supported by language in the policy, certificate of coverage and marketing materials.

e. Obtain listings of utilization review approvals or certifications, denials and requests for reconsideration. Use sampling techniques to review specific cases. Evaluate handling for adherence to written guidelines and standards.

3. Tests and Standards

The utilization review assessment includes, but is not limited to, the following standards related to the performance of utilization review activities by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UTILIZATION REVIEW

Standard 1
The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations, including those related to mandated benefits and services

_____ Utilization review policies and procedures

_____ Utilization review program or plan documentation

_____ Medical criteria used to make utilization review determinations

_____ Job description of the staff position functionally responsible for day-to-day management

_____ Minutes of the health carrier's board of directors

_____ Minutes of the health carrier's utilization review committee

_____ Documentation of clinical staff credentialing maintenance and education requirements

_____ Program assessment reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Sections 5, 7 & 12

Review Procedures and Criteria

Verify that the health carrier implements procedures to ensure effective corporate oversight of its utilization review program.

Verify that a health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review, implements a written utilization review program that describes all review activities, both delegated and nondelegated for:

- The filing of benefit requests;
- The notification of utilization review and benefit determinations; and
- The review of adverse determinations in accordance with applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

Verify that the health carrier's written utilization review program document describes all of the following:

- Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;
- Data sources and clinical review criteria used in decision-making;
- Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
- Data collection processes and analytical methods used in assessing utilization of health care services;
- Provisions for ensuring confidentiality of clinical and proprietary information;
- The organizational structure (e.g., utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the health carrier's governing body; and
- The staff position functionally responsible for day-to-day program management.

Verify that the health carrier ensures that appropriate personnel have operational responsibility for conducting the carrier's utilization review program.

The health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

The health carrier shall comply with all applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and accompanying regulations not expressly covered by any other of these standards.

Standard 2
The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 8

Review Procedures and Criteria

Verify that the health carrier's utilization review program uses documented clinical review criteria that are based on sound clinical evidence and evaluated periodically to assure ongoing efficacy.

Note: The health carrier may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

Verify that the health carrier makes its clinical review criteria available upon request to authorized government agencies.

Verify that the health carrier ensures that qualified health care professionals administer the utilization review program and oversee review decisions. Verify that the health carrier has appointed clinical peers to evaluate the clinical appropriateness of adverse determinations.

Verify that the health carrier issues utilization review decisions and benefit determinations in a timely and efficient manner pursuant to the requirements set forth in applicable state statutes, rules and regulations.

Verify that the health carrier has a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

Verify that the health carrier conducts routine assessments of the effectiveness and efficiency of its utilization review program.

Verify that the health carrier's data systems are sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

If a health carrier delegates any utilization review activities to a utilization review organization, verify that the health carrier maintains adequate oversight, to include all of the following:

- A written description of the utilization review organization's activities and responsibilities, including reporting requirements;
- Evidence of formal approval of the utilization review organization program by the health carrier; and
- A process by which the health carrier evaluates the performance of the utilization review organization.

Verify that the health carrier coordinates its utilization review program activities with other medical management activity conducted by the health carrier—such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, claims adjudication, processes for assessing member satisfaction and risk management.

Verify that the health carrier provides covered persons, or, if applicable, the covered person's authorized representatives and participating providers with access to its utilization review staff via a toll-free number or collect call telephone line.

Verify that the health carrier, when conducting utilization review, collects only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

Standard 3
The health carrier discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Member materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 13

Review Procedures and Criteria

Verify that the health carrier provides a clear and accurate summary of its utilization review and benefit determination procedures to prospective covered persons, or, if applicable, to the covered person's authorized representative.

Verify that the health carrier provides a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons, or, if applicable, the covered person's authorized representative, with respect to those procedures, in the certificate of coverage or member handbook provided to covered persons.

Verify that the health carrier prints on its membership cards a toll-free telephone number to call for utilization review and benefit determination decisions.

Standard 4
The health carrier makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify that all levels of authorized, appealed and disapproved requests are reviewed)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 9

Review Procedures and Criteria

Verify that the health carrier maintains written procedures, pursuant to applicable state statutes, rules and regulations, for making standard utilization review and benefit determinations on requests submitted to the health carrier by the covered person, or, if applicable, the covered person's authorized representative, for benefits and for notifying the covered person, and, if applicable, the covered person's authorized representative, of its determinations with respect to these requests within the specified time frames required pursuant to applicable state statutes, rules and regulations.

For prospective review determinations, verify that the health carrier makes the determination and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than 15 days after the date the health carrier receives the request.

Whenever the determination is an adverse determination, verify that the health carrier makes the notification of the adverse determination in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination.

Verify that if the health carrier extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to 15 days pursuant to applicable state statutes, rules and regulations, the health carrier has:

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 15-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the health carrier issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least 45 days from the date of receipt of the notice to provide the specified information.

Whenever the health carrier receives a prospective review request from a covered person, or, if applicable, the covered person's authorized representative, that fails to meet the health carrier's filing procedures, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of this failure and provides in the notice information on the proper procedures to be followed for filing a request.

Verify that the notice referenced in the previous paragraph is provided by the health carrier as soon as possible, but in no event later than five days following the date of the failure.

Verify that the health carrier provides the notice orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing.

Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to meet the health carrier's filing procedures apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.

For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments, examiners need to be aware that:

- Any reduction or termination by the health carrier during the course of treatment before the end of the period or number of treatments, other than by health benefit plan amendment or termination of the health benefit plan, constitutes an adverse determination; and
- The health carrier shall notify the covered person, or, applicable, the covered person's authorized representative, of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination at a time sufficiently in advance of the reduction or termination to allow the covered person, or, if applicable, the covered person's authorized representative, to file a grievance to:
    - Request a review of the adverse determination pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72); and
    - Obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

Verify that the health care service or treatment that is the subject of the adverse determination is continued by the health carrier without liability to the covered person with respect to the internal review request made pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

For retrospective review determinations, verify that the health carrier makes the determination within a reasonable period of time, but in no event later than 30 working days after the date of receiving the benefit request.

If the retrospective review determination is an adverse determination, verify that the health carrier provides notice of the adverse determination to the covered person, or, if applicable, the covered person's authorized representative, in accordance with applicable state statutes regarding procedures for standard utilization review and benefit determination.

Verify that if the health carrier extends the time period for making a determination and notifying the covered person, or, if applicable, the covered person's authorized representative, of the determination one time for up to 15 days pursuant to applicable state statutes, rules and regulations, the health carrier has:

- Determined that the extension was necessary due to matters beyond the health carrier's control; and
- Notified the covered person, or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30 day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension referenced above is necessary due to the failure of the covered person, or, if applicable, the covered person's authorized representative, to submit information necessary to reach a determination on the request, verify that the health carrier issues a notice of extension that:

- Specifically describes the required information necessary to complete the request; and
- Gives the covered person, or, if applicable, the covered person's authorized representative, at least 45 days from the date of receipt of the notice to provide the specified information.

Verify that the health carrier calculates the time periods, within which a prospective or retrospective determination is required to be made pursuant to applicable state statutes, rules and regulations, to begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to applicable state statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

If the time period for making a prospective or retrospective determination is extended due to the covered person's, or, if applicable, the covered person's authorized representative's, failure to submit the information necessary to make the determination, verify that the health carrier calculates the time period for making the determination to begin on the date on which the health carrier sends the notification of the extension to the covered person, or, if applicable, the covered person's authorized representative, until the earlier of:

- The date on which the covered person, or, if applicable, the covered person's authorized representative, responds to the request for additional information; or
- The date on which the specified information was to have been submitted.

Unless the state has a specific exemption because of an alternative law, HIPAA requires that all group health plans, insurance companies and HMOs offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum of 48 hours for a normal vaginal delivery and 96 hours for a cesarean section. (Coverage is required for both the mother and the newborn.) Deductibles, coinsurance and other cost-sharing methods may be applied.

Verify that the company does not engage in incentive arrangements to circumvent the requirements of the law. Such incentive requirements could include: making monetary payments or rebates to mothers to encourage them to accept a shorter length of stay; penalizing or reducing or limiting reimbursement of an attending provider because they provided care to an individual for the above minimum time frames; or providing incentives to induce a provider to provide care in a manner inconsistent with the law.

Standard 5
The health carrier provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Utilization review files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 9F

Review Procedures and Criteria

Verify that the health carrier issues notification of an adverse determination, in a manner calculated to be understood by the covered person, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
- A description of the health carrier's grievance procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative, upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;

- A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination;
- The written statement of the scientific or clinical rationale for the adverse determination; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the health carrier provides the notice in writing or electronically.

Standard 6
The health carrier conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations.

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Form letters

_____ Utilization review files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Section 10

Review Procedures and Criteria

Verify that the health carrier has established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons, or, if applicable, their authorized representatives, and for making and notifying the covered person, or, if applicable, the covered person's authorized representative, of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

Verify that the health carrier, in the case of a failure by a covered person, or, if applicable, the covered person's authorized representative, to follow the health carrier's procedures for filing an urgent care request, notifies the covered person, or, if applicable, the covered person's authorized representative, of the failure and the proper procedures to be followed for filing the request.

Verify that the health carrier's notice regarding a covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request:

- Is provided to the covered person, or, if applicable, the covered person's authorized representative, as appropriate, as soon as possible, but not later than 24 hours after receipt of the request; and
- May be oral, unless the covered person, or, if applicable, the covered person's authorized representative, requests the notice in writing.

Note: The provisions regarding the covered person's, or, if applicable, the covered person's authorized representative's, failure to follow the health carrier's procedures for filing an urgent care request apply only in the case of a failure that:

- Is a communication by a covered person, or, if applicable, the covered person's authorized representative, that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
- Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.

For an urgent care request, unless the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than 72 hours after the receipt of the request by the health carrier.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

If the covered person, or, if applicable, the covered person's authorized representative, has failed to provide sufficient information for the health carrier to make a determination, verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, either orally or, if requested by the covered person, or, if applicable, the covered person's authorized representative, in writing of this failure and states what specific information is needed as soon as possible, but in no event later than 24 hours after receipt of the request.

Verify that the health carrier provides the covered person, or, if applicable, the covered person's authorized representative, a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than 48 hours after notifying the covered person, or, if applicable, the covered person's authorized representative, of the failure to submit sufficient information, pursuant to applicable state statutes, rules and regulations.

Verify that the health carrier notifies the covered person, or, if applicable, the covered person's authorized representative, of its determination with respect to the urgent care request as soon as possible, but in no event more than 48 hours after the earlier of:

- The health carrier's receipt of the requested specified information; or
- The end of the period provided for the covered person, or, if applicable, the covered person's authorized representative, to submit the requested specified information.

If the health carrier's determination is an adverse determination, verify that the health carrier provides notice of the adverse determination accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

For concurrent review urgent care requests involving a request by the covered person, or, if applicable, the covered person's authorized representative, to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, verify that the health carrier makes a determination with respect to the request and notifies the covered person, or, if applicable, the covered person's authorized representative, of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than 24 hours after the health carrier's receipt of the request.

If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination.

Verify that the health carrier calculates the time period within which a determination is required to be made pursuant to applicable state statutes, rules and regulations, to begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to applicable state statutes, rules and regulations for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Verify that the health carrier's notification of an adverse determination pursuant to an expedited utilization review and benefit determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the covered person, or, if applicable, the covered person's authorized representative, to complete the request, including an explanation of why the material or information is necessary to complete the request;
- A description of the health carrier's internal review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures;
- A description of the health carrier's expedited review procedures established pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
- If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person, or, if applicable, the covered person's authorized representative upon request;
- If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person, or, if applicable, the covered person's authorized representative, free of charge upon request;
- If applicable, instructions for requesting:
    - A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as set forth in applicable state statutes, rules and regulations; or
    - The written statement of the scientific or clinical rationale for the adverse determination, as set forth in applicable state statutes, rules and regulations; and
- A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office.

Verify that the health carrier provides the notice orally, in writing or electronically.

If the health carrier provides the notice of adverse determination orally, verify that the health carrier also provides written or electronic notice of the adverse determination within three days following the oral notification.

Standard 7
The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and accompanying regulations.

Apply to: Health carriers offering a health benefit plan contracting out utilization review services

Priority: Essential

Documents to Be Reviewed

_____ Applicable statutes, rules and regulations

_____ Utilization review policies and procedures

_____ Contracts with organizations or entities

_____ Reports of entity reviews and audits (if any) by health carrier

_____ Periodic reports from the organization or entity

_____ Minutes of the health carrier's board of directors

_____ Minutes of the health carrier's utilization review committee

_____ Policies and procedures for oversight

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73), Sections 6 & 12

Review Procedures and Criteria

Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by the *Utilization Review and Benefit Determination Model Act* (#73) or applicable state statutes, rules and regulations, the health carrier is responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of the *Utilization Review and Benefit Determination Model Act* (#73) and applicable state statutes, rules and regulations are met.

Verify that the health carrier has policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state and federal laws establishing confidentiality and reporting requirements.

The health carrier shall annually certify in writing to the commissioner that the utilization review program of its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

M. External Review

Use the standards set forth below.

STANDARDS
EXTERNAL REVIEW

Standard 1
Companies covered under the *Health Carrier External Review Model Act* (#75) will be in compliance with the following procedures and criteria, as well as with other applicable statutes, rules and regulations.

Apply to: Health insurance carriers under the *Health Carrier External Review Model Ac*t (#75)

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75), Section 4
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

The health carrier shall notify covered persons in writing of the right to request an external review and shall:

- Include in the notice what circumstances constitute sufficient grounds for a standard, expedited or experimental/investigational review, and what procedures must be followed to request a review;
- Include an authorization form that allows the health carrier to disclose protected health information;
- Pay the cost of the independent review to the organization conducting the external review; and
- Include the telephone number and address of the insurance commissioner.

The health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, an outline of coverage or other evidence of coverage it provides to covered persons.

The health carrier shall maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review. This information must be submitted to the insurance commissioner, at least annually, via a report in a format specified by the insurance commissioner.

Standard 2
In jurisdictions that choose Option 1 or Option 2 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is for a standard, expedited or experimental/investigational review.

Apply to: Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75), Section 4
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria (Option 1, Option 2)

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

External Review Process, Option 1
The external review process resides in the office of the insurance commissioner and requires that covered persons file all requests for external review with the commissioner. This option also provides that the commissioner will conduct a preliminary review of the request for external review to ensure that it meets all of the requirements to be eligible for external review. If the request for external review is determined to be eligible for external review, the commissioner is required to assign an independent review organization to conduct the external review. This option requires the assigned independent review organization to provide the commissioner with a written recommendation on whether to uphold or reverse the adverse determination or final adverse determination. After reviewing the recommendation, the commissioner is required to notify the covered person, if applicable, the covered person's authorized representative and the health carrier of the external review decision.

External Review Process, Option 2
This alternative is the same as Option 1, except the independent review organization assigned to conduct the review makes the determination, if the company's decision is to be reversed.

Standard Review Procedures
Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of a notice of a decision reversing the adverse determination or final adverse determination.

Expedited External Review Procedures
Provide in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization upon receipt of notice that the case has been accepted for an expedited external review.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

Experimental or Investigational Treatment Procedures
Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Provide within 7 days the documents and any information considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of the adverse determination or final adverse determination upon receipt of the notice of a decision reversing the original determination.

STANDARDS
EXTERNAL REVIEW

Standard 3
In states that choose Option 3 under the *Health Carrier External Review Model Act* (#75) for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is a standard, expedited or experimental/investigational review.

Apply to: Health insurance carriers in jurisdictions where the *Health Carrier External Review Model Act* (#75) has been adopted

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Reports on external review requests

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier External Review Model Act (#75)
Health Maintenance Organization Model Act (#430)
Issues Involving External Review Procedures White Paper

Review Procedures and Criteria

The *Health Carrier External Review Model Act* (#75) shall apply to all health carriers that provide or perform utilization review, except for the following:

> "The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis."

External Review Process, Option 3

This option makes it the responsibility of the health carrier to provide for an external review process and requires that covered persons file requests for external review with the health carrier. The health carrier must also assign an independent review organization, from the list of approved independent review organizations compiled by the insurance commissioner, to conduct a preliminary review of the request and conduct an external review of the request, if the request has satisfied specified requirements to be eligible for external review.

Standard Review Procedures

Send a copy of the request for an external review to the insurance commissioner.

Assign an independent review organization, upon receiving a request for an expedited external review, from the list compiled and maintained pursuant to Section 13 of this Act, to determine whether the request meets the reviewability requirements set forth in Section 8B of this Act and conduct the external review, if the request meets the reviewability requirements of Section 8B of this Act.

Provide within 7 days the documents considered in making the adverse determination or the final adverse determination to the assigned independent review organization.

Notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization and the commissioner in writing of its decision upon making the decision to reverse its adverse determination or final adverse determination before a determination by the independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

Expedited External Review

Assign an independent review organization, from the list compiled and maintained pursuant to Section 13 of the Act, to determine whether the request meets the reviewability requirements set forth in the Act and conduct the external review if the request meets the reviewability requirements of the Act; and send a copy of the request to the commissioner.

Send a copy of the request for an external review to the commissioner.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

Expedited Experimental or Investigational Review

Assign an independent review organization from the list of approved independent review organizations to determine whether the request meets the reviewability requirements and, if the request meets those requirements, conduct the review.

Provide or transmit in an expeditious manner all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization.

Standard Experimental or Investigational Review

Send a copy of the request for an external review to the commissioner.

Assign an independent review organization, from the list of approved independent review organizations compiled and maintained by the insurance commissioner pursuant to the Act, to conduct a preliminary review of the request to determine whether:

Note: The independent review organization can deny the request for an external review.

Not choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

Approve the coverage that was the subject of original adverse determination or final adverse determination upon receipt of a notice of a decision reversing the original determination.

N. Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (#40)

Applies to State?	Review Criteria	Pass	Fail	N/A
	This regulation shall apply to individual and group accident and sickness insurance (except Medicare supplement insurance or any other insurance that is covered by a separate state statute) "advertisement," as that term is defined in Section 3B, G, H and I, unless otherwise specified in this regulation. **(Section 2A)**			
	Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All of the insurer's advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are advertised. **(Section 2B)**			
	Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer. **(Section 2C)**			
	All information, exceptions, limitations, reductions and other restrictions required to be disclosed by this regulation shall be set out conspicuously and in close conjunction to the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading. This regulation permits, but is not limited to, the use of either of two methods of disclosure listed in this Section. **(Section 4)**			
	The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Format means the arrangement of the text and the captions. **(Section 5A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Distinctly different advertisements are required for publication in different media, such as newspapers or magazines of general circulation as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this regulation. **(Section 5B)**			
	Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. **(Section 5C)**			
	Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. **(Section 5D)**			
	An insurer shall clearly identify its accident and sickness insurance policy as an insurance policy. A policy trade name shall be followed by the words "insurance policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered. **(Section 5E)**			
	An advertisement that is an invitation to contract[30] shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions. **(Section 7A)**			

[30] An advertisement providing details about specific products and intended to promote consumer purchase of insurance. An advertisement that includes an application is generally considered an invitation to contract. Such an advertisement would be regarded as an offer to contract if it contains some language of commitment or some invitation to take action without further communication.

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertisements of cancelable accident and sickness insurance policies shall state that the contract is cancelable or renewable at the option of the company, as the case may be, in language substantially similar to the following: A policy that is renewable at the option of the insurance company shall be advertised in a manner similar to, "This policy is renewable at the option of the company," "The company has the right to refuse renewal of this policy," "Renewable at the option of the insurer" or "This policy can be cancelled by the company at any time." **(Section 7B)**			
	Advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company shall disclose that the insurer has the right to increase premium rates, if the policy so provides. **(Section 7C)**			
	Qualifying conditions that constitute limitations on the permanent nature of the coverage shall be disclosed in advertisements of insurance policies that are guaranteed renewable, cancelable or renewable at the option of the company. Examples of qualifying conditions are (1) age limits, (2) reservation of a right to increase premiums and (3) the establishment of aggregate limits. (1) Provisions for reduction of benefits at stated ages shall be set forth. For example, a policy may contain a provision that reduces benefits 50 percent after age 60, although it is renewable to age 65. Such a reduction shall be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time shall be set forth. (2) An advertisement for a policy that provides for step-rated premium rates based upon the policy year or the insured's attained age shall disclose the rate increases and the times or ages at which the premiums increase. **(Section 7D)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, directly or through its agents or brokers, shall: (1) Establish marketing procedures to assure that any comparison of policies by its agents or brokers will be fair and accurate; (2) Establish marketing procedures assuring excessive insurance is not sold or issued, except this requirement does not apply to group major medical expense coverage and disability income coverage; and (3) Establish auditable procedures for verifying compliance with this subsection. **(Section 8A)**			
	In addition to the practices prohibited in [insert reference to state law equivalent to the *Unfair Trade Practices Act* (#880)], the following acts and practices are prohibited: (1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or intending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy, or to take out a policy of insurance with another insurer; (2) High Pressure Tactics. Employing a method of marketing that has the effect of inducing the purchase of insurance, or tends to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and (3) Cold Lead Advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. **(Section 8B)**			
	Testimonials and endorsements used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statements contained in it, and the advertisement, including the statement, is subject to all the provisions of this regulation. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained. **(Section 9A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	A person shall be deemed a "spokesperson" if the person making the testimonial or endorsement: (1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise; (2) Has been formed by the insurer, is owned or controlled by the insurer, its employees or the person or persons who own or control the insurer; (3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or (4) Is in any way directly or indirectly compensated for making a testimonial or endorsement. **(Section 9B)**			
	The fact of a financial interest or the proprietary or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equal prominence. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." The requirement of this disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. In the case of television or radio advertising, the required disclosure shall be accomplished in the introductory portion of the advertisement and shall be given prominence. **(Section 9C)**			
	The source of any statistics used in an advertisement shall be identified in the advertisement. **(Section 10C)**			
	When a choice of the amount of benefits is referred to, an advertisement that is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected, and that the premium will vary with the amount of the benefits selected. **(Section 11B)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	When an advertisement that is an invitation to contract refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that the benefits are provided only though a combination of policies. **(Section 11C)**			
	The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement that is an invitation to contract. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device that without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer. **(Section 14A)**			
	Advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used. **(Section 14L)**			
	An agent who makes contact with a consumer, as a result of acquiring that consumer's name from a lead-generating device, shall disclose that fact in the initial contact with the consumer. An agent or insurer may not use names produced from lead-generating devices that do not comply with the requirements of this regulation. **(Section 14M)**			
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in an other state, with a notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised. The file shall be subject to regular and periodical inspection by the commissioner. All of these advertisements shall be maintained in a file for a period of either 4 years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. **(Section 18A)**			
	Certificate of Compliance. Each insurer required to file an annual statement shall file with the commissioner, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer that states that, to the best of the officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of this regulation and the insurance laws of this state as implemented and interpreted by this regulation. **(Section 18B)**			
	An insurer, agent, broker, producer, solicitor or other person shall not solicit a resident of this state for the purchase of accident and sickness insurance in connection with or as the result of the use of advertisement by the person or any other persons, where the advertisement: (1) Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of the person or the true purpose of the advertisement; or (2) Otherwise violates the provisions of this regulation. **(Section 5F)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An insurer, agent, broker, producer, solicitor or other person shall not solicit residents of this state for the purchase of accident and sickness insurance through the use of a true or fictitious name that is deceptive or misleading with regard to the status, character or proprietary or representative capacity of the person or the true purpose of the advertisement. **(Section 5G)**			
	Covered Benefits. (1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited. **(Section 6A)**			
	(2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited. **(Section 6A)**			
	(3) An advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of information or use of words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements. **(Section 6A)**			
	(4) An advertisement shall not contain or use words or phrases such as "all," "full," "complete" "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "the policy will help to replace your income" (when used to express loss of time benefits) or similar words and phrases, in a manner that exaggerates a benefit beyond the terms of the policy. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(5) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholder is prohibited unless, in making the reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility, if an assignment of benefits is made by the policyholder. An advertisement of medical and surgical expense benefits shall comply with this regulation in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you" or other words or phrases of similar import may be used so long as the advertisement indicates that it is payable to the insured or someone designated by the insured. **(Section 6A)**			
	(6)(a) An advertisement for basic hospital expense coverage, basic medical-surgical expense coverage, basic hospital/medical-surgical expense coverage, hospital confinement indemnity coverage, accident only coverage, specified disease coverage, specified accident coverage or limited benefit health coverage or for coverage that covers only a certain type of loss is prohibited, if: (i) The advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without also in the same headline, lead-in or caption specifying the applicable daily limits and other internal limits; (ii) The advertisement states a total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit; or (iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim. (b) This paragraph does not apply to individual major medical expense coverage, individual basic medical expense coverage or disability income insurance. **(Section 6A)**			
	(7) Advertisements that emphasize total amounts payable under hospital, medical or surgical accident and sickness insurance coverage or other benefits in a policy, such as benefits for private duty nursing, are prohibited, unless the actual amounts payable per day for the indemnity or benefits are stated. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(8) Advertisements that include examples of benefits payable under a policy shall not use examples in a way that implies that the maximum payable benefit payable under the policy will be paid, when less than maximum benefits are paid in an average claim. **(Section 6A)**			
	(9) When a range of benefit levels is set forth in an advertisement, it shall be clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language that implies that the insured may select the benefit level at the time of filing claims is prohibited. **(Section 6A)**			
	(10) Language in an advertisement that implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is prohibited. **(Section 6A)**			
	(11) Advertisements for policies with premiums that are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low," "low cost," "budget" or use qualifying words of similar import. The use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain is prohibited. **(Section 6A)**			
	(12) Advertisements that state or imply that premiums will not be changed in the future are prohibited, unless the advertised policies expressly provide that the premiums will not be changed in the future. **(Section 6A)**			
	(13) An advertisement for a policy that does not require the premium to accompany the application shall not overemphasize that fact and shall clearly indicate under what circumstances coverage will become effective. **(Section 6A)**			
	(14) An advertisement that exaggerates the effects of statutorily-mandated benefits or required policy provisions or that implies that the provisions are unique to the advertised policy is prohibited. **(Section 6A)**			
	(15) An advertisement that implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough" or is otherwise unusual is prohibited. The addition of a novel method of premium payment to an otherwise common plan of insurance does not render it new. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(16) Language in an advertisement that states or implies that each member under a family contract is covered as to the maximum benefits advertised, where that is not the fact, is prohibited. **(Section 6A)**			
	(17) An advertisement that contains statements such as "anyone can apply" or "anyone can join," other than with respect to a guaranteed-issue policy, for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is prohibited. **(Section 6A)**			
	(18) An advertisement that states or implies immediate coverage of a policy is prohibited, unless administrative procedures exist so that the policy is issued within 15 working days after the insurer receives the completed application. **(Section 6A)**			
	(19) An advertisement that contains statements such as "here is all you do to apply," "simply" or "merely" to refer to the act of applying for a policy that is not a guaranteed- issue policy is prohibited, unless it refers to the fact that the application is subject to acceptance or approval by the insurer. **(Section 6A)**			
	(20) An advertisement of accident and sickness insurance sold by direct response shall not state or imply that because no insurance agent will call and no commissions will be paid to agents that it is a low cost plan, or use other similar words or phrases because the cost of advertising and servicing the policies is a substantial cost in the marketing by direct response. **(Section 6A)**			
	(21) Applications, request forms for additional information and similar related materials are prohibited if they resemble paper currency, bonds, stock certificates, etc., or use any name, service mark, slogan, symbol or device in a manner that implies that the insurer or the policy advertised is connected with a government agency, such as the Social Security Administration or the Department of Health and Human Services. **(Section 6A)**			
	(22) An advertisement that implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is prohibited. **(Section 6A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(23) An advertisement that uses words such as "extra," "special" or "added" to describe a benefit in the policy is prohibited. No advertisement of a benefit for which payment is conditioned upon confinement in a hospital or similar facility shall use words or phrases such as "tax-free," "extra cash," "extra income," "extra pay" or substantially similar words or phrases, because these words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized. **(Section 6A)**			
	(24) An advertisement of a hospital or other similar facility confinement benefit shall not advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement, unless the statements of the monthly or weekly benefit amounts are in juxtaposition with equally prominent statements of the benefit payable on a daily basis. The term "juxtaposition" means side by side or immediately above or below. When the policy contains a limit on the number of days of coverage provided, the limit shall appear in the advertisement. **(Section 6A)**			
	(25) An advertisement of a policy covering only one disease or a list of specified diseases shall not imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact. **(Section 6A)**			
	(26) An advertisement that is an invitation to contract for a specified disease policy that provides lesser benefit amounts for a particular subtype of disease, shall clearly disclose the subtype and its benefits. This provision shall not apply to institutional advertisements.[31] **(Section 6A)**			

[31] An advertisement that is intended to provide general information about an insurer or company that does not include detailed product or policy specific information. Such an advertisement may, for example, be intended to promote company name recognition or to generate good will.

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(27) An advertisement of a specified disease policy providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount for expenses. Instead, the term "charges" or substantially similar language should be used that does not create the misleading impression that there is full coverage for expenses. **(Section 6A)**			
	(28) An advertisement that describes any benefits that vary by age shall disclose that fact. **(Section 6A)**			
	(29) An advertisement that uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, shall disclose that fact. **(Section 6A)**			
	(30) A television, radio, mail or newspaper advertisement or lead-generating device that is designed to produce leads either by use of a coupon, a request to write or to call the company or a subsequent advertisement prior to contact shall include information disclosing that an agent may contact the applicant. **(Section 6A)**			
	(31) Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had his or her eligibility for the insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list. **(Section 6A)**			

Applies to State?	Review Criteria	Pass	Fail	N/A
	(32) An advertisement, including invitations to inquire[32] or invitations to contract, shall not employ devices that are designed to create undue fear or anxiety in the minds of those to whom they are directed. Examples of prohibited devices are: (a) The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents," without reference to the total population from which the statistics are drawn; (b) The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered; (c) The use of phrases such as "the finest kind of treatment," implying that the treatment would be unavailable without insurance; (d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures; (e) The use of images that unduly emphasize automobile accidents, disabled persons or persons confined in beds who are in obvious distress, persons receiving hospital or medical bills or persons being evicted from their homes due to their medical bills; (f) The use of phrases such as "financial disaster," "financial distress," "financial shock" or another phrase implying that financial ruin is likely without insurance is only permissible in an advertisement for major medical expense coverage, individual basic medical expense coverage or disability income coverage, and only if the phrase does not dominate the advertisement; (g) The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and (h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly. **(Section 6A)**			

[32] An advertisement intended to promote inquiries to the insurer or its producers about a specific product or line of products. Such an advertisement would not be intended to induce an express undertaking to contract without further information, comparison or inquiry. Such advertisement may be an invitation to enter into negotiations, which may subsequently result in an offer and acceptance.

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Exceptions, Reductions and Limitations (1) An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating, "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe the policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of the limitations, exceptions and reductions of the policy offered. **(Section 6B)**			
	(2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy. **(Section 6B)**			
	(3) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement that is subject to the requirements of the preceding paragraph shall prominently disclose the existence of the periods. **(Section 6B)**			
	(4) An advertisement shall not use the words "only," "just," "merely," "minimum," "necessary" or similar words or phrases to describe the applicability of any exceptions, reductions, limitations or exclusions such as: "This policy is subject to the following minimum exceptions and reductions." **(Section 6B)**			
	(5) An advertisement that is an invitation to contract that fails to disclose the amount of any deductible or the percentage of any coinsurance factor is prohibited. **(Section 6B)**			
	(6) An advertisement for loss-of-time coverage that is an invitation to contract that sets forth a range of amounts of benefit levels is prohibited unless it also states that eligibility for the benefits is based upon condition of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact. **(Section 6B)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(7) An advertisement that refers to "hospitalization for injury or sickness" omitting the word "covered" when the policy excludes certain sicknesses or injuries, or that refers to "whenever you are hospitalized," "when you go to the hospital" or "while you are confined in the hospital" omitting the phrase "for covered injury or sickness." if the policy excludes certain injuries or sickness, is prohibited. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement, and where the description of sicknesses or injuries not covered is prominently set forth. **(Section 6B)**			
	(8) An advertisement that fails to disclose that the definition of "hospital" does not include certain facilities that provide institutional care such as a nursing home, convalescent home or extended care facility, when the facilities are excluded under the definition of hospital in the policy, is prohibited. **(Section 6B)**			
	(9) The term "confining sickness" shall be explained in an advertisement containing the term. The explanation might be as follows: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete, if the benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime House Confining Sickness Benefits" or "Five-Year House Confining Sickness Benefits" would be permissible. **(Section 6B)**			
	(10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited. **(Section 6B)**			
	(11) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, or other policies providing benefits that are limited in nature, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "This Is A Limited Policy," "This Policy Provides Limited Benefits," "This Is A Cancer Only Policy" or "This Is An Automobile Accident Only Policy." **(Section 6B)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	Preexisting Conditions (1) An advertisement that is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered, if the cause of the loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used. **(Section 6C)**			
	(2) When an accident and sickness insurance policy does not cover losses resulting from preexisting conditions, an advertisement of the policy shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under the policy. This regulation prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required. **(Section 6C)**			
	(3) When an advertisement contains an application form to be completed by the applicant and returned by mail, the application form shall contain a question or statement that reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, the application form shall contain a question or statement substantially as follows: "Do you understand that this policy will not pay benefits during the first [insert number] [years, months] after the issue date for a disease or physical condition that you now have or have had in the past? YES" Or substantially the following statement: "I understand that the policy applied for will not pay benefits for any loss incurred during the first [insert number] [years, months] after the issue date on account of disease or physical condition that I now have or have had in the past." **(Section 6C)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	The disclosure requirements of this regulation shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consists of the payment of union scale wages required by union rules, and if the payment is actually the scale for TV or radio performances. **(Section 9D)**			
	An advertisement shall not state or imply that an insurer or an accident and sickness insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless that is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, the fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed. **(Section 9E)**			
	When a testimonial refers to benefits received under an accident and sickness insurance policy, the specific claim data, including claim number, date of loss and other pertinent information shall be retained by the insurer for inspection for a period of 4 years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible. **(Section 9F)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement relating to the dollar amounts of claims paid, the number of people insured, or similar statistical information relating to an insurer or policy shall not use irrelevant facts, and shall not be used, unless it accurately reflects all of the current and relevant facts. The advertisement shall not imply that the statistics are derived from the policy advertised, unless that is the fact, and when applicable to other policies or plans shall specifically so state. (1) An advertisement shall specifically identify the accident and sickness insurance policy to which statistics relate and where statistics are given that are applicable to a different policy, it shall be stated clearly that the data do not relate to the policy being advertised. (2) An advertisement using statistics that describe an insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, shall be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for accident and sickness insurance that refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible, unless the advertisement clearly indicates the amount paid out for each line of insurance. **(Section 10A)**			
	An advertisement shall not represent or imply that claim settlements by the insurer are "liberal," "generous" or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used. **(Section 10B)**			
	An advertisement that uses the word "plan" without prominently identifying it as an accident and sickness insurance policy is prohibited. **(Section 11A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, shall not disparage competitors, their policies, services or business methods and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements such as "no red tape" or "here is all you do to receive benefits." **(Section 12A)**			
	Advertisements that state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are prohibited, unless the exceptions, reductions or limitations are contained in a substantial majority of the competing coverages. **(Section 12B)**			
	Advertisements that state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are prohibited. **(Section 12C)**			
	An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits. **(Section 13A)**			
	An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed or accredited by any division or agency of this state or the federal government. Terms such as "official" or words of similar import, used to describe any policy or application form are prohibited because of the potential for deceiving or misleading the public. **(Section 13B)**			
	An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal government. Approval of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition. **(Section 13C)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government. **(Section 14B)**			
	Advertisements, envelopes or stationery that employ words, letters, initials, symbols or other devices that are similar to those used in governmental agencies or by other insurers are not permitted, if they may lead the public to believe: (1) That the advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers; (2) That the advertiser is the same, connected with or is endorsed by the governmental agencies or the other insurers. **(Section 14C)**			
	An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description. **(Section 14D)**			
	An advertisement in the form of envelopes or stationery of any kind may not use any name, service mark, slogan, symbol or any device in a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration. **(Section 14E)**			
	An advertisement may not incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating it from Medicare. The advertisement, however, shall not use the phrase "[…] Medicare Department of the […] Insurance Company" or language of similar import. **(Section 14F)**			
	An advertisement may not imply that the reader may lose a right or privilege or benefit under federal, state or local law if he or she fails to respond to the advertisement. **(Section 14G)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	The use of letters, initials or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited, unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letters, initials or symbols of the corporate name or trademark. **(Section 14H)**			
	The use of the name of an agency or "[ ] Underwriters" or "[ ] Plan" in type, size and location, so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer, is prohibited. **(Section 14I)**			
	The use of an address so as to mislead or deceive as to the true identity of the insurer, its location or licensing status is prohibited. **(Section 14J)**			
	An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser. **(Section 14K)**			
	An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as members, enjoy special rates or underwriting privileges, unless that is the fact. **(Section 15A)**			
	This regulation prohibits the solicitations of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates. **(Section 15B)**			
	Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited. **(Section 15C)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct applications required need not be on separate documents or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly, it is prohibited to use terms such as "enroll" or "join" to imply group or blanket insurance coverage, when that is not the fact. **(Section 15D)**			
	Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact. **(Section 15E)**			
	(1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited" or similar words or phrases when the insurer uses the enrollment periods as the usual method of marketing accident and sickness insurance. **(Section 16A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state, unless there has been a lapse of not less than [insert number] months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This regulation applies to all advertising media, i.e., mail, newspapers, the Internet, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the insurance code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. **(Section 16A)**			
	(3) This regulation prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless that is the fact. **(Section 16A)**			
	The phrase "a particular insurance product" in Paragraph (2) of this subsection means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods. **(Section 16A)**			

Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	B. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. **(Section 16B)**			
	C. Special awards, such as a "safe driver's award," shall not be used in connection with advertisements of accident and sickness insurance. **(Section 16C)**			
	An advertisement shall not contain statements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system, unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations. **(Section 17)**			

Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

Introduction
The intent of Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies that are intended to serve as Qualified Health Plans (QHPs) as defined by the Affordable Care Act (ACA). In its current form, Chapter 24A is not intended to fully provide guidance on which standards are applicable to Minimum Essential Coverage (MEC) policies that are not designated as QHPs. Where possible, reference to the applicability of the standards to MEC policies has been included.

The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health plans that may or may not include MEC, as defined by the ACA, whereas Chapter 24A applies only to QHPs; NAIC models related to the ACA are set forth separately under each examination standard in Chapter 24A. When developing an examination or review plan related to MEC or ACA compliance, it is important to consider examination standards as applicable from both Chapter 24 and Chapter 24A. In the event of duplication or conflict of examination standards between the chapters, the examination standards and review criteria located in Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination will generally take precedence for QHP and ACA-related compliance, barring applicable state or federal laws to the contrary.

Regardless of which chapter is used in the *Market Regulation Handbook,* the examiner will also need to reference Chapter 20—General Examination Standards for general examination standards that apply to all insurers.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group and large group insurance markets. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace. Examination standards continue to be developed for the health reform-related requirements that became effective Jan. 1, 2014.

Examination Standards
States are developing examination standards for the immediate mandates of health reform. Since the immediate mandates are new to the marketplace and regulators, each examination standard includes introductory language setting forth the appropriate health reform provision title, citation, effective date, summary of the provision, background and cross-references to FAQs. The introductory language is followed by the examination standards for the health reform mandate formatted for the *Market Regulation Handbook.*

Examination Checklist
Once the examination standards are finalized, the standards will be placed into an examination checklist for use by state insurance regulators and health carriers. The examination checklist will serve as a uniform tool through which states and health carriers can measure compliance.

Additional Data Collection
As the examination standards and checklist are developed, additional data may need to be collected for monitoring and oversight of the marketplace.

Collaboration Methodology
The final component of state market conduct compliance tools for health reform is enhanced state collaboration, which would provide consistent interpretation and review of the health reform standards.

Health Reform Complaint Codes and Complaint Code Definitions
At the NAIC 2014 Spring National Meeting, the NAIC adopted complaint codes and complaint code definitions related to the ACA to be added to the NAIC Complaints Database System (CDS). Recognizing jurisdictions have varying policy directions regarding the enforcement of the ACA, the purpose of the adopted health reform complaint coding is to provide a uniform manner, regardless of the mechanism of administration of the ACA in each state, for jurisdictions to classify, process and track consumer complaints relating to the health reform mandates of the ACA.

The health reform complaint codes and definitions are provided as reference documents to the *Market Regulation Handbook*, and regulators may access these documents via myNAIC at **StateNet** >> **Market Regulation Handbook, Handbook Updates and Reference Documents** >> **Market Regulation Handbook Reference Documents**. The NAIC Standard Complaint Data Form as well as the CDS Definitions and Basics Manual on StateNet were also updated to include the adopted health reform complaint codes and their corresponding definitions.

For non-regulators, the health reform complaint codes and complaint code definitions are available on the NAIC Account Manager web page at *https://www.naic.org/account_manager.htm*.

Health Reform Survey, Health Reform Standardized Data Request and Corresponding Standardized Data Request Definitions
The NAIC adopted a health reform survey, health reform standardized data request and corresponding standardized data request definitions at the NAIC 2015 Spring National Meeting. The survey, standardized data request and the corresponding definitions were developed to assist states in gathering the data needed to monitor regulated entity compliance with the provisions of the ACA**.**

The NAIC health reform survey, standardized data request and standardized data request definitions are provided as reference documents to the *Market Regulation Handbook*; regulators may access these documents via myNAIC at **StateNet** >> **Market Regulation Handbook, Handbook Updates and Reference Documents** >> **Market Regulation Handbook Reference Documents** >> **Standardized Data Requests**.

Non-regulators may access the health reform survey, health reform standardized data request and corresponding standardized data request definitions on the NAIC Account Manager web page at *https://www.naic.org/account_manager.htm*.

ACA-RELATED MARKET CONDUCT EXAMINATION STANDARDS

ACA Provision	PHSA Citation
(Coverage for Individuals Participating in Approved) Clinical Trials	PHSA §2709
(Extension of) Dependent Coverage to Age 26	PHSA §2714
Direct Access to Providers	PHSA §2719A
Essential Health Benefits	PHSA §2707 & §1302
(Prohibition on) Excessive Waiting Periods	PHSA §2708
Grievance Procedures	PHSA §2719
Guaranteed Availability of Coverage	PHSA §2702
Guaranteed Renewability of Coverage	PHSA §2703
Lifetime/Annual Benefit Limits	PHSA §2711
Network Adequacy	PHSA §2702
(Prohibition on) Preexisting Condition Exclusions	PHSA §2704 & §1255
Preventive Health Services	PHSA §2713
Rescissions	PHSA §2712
Summary of Benefits and Coverage (SBC) and Uniform Glossary	PHSA §2715
Utilization Review	PHSA §2719

PROVISION TITLE: ***Coverage for Individuals Participating in Approved Clinical Trials***

CITATION: PHSA §2709

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth requirements that if a group health plan or health carrier provides coverage to a "qualified individual," then the plan or health carrier:

- May not deny the individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; or
- May not discriminate against the individual on the basis of the individual's participation in such trial.

BACKGROUND: Regulations and associated FAQs issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that if a group health plan or health insurance issuer in the group and individual health insurance market provides coverage to a qualified individual (as defined under PHSA §2709(b)), then such plan or issuer: 1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; 2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and 3) may not discriminate against the individual on the basis of the individual's participation in the trial.

A qualified individual under PHSA §2709(b) is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: 1) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate; or 2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

Standard 1
A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials.

Apply to: All group health products (non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

Priority: Essential

Documents to be Reviewed

_____ Health carrier claim handling policies and procedures related to individuals participating in approved clinical trials

_____ Claim files and supporting documentation regarding coverage of individuals participating in approved clinical trials, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning coverage denial or restriction of coverage of individuals participating in approved clinical trials (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claim files

_____ Health carrier prior authorization policies

_____ Internal appeals/grievances files

_____ Applicable external appeals related to individuals participating in approved clinical trials, external appeal resolution and associated documentation

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to coverage of individuals participating in approved clinical trials

_____ Health carrier communication and educational materials related to coverage of individuals participating in approved clinical trials, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials in accordance with statute and regulatory guidance established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to coverage of individuals participating in clinical trials to verify adequate and appropriate policies/procedures are in place to ensure the health carrier does not deny or impose restrictions on coverage for qualified individuals participating in approved clinical trials in compliance with statute and regulatory guidance established by HHS, the DOL and the Treasury.

Review health carrier claim files to verify the health carrier does not:

- Deny participation by a qualified individual in an approved clinical trial;
- Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in a trial; or
- Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

Note: Examiners need to be aware that a network plan may require a qualified individual who wishes to participate in an approved clinical trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

This provision applies to any qualified individual who participates in an approved clinical trial that is conducted outside of the state in which the individual resides.

A health carrier is not required to offer individual market or small group market health insurance coverage through a network plan to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction of coverage imposed upon individuals participating in approved clinical trials.

Review complaint records to verify that when a health carrier has inappropriately restricted or denied coverage for a qualified individual who participated in an approved clinical trial, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage for participation in an approved clinical trial was inappropriately restricted or denied.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage of participation in an approved clinical trial was inappropriately restricted or denied.

Review prior authorization policies to verify that insurers are not inappropriately denying or restricting coverage for qualified individuals participating in approved clinical trials.

Review health carrier internal appeals/grievance files to identify any coverage denials for individuals for whom coverage of participation in an approved clinical trial was inappropriately restricted or denied.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing coverage of participation in approved clinical trials.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about coverage for individuals participating in approved clinical trials.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about coverage for individuals participating in approved clinical trials.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and statute and regulatory guidance pertaining to coverage for individuals participating in approved clinical trials.

Review health carrier training materials to verify that information provided is complete and accurate with regard to coverage for individuals participating in approved clinical trials.

Determine if the health carrier monitors producer-generated coverage denials/restrictions of coverage pertaining to qualified individuals participating in approved clinical trials. Review any such producer records of coverage denials/restrictions of coverage for compliance with statute and regulatory guidance established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Extension of Dependent Coverage to Age 26***

CITATION: PHSA §2714

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier that makes available dependent coverage of children must make that coverage available for children until attainment of 26 years of age.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that group health plans and health carriers offering dependent coverage must make that coverage available until a child reaches the age of 26. This is the case even if a young adult no longer lives with his or her parents, is not a dependent on a parent's tax return or is no longer a student. These provisions apply to both married and unmarried children; affected children's spouses and children do not qualify for this coverage extension.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to both grandfathered and non-grandfathered group health plans.

DENTAL & VISION PLANS: The extension of dependent coverage to age 26 provision applies to medical, behavioral and pharmacy benefits. The provision does not apply to employer-sponsored dental or vision benefits if they are in a separate dental or vision policy. If the dental or vision plan is not a separate plan, but part of the employer-sponsored medical plan, the health reform provisions apply to the entire plan, including the dental and vision coverage.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
EXTENSION OF DEPENDENT COVERAGE TO AGE 26

Standard 1
A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to extension of dependent coverage for individuals to age of 26

_____ Underwriting files and supporting documentation regarding extension of dependent coverage for individuals to age of 26, including letters, notices, telephone scripts, etc.

_____ Health carrier notices issued addressing opportunity to enroll in dependent coverage to age 26

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning extension of dependent coverage for individuals to age of 26 (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claim files

_____ Internal appeals/grievances

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to extension of dependent coverage for individuals to age of 26

_____ Health carrier communication and educational materials related to extension of dependent coverage for individuals to age of 26, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding extension of dependent coverage for individuals to age 26 in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to extension of dependent coverage for individuals to age 26 to verify adequate and appropriate policies/procedures are in place to ensure the health carrier extends dependent coverage for individuals to age 26 in compliance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures regarding extension of dependent coverage for individuals to age 26 to verify the health carrier does not define dependent, for the purposes of eligibility for dependent coverage of children, other than in the terms of a relationship between a child and the plan participant, and in the individual market, a primary subscriber.

Review health carrier underwriting and claim files regarding extension of dependent coverage for individuals to age 26 to verify the health carrier does not deny or restrict coverage for a dependent child, who has not attained 26 years of age, based upon the following factors:

- The presence or absence of the child's financial dependency upon the plan participant, primary subscriber or any other person;
- Residency with the plan participant and, in the individual market, the primary subscriber, or with any other person;
- Marital status;
- Student status;
- Employment; or
- Any combination thereof.

Review health carrier underwriting files to verify that the terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children do not vary based upon age, except for dependent children who are 26 years of age or older.

Note: Examiners need to be aware that:

- A health carrier is not required to make coverage available for a child of a child receiving dependent coverage, unless a grandparent becomes the legal guardian or adoptive parent of that grandchild; and
- HHS, DOL and Treasury preemption standards permit states to establish more stringent consumer protection requirements, such as requiring health carriers who provide dependent coverage to extend dependent coverage to unmarried disabled unmarried dependent children who are over the age of 26. Applicable state statutes, rules and regulations regarding extension of coverage, including, but not limited to, extension of coverage to disabled unmarried dependent children who are over the age of 26 may apply.

Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status

Review health carrier underwriting files and claim files to verify that the health carrier does not deny or restrict coverage for a dependent child:

- Whose coverage ended;
- Who was denied coverage; or
- Who was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage for a child ended before the child attained of 26 years of age.

Review health carrier underwriting files and claim files to verify the health carrier does not deny or restrict coverage for any individual who became eligible, or were required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting files to verify the health carrier provides a dependent child with at least a 30-day written notice of the opportunity to enroll in a health benefit plan. Verify that the 30-day written notice is provided in the following instances:

- To any child whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan, because, under the terms of coverage, the availability of dependent coverage of a child ended before the child attained 26 years of age; and
- To any child who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year, and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Review the health carrier's underwriting files to verify the health carrier provides a dependent child with a written notice of opportunity to enroll, beginning, in the group health plan market, not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Review the health carrier's written notices to verify that each written notice of opportunity to enroll includes a statement that dependent children whose coverage ended, who were denied coverage or who were not eligible for coverage, because the availability of dependent coverage of children ended, before the dependent child attained 26 years of age, are eligible to enroll in health coverage.

Note: Examiners need to be aware that:

- The health carrier written notice of opportunity to enroll may be provided to an employee on behalf of the employee's child, and in the individual market, to the primary subscriber on behalf of the primary subscriber's child; and
- With regard to group health insurance coverage:
    - The written notice of opportunity to enroll may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and
    - If a written notice satisfying the requirements of HHS, DOL and Treasury final regulations is provided to an employee whose child is entitled to an enrollment opportunity under HHS, DOL and Treasury provisions, the obligation to provide the notice of enrollment opportunity with respect to that child is satisfied for both the plan and health carrier.

Review the health carrier's written notices of opportunity to enroll to verify notices are provided beginning not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Review the health carrier's underwriting files to verify that for any dependent child who enrolls under the provisions of HHS, the DOL and the Treasury, the coverage for that dependent child takes effect no later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after Sept. 23, 2010.

Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status—Group Health Plan Special Enrollees

Review the health carrier's underwriting files to verify that a dependent child enrolling in group health insurance coverage is treated as a special enrollee, as provided under final regulations established by HHS, the DOL and the Treasury.

Review the health carrier's underwriting files to verify that a dependent child, and, if the child would not be a participant once enrolled, the participant or primary subscriber through whom the child is otherwise eligible for coverage under the plan, is offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

Note: Examiners need to be aware that any difference in benefits or cost-sharing requirements offered by the health carrier to plan participants or, in the individual market, primary subscribers constitutes a different benefits package.

Review the health carrier's underwriting files to verify that the health carrier does not require a child to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

Grandfathered Group Health Plans—Applicability

Note: Examiners need to be aware that:

- For plan years beginning before Jan. 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored group health plan, as defined in Section §5000A(f)(2) of the Internal Revenue Code, other than the group employer-sponsored health plan of a parent; and

- For plan years beginning on or after Jan. 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan shall comply with the requirements of HHS, DOL and Treasury final regulations regarding extension of dependent coverage for individuals to age of 26. Applicable state statutes, rules and regulations including, but not limited to, extension of coverage to disabled unmarried dependent children who are over the age of 26 may apply. For plan years beginning on or after Jan. 1, 2014, a group health plan may no longer exclude an adult child who is eligible to enroll in an eligible employer-sponsored group health plan.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to extension of dependent coverage to age 26.

Review complaint records to verify that if the health carrier has inappropriately denied or restricted coverage for a dependent child, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a dependent child whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the child attained 26 years of age.

Review health carrier claim files to identify any inappropriate coverage denials for claimants whose coverage ended by reason of cessation of dependent status.

Review health carrier internal appeals/grievance files to identify any inappropriate coverage denials for claimants whose coverage ended by reason of cessation of dependent status.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about extension of dependent coverage for individuals to age 26.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about extension of dependent coverage for individuals to age of 26.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to extension of dependent coverage for individuals to age 26.

Review health carrier training materials to verify that information provided is complete and accurate with regard to extension of dependent coverage for individuals to age 26.

Determine if the health carrier monitors producer-generated coverage denials/restrictions of coverage for dependent children. Review producer records of coverage denials/restrictions of coverage for dependent children for compliance with final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Direct Access to Providers***

CITATION: PHSA §2719A

EFFECTIVE DATE: Plan years, and in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the health reform act require that non-grandfathered small and large group employer plans and individual plans, which require or provide for designation by a covered person of a participating primary health care professional, shall permit covered individuals to designate any participating primary health care professional who is available to accept the covered person.

The provisions of the health reform act also require that a covered individual may, on behalf of a covered child, designate any participating pediatric physician as the child's primary care health care professional, if the health care professional is available to accept the child.

The provisions of the health reform act prohibit a health carrier that requires the designation of a primary care health care professional from imposing prior authorization or referral requirements for access to an obstetrical or gynecological health care professional.

The health carrier shall provide a notice to a covered person that satisfies the requirements of U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury final regulations regarding a covered individual's right to designate a participating primary health care professional, including the designation of pediatric and obstetrical and gynecological specialists and the prohibition of a health carrier from imposing prior authorization or referral for a female covered person seeking access to an obstetrical or gynecological health care professional.

BACKGROUND: Regulations and associated FAQs, issued by HHS, the DOL and Treasury set forth the requirement that for group health benefit plans, individual health plans or health carriers that require a participant to choose a participating primary care provider, the health benefit plan or health carrier must allow the participant to choose any participating primary care provider who is available to accept the participant.

With respect to a child, a health benefit plan or health carrier must allow the designation of a pediatrician as a child's primary care provider if the provider participates in the health carrier's health benefit plan network.

A health benefit plan or health carrier that requires the designation of a primary health care professional may not impose prior authorization or referral requirements for access to obstetrical and gynecological health care professionals for a female plan participant who seeks access to an obstetrical or gynecological health care professional.

A health benefit plan or health carrier must provide a notice informing the participants of the terms of the plan regarding designation of a primary care provider.

This provision applies to all health carriers in the individual market and to small and large group employer plans. This provision applies to non-grandfathered individual market small group and large group market health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
DIRECT ACCESS TO PROVIDERS

Standard 1
A health carrier providing individual, small group and large group market health coverage under a health benefit plan that requires or provides for designation of a participating primary health care professional: 1) shall permit a covered person to choose any participating primary care health care professional; 2) shall allow a covered individual, on behalf of a child, to designate any participating pediatric physician as the child's primary care health care professional; and 3) for health carriers providing coverage for obstetrical or gynecological care, shall be precluded from imposing upon an insured prior authorization or referral requirements with respect to access to participating health care professionals who specialize in obstetrics or gynecology.

Apply to: All group health products, (non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products, (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service, complaint handling, claim handling, and utilization management policies and procedures related to designation of participating primary health care professionals, including the designation of pediatric and obstetrical and gynecological specialists and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Policyholder files and supporting documentation, including a copy of the issued certificate of coverage or policy, letters, notices, telephone scripts, etc., regarding designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal appeals/grievance files and adverse utilization review determinations concerning designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to designation of participating primary health care professionals, pediatric, obstetrical and gynecological specialists, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries related to designation of participating primary health care professionals, pediatric, obstetrical and gynecological, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Student health coverage is subject to the direct access requirements of Section 2719A. However, federal regulations permit a student health insurance plan to designate providers at a student health center as its in-network providers, thus allowing students to choose from among the student health center's providers for purposes of satisfying Section 2719A, provided that the center has sufficient provider capacity and range of services available to support this designation and provides students with a choice of providers while away from campus. Examiners are encouraged to review CMS–9981–F with regard to federal regulations pertaining to student health insurance coverage.

Verify that a health carrier, which requires the designation by an insured of a participating primary care health care professional, has established and implemented policies and procedures regarding: 1) an insured's right to designate any participating primary health care professional who is willing to accept the covered person; 2) an insured's right to designate, for a covered child, any participating pediatric physician as the child's primary care health care professional; and 3) for health carriers providing coverage for obstetrical or gynecological care, the prohibition by a health carrier of imposing upon an insured prior authorization or referral requirements with respect to the insured's access to participating health care professionals who specialize in obstetrics or gynecology, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier policyholder service, complaint handling, claim handling and utilization management policies and procedures related to the designation of a primary health care professional to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured to designate any participating primary health care professional who is available to accept the covered person, as required under final regulations established by HHS, the DOL and the Treasury.

Review health carrier policyholder service, complaint handling, and claim handling policies and procedures related to the designation of a primary health care professional to verify adequate and appropriate policies/procedures are in place to ensure that a health carrier permits an insured, on behalf of a child, to designate any participating physician who specializes in pediatrics as the child's primary care health care professional and who is available to accept the child.

Note: Examiners need to be aware that this provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

If a health carrier provides individual market, small group or large group market health insurance coverage under a health benefit plan for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, review health carrier policyholder service, complaint handling, and claim handling policies and procedures related to the designation of a primary health care professional to verify that the health carrier:

- Does not require any insured's, including a primary care health care professional's, authorization or referral in the case of a female covered person who seeks access to a participating health care professional who specializes in obstetrics or gynecology; and
- Treats the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

Note: Examiners need to be aware that the health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier. A health care professional who specializes in obstetrics or gynecology means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care. This provision shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care, or preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction relating to designation of participating primary health care professional and prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review complaint records to verify that when an individual has been the subject of a restriction of health benefits coverage or has been denied health benefits coverage, due to the health carrier having restricted the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or the health carrier having imposed prior authorization or referral requirements upon the insured regarding access to an in-network obstetrical and gynecological health care professional, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage of health benefits were inappropriately restricted or denied due to the health carrier having restricted the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or due to the health carrier having imposed prior authorization or referral requirements upon the insured regarding access to an in-network obstetrical and gynecological health care professional.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage was improperly restricted or denied, due to the health carrier having restricted the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or due to the health carrier having imposed prior authorization or referral requirements upon the insured regarding access to an in-network obstetrical and gynecological health care professional.

Review health carrier internal appeals/grievance register/logs/files, as well as records of appeals of adverse utilization review determinations, to identify any individuals for whom coverage of was improperly restricted or denied due to the health carrier restricting the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review of procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage due to the health carrier restricting the insured's ability to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, or the health carrier imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review policy form files to verify approval(s) from the applicable state and (if applicable) from the Marketplace and compare against the issued certificate or policy provided in the sample.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about the insured's right to designate a participating primary health care professional, pediatric, or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to notices required to be provided to the insured regarding the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Review health carrier training materials to verify that information provided is complete and accurate with regard to the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
DIRECT ACCESS TO PROVIDERS

Standard 2
A health carrier shall provide a notice to covered persons, addressing terms and conditions of the health benefit plan relating to: 1) the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist; and 2) for health carriers providing coverage for obstetrical or gynecological care, which require the designation of a primary care health professional, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional, in compliance with final regulations issued by HHS, the DOL and the Treasury.

Apply to: All group health products, (non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products, (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service, complaint handling, claim handling, and new business-related policies and procedures related to health carrier-issued notices regarding the insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist, and prior authorization or referral regarding access to an in-network obstetrical and gynecological health care professional

_____ Consumer notice-related requests and health carrier delivery logs, or other related information or protocols

_____ Samples of notices, including any web-based forms

_____ Health carrier complaint handling policies and procedures related to incorrectly issued and/or missing notices

_____ Health carrier complaint records regarding notices (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures' references to notices

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the issuance and delivery of notices to insureds regarding: 1) an insured's right to designate a participating primary health care professional, pediatric or obstetrical/gynecological specialist; and 2) for health carriers providing coverage for obstetrical or gynecological care, the prohibition of the health carrier from imposing prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier policyholder service, complaint handling, claim handling, and new business-related policies and procedures to verify that the health carrier provides notice to covered persons of the terms and conditions of the health benefit plan and a covered person's rights with respect to the following: 1) the designation of a participating health care professional, pediatric or obstetrical/gynecological specialist; and 2) for health carriers providing coverage for obstetrical or gynecological care, the requirement, as set forth under final regulations established by HHS, the DOL and the Treasury, that a health carrier shall not impose prior authorization or referral requirements regarding access to an in-network obstetrical and gynecological health care professional.

For group health insurance coverage, verify that the health carrier provides notices whenever the health carrier provides a participant with a summary plan description or other similar description of benefits under a health benefit plan, in accordance with final regulations established by HHS, the DOL and the Treasury.

For individual health insurance, verify that the health carrier provides notices whenever the health carrier provides a primary subscriber with a policy, certificate or contract of health insurance in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that federal regulations 45 CFR §147.138(a)(4)(iii) provide templates of notices for health carriers to use to provide insureds with notices of rights with regard to direct access to providers.

Review notices issued: 1) to verify that when a health carrier has not made available or has improperly issued such notice, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner; and 2) to ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete, accurate and current information about the issuance and delivery of such notices.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and regulations pertaining to issuance and delivery of such notices.

Review the health carrier's training materials to verify that the information provided is complete and accurate with regard to the issuance and delivery of such notices.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Essential Health Benefits***

CITATION: PHSA §2707 & §1302

EFFECTIVE DATE: Plan years, and in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the health reform act require that non-grandfathered small group employer plans and individual plans provide a core package of health care services, known as essential health benefits (EHB).

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury set forth the requirement that Qualified Health Plans (QHPs) in the Marketplace, as well as individual and small group employer plans offered outside of the Marketplace, provide EHB, to include the following general categories of services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services, and chronic disease management; and
- Pediatric services, including oral and vision care.

The provisions of the health reform act require that states define EHB for policies issued in a state. To meet this requirement, each jurisdiction selected an existing health plan as a "benchmark" to establish services and items included in that jurisdiction's EHB package.

Nothing in the health reform act prohibits a QHP from providing benefits in excess of the essential benefits package.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered individual market and small group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
ESSENTIAL HEALTH BENEFITS

Standard 1
A health carrier offering health benefit plans providing individual market health insurance coverage and small group market health insurance coverage plans shall provide coverage for a core package of health care services, known as "essential health benefits" (EHB).

Apply to: All group health products, (non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

All individual health products, (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting, complaint handling, and claim handling policies and procedures related to EHB

_____ Underwriting files and supporting documentation regarding EHB, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning EHB (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal appeals/grievance files

_____ Applicable external appeals register/logs/files related to EHB, external appeal resolution and associated documentation

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to EHB

_____ Health carrier communication and educational materials related to EHB, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state and federal statutes, rules and regulations, and guidances

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Individual Market Health Insurance Coverage Model Regulation (#26)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the mandate of coverage for essential health benefits in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting, complaint handling, and claim handling policies and procedures related to EHB to verify adequate and appropriate policies/procedures are in place to ensure a health carrier that offers health benefit plans providing individual market health insurance coverage or small group market health insurance coverage includes an EHB package required under final regulations established by HHS, the DOL and the Treasury.

Review the health carrier's underwriting, complaint and claim files to verify that the health carrier does not deny or restrict EHB coverage.

Examiners need to be aware that EHB means that a health benefit plan provides health benefits that:

- Are substantially equal to the EHB-benchmark plan including:
    - Covered benefits;
    - Limitations on coverage, including coverage of benefit amount, duration and scope; and
    - Prescription drug benefits that meet the requirements of the final regulations established by HHS, the DOL and the Treasury;
- With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category;
- With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of the final regulations established by HHS, the DOL and the Treasury related to parity in mental health and substance use disorder benefits;
- Include preventive health services, as defined in applicable statutes, rules and regulations;
- If the EHB benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:
    - Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services;
    - Is determined by the health carrier and reported to HHS; or
    - As determined by the state.

Examiners need to be aware that a health carrier offering a health benefit plan in the individual or small group market providing EHB may substitute benefits if the health carrier meets the following conditions:

- The health carrier substitutes a benefit that:
    - Is actuarially equivalent to the benefit that is being replaced;
    - Is made only within the same EHB category; and
    - Is not a prescription drug benefit; and
- The health carrier also submits evidence of actuarial equivalence that is:
    - Certified by a member of the American Academy of Actuaries;
    - Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
    - Based on a standardized plan population; and
    - Determined regardless of cost sharing.

A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).

A health carrier offering a health benefit plan in the individual or small group market providing EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term custodial nursing home care benefits or nonmedically necessary orthodontia as EHB.

Review the health carrier's claim handling procedures to verify that a health carrier offering health benefit plans in the individual market or small group market providing EHB does not impose annual and lifetime dollar limits on EHB, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review the health carrier's health benefit plans to verify that the coverage, in accordance with final regulations established by HHS, the DOL and the Treasury:

- Provides for EHB;
- Limits annual cost-sharing charges under such coverage to specified limits; and
- Provides bronze, silver, gold or platinum level of coverage as follows:
    - A health benefit plan in the bronze level has an actuarial value of 60%;
    - A health benefit plan in the silver level has an actuarial value of 70%;
    - A health benefit plan in the gold level has an actuarial value of 80%;
    - A health benefit plan in the platinum level has an actuarial value of 90%; and
    - If a plan does not provide coverage at the bronze, silver, gold or platinum level, that it meets the standards established for catastrophic plans.

Examiners need to be aware that a health carrier may convert an annual dollar limit that is imposed in the state's EHB benchmark plan to an actuarial equivalent visit limit.

Review the health carrier's health benefit plans to verify that EHB coverage includes the following general categories of services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services, and chronic disease management; and
- Pediatric services, including oral and vision care.

EHB vary by state, based on the EHB benchmark plan selection process described in 45 CFR §156.100 and 156.110. The HHS has provided additional guidance on how states will supplement a benchmark plan with coverage for habilitative services and pediatric dental and vision services, as these types of services are not traditionally offered in health plans today. The process for determining EHB may change in 2016, as the HHS plans to revisit the benchmark approach at that time.

A health carrier offering a health benefit plan providing individual market health insurance coverage or small group market health insurance coverage does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions. The design of benefits includes covered benefits, cost-sharing charges, exclusions, medical necessity definitions, drug formularies, visit limits, benefit substitutions and utilization management. Therefore, review the health carrier's health benefit plans to ensure these benefit design elements are consistent with reasonable medical management techniques and are not discriminatory. In addition, review the health carrier's underwriting, complaint and claim files to verify the heath carrier does not discriminate against an individual with regard to the aforementioned bases.

Review health carrier underwriting, complaint and claim files to verify the health carrier, in providing EHB, or in coverage denials/restrictions of coverage of EHB, does not discriminate against an individual on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

With regard to coverage of emergency services health benefits, review health carrier's underwriting, complaint and claim files to verify that coverage for emergency services is provided as follows:

- Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency services received in network; and
- If such services are provided out of network, cost-sharing must be limited as provided in applicable federal and state statutes, rules and regulations.

With regard to mental health and substance use disorder health benefits, review the health carrier's underwriting, complaint and claim files to ensure that coverage for mental health and substance use disorder services, including behavioral health treatment, is provided as follows:

- The provisions of 45 CFR §146.136 relating to parity in mental health and substance use disorder benefits apply to a health carrier offering a health benefit plan providing individual market health insurance coverage and small group market health insurance coverage. The provisions of 45 CFR §146.136 also apply to the same extent to health insurance coverage in connection with a group health insurance plan in the large group market, as defined in 45 CFR §146.103; and
- The provisions of 45 CFR §146.136 relating to parity in mental health and substance use disorder benefits apply to non-grandfathered health plan coverage and grandfathered health plan coverage. Per 45 CFR §156.115(a)(3), for the mental health and substance use disorder benefit, EHB plans must comply with parity standards set forth in the federal Mental Health Parity and Addiction Equity Act of 2008.

Note: Examiners need to be aware that Section 1304 of the federal act gives states the option, prior to Jan. 1, 2016, to define a "small employer" as an employer that employed an average of at least one, but not more than 50 employees on business days during the preceding calendar year and that employs at least one employee on the first day of the plan year. On or after Jan. 1, 2016, a "small employer" must be defined as an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. As such, the small employer exemption provided in PHSA §2726 and implementing regulations will continue to apply to employers with 51 or more employees in 2016, when the upper limit of the small employer size increases in accordance with Section §1304 of the federal act. For more information, examiners can refer to page 68248 of the final rules published in the Federal Register (78 FR 68240), Nov. 13, 2013.

With regard to prescription drug EHB, review the health carrier's underwriting, complaint and claim files to verify that the health carrier's health benefit plan:

- Except as provided in the asterisked paragraph below, covers at least the greater of:
    - One drug in every United States Pharmacopeia (USP) category and class; or
    - The same number of prescription drugs in each category and class as the EHB-benchmark plan; and
- Submits its drug list to the state.

Note: A health benefit plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).

A health benefit plan providing EHB must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan:

- The procedures must include a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician or other prescriber to request an expedited review based on exigent circumstances;
- Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug;
- A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than 24 hours after it receives the request; and
- A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Examiners need to be aware that the provisions regarding prescriptions above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the *Health Carrier Prescription Drug Benefit Management Model Act* (#22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction of coverage of EHB.

Review complaint records to verify that when an individual has been the subject of a restriction of health benefits coverage or denied EHB coverage, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage of EHB were inappropriately restricted or denied.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage for EHB was improperly restricted or denied.

Review health carrier internal appeals/grievance register/logs/files to identify any individuals for whom coverage of EHB was improperly restricted or denied.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage for EHB.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about coverage of EHB.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about coverage of EHB.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to coverage of EHB.

Review health carrier training materials to verify that information provided is complete and accurate with regard to coverage of EHB.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Prohibition on Excessive Waiting Periods***

CITATION: PHSA §2708

EFFECTIVE DATE: Plan years beginning on or after Jan. 1, 2014

PROVISION: A group health plan and a health carrier offering group health insurance coverage shall not apply to any waiting period (as defined in PHSA §2704(b)(4)) that exceeds 90 days.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury set forth the requirement that a group health plan or health insurance issuer offering group health insurance coverage shall not apply to any waiting period (as defined in PHSA §2704(b)(4)) that exceeds 90 days.

PHSA §2704(b)(4), ERISA Section 701(b)(4) and 26 U.S. Code Section 9801(b)(4) define a waiting period to be the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the plan.

The provisions in PHSA §2708 prevent an otherwise eligible individual from being required to wait more than 90 days before coverage becomes effective.

The final regulations implementing PHSA §2708 set forth rules governing the relationship between a plan's eligibility criteria and the 90-day waiting period limitation. Specifically, the final regulations provide that being otherwise eligible to enroll in a plan means having met the plan's substantive eligibility conditions (for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). Under the final regulations, after an individual is determined to be otherwise eligible for coverage under the terms of the plan, any waiting period may not extend beyond 90 days, and all calendar days are counted beginning on the enrollment date, including weekends and holidays.

HHS guidance states that plans that must provide the essential health benefits (EHB) may not impose benefit-specific waiting periods except for reasonable waiting periods for the coverage of pediatric orthodontia.

This provision applies to all health carriers offering group health insurance plans. This provision applies to both grandfathered and non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
PROHIBITION ON EXCESSIVE WAITING PERIODS

Standard 1
A health carrier may not impose excessive waiting periods, as defined in applicable statutes, rules and regulations, to individuals determined by the health carrier to be otherwise eligible for coverage under the terms of the plan.

Apply to: All group health products, (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to waiting periods

_____ Underwriting files and supporting documentation regarding waiting periods, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning waiting periods (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal and external appeals register/logs/files

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to waiting periods

_____ Health carrier communication and educational materials related to waiting periods, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of excessive waiting periods in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to waiting periods to verify adequate and appropriate policies/procedures are in place to ensure the length of waiting periods imposed by the health carrier to otherwise eligible individuals is in compliance with final regulations and guidance established by HHS, the DOL and the Treasury.

Review policies to verify that the health carrier does not apply waiting periods longer than 90 days, and for health carriers that must provide EHB, to verify that the health carrier does not impose benefit-specific waiting periods.

Review health carrier underwriting policies and procedures to ensure that the health carrier does not consider the period before an individual's late or special enrollment date as a waiting period.

Verify that if an individual loses eligibility for coverage under a health benefit plan and subsequently becomes eligible for coverage, a health carrier only considers the individual's most recent period of eligibility in determining whether the individual is a late enrollee under the plan with respect to the most recent period coverage.

Verify that the health carrier does not apply a waiting period longer than 90 days to an individual who became eligible for coverage under the health benefit plan after a suspension of coverage that applied generally under the plan.

Note: Examiners need to be aware that, except as noted below, an individual is otherwise eligible to enroll under the terms of a health benefit plan if the individual has met the plan's substantive eligibility conditions, such as being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms or satisfying a reasonable bona fide employment-based orientation period.

A health carrier is not required to offer small group market health insurance coverage to any particular individual or class of individuals despite an individual being otherwise eligible to enroll under the plan, but individuals otherwise eligible for coverage under the plan may not be required to wait more than 90 days before coverage is effective.

Conditions of eligibility to enroll for coverage under the terms of a health benefit plan may be based solely on the lapse of a time period, but only for a time period of no more than 90 days.

Other conditions of eligibility to enroll for coverage under the terms of a health benefit plan are permitted unless the condition is designed to avoid compliance with applicable statutes, rules and regulations regarding excessive waiting periods, as determined in accordance with the following provisions:

- If eligibility is based on an employee having a specified number of hours of service per pay period, or working full-time, and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period, or work full-time, the terms of the health benefit plan may allow a reasonable time period of time, not to exceed 12 months and beginning on any date between the employee's employment start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition; or
- If eligibility is based on an employee having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation, if the cumulative hours of service required does not exceed 1,200 hours.

Except for cases in which the health benefit plan imposes a waiting period exceeding a 90-day period in addition to a measurement period, as described in applicable statutes, rules and regulations, the time period for determining whether the employee meets the plan's eligibility requirements will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no more than 13 months after the employee's employment start date plus the time remaining until the first day of the next calendar month, if the employee 's employment start date is not the first day of a calendar month.

To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For the purposes of calculating one month, as described above, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position otherwise eligible for small group market health insurance coverage under a health benefit plan.

A health carrier may treat an employee whose employment has terminated and then rehired as newly eligible to enroll for coverage upon rehire and, therefore, required to meet the health benefit plan's eligibility requirements and waiting period anew, if reasonable under the circumstances and the termination and rehiring is not used or designed as a subterfuge to avoid compliance with the 90-day waiting period limitation.

For the purpose of calculating waiting periods, all calendar days are counted beginning on the enrollment date, including weekends and holidays.

For administrative convenience, a health carrier that imposes a 90-day waiting period may choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

A health carrier satisfies the requirements set forth regarding excessive waiting periods in applicable statutes, rules and regulations if, under the terms of the health benefit plan, an individual employee elects coverage that begins on a date before the end of a 90-day waiting period and the health carrier is also not considered to be in violation of applicable statutes, rules and regulations if an individual employee takes, or is permitted to take, additional time beyond any 90-day waiting period to elect coverage.

A health carrier that relies on the eligibility information reported to it by the small group employer will not be considered to have violated the requirements set forth in applicable statutes, rules and regulations regarding excessive waiting periods with respect to the health carrier's administration of any waiting period, if the following is satisfied:

- The health carrier requires the small group to make a representation and update this representation with any changes regarding the terms of any eligibility conditions or waiting periods imposed before an individual is eligible for coverage under the health benefit plan; and
- The health carrier has no specific knowledge of a waiting period imposed that exceeds the permitted 90-day period.

Review complaint register/logs and complaint files to identify complaints pertaining to excessive waiting periods.

Review complaint records to verify that when an excessive waiting period has been inappropriately applied, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual upon whom a waiting period longer than 90 days was inappropriately imposed.

Review internal and external appeals register/logs/files to determine if there have been any appeals based on excessive waiting periods

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about the prohibition of excessive waiting periods.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about the prohibition of excessive waiting periods.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to the prohibition of excessive waiting periods.

Review health carrier training materials to verify that information provided is complete and accurate with regard to excessive waiting periods.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Grievance Procedures***

CITATION: PHSA §2719

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth requirements with respect to internal claims and appeals and external review processes for group health plans and health carriers that are not grandfathered health plans under 45 CFR §147.140.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual and small group market in a state must implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- For health carriers offering individual health insurance coverage, maintain for six years records of all claims and notices associated with the internal claims and appeals process, and must make such records available for examination by the claimant or state or federal oversight agency upon request;
- Have an independent and impartial review process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under PHSA §2793 to assist such enrollees with the appeals processes; and
- Allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
GRIEVANCE PROCEDURES

Standard 1
A health carrier offering individual health insurance coverage shall maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to policy years beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of grievances

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding grievance records handling in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify the health carrier maintains grievance records for at least six years for first level grievances involving an adverse determination and for expedited reviews of grievances involving an adverse determination.

Verify the health carrier makes grievance records available for examination by covered persons, or, if applicable, the covered person's authorized representative, or the appropriate state or federal oversight agencies upon request.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The health carrier shall comply with grievance procedures requirements, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to plan years (in the individual market, policy years) beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of grievances

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier utilizes written procedures for receiving and resolving first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination; and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, in accordance with final regulations in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that whenever a health carrier fails to adhere to the requirements set forth in applicable state statutes, rules and regulations with respect to receiving and resolving first level review of grievances involving an adverse determination and expedited review of grievances involving an adverse determination, the covered person, or, if applicable, the covered person's authorized representative, shall be deemed to have exhausted the provisions of applicable state statutes, rules and regulations and may file a request for external review in accordance with the procedures outlined in applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#76).

The provisions of applicable state statutes, rules and regulations regarding first level review of grievances involving an adverse determination and expedited review of grievances involving an adverse determination shall not be deemed exhausted based on a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person.

The exception noted above does not apply if the violation is part of a pattern or practice of violations by the health carrier.

A covered person, or, if applicable, the covered person's authorized representative, may request a written explanation of the violation from the health carrier. Verify that the health carrier has:

- Provided the written explanation within 10 days of receiving the request; and
- Included in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of applicable state statutes, rules and regulations to be exhausted.

Note: Examiners need to be aware that if an independent reviewer or a court of competent jurisdiction rejects the grievance involving an adverse determination for immediate review on the basis that the health carrier met the requirements of the exception outlined above, the covered person, or, if applicable, the covered person's authorized representative, has the right to resubmit and pursue a review of the grievance under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

In this case, verify that the health carrier has provided to the covered person, or, if applicable, the covered person's authorized representative, notice, within a reasonable period of time, but not to exceed 10 days after the independent reviewer or the court rejects the grievance involving an adverse determination for immediate review, of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

For purposes of calculating the time period for refiling the benefit request or claim, verify that the health carrier calculates the time period to begin upon the covered person's, or, if applicable, the covered person's authorized representative's receipt of the notice of opportunity to resubmit.

Verify that the health carrier's grievance procedure documents include a statement of a covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office or ombudsman's office for assistance at any time. Verify that the statement includes the telephone number and address of the insurance commissioner or ombudsman's office.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GRIEVANCE PROCEDURES

Standard 3
The health carrier shall conduct first level reviews of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to plan years (in the individual market, policy years) beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of first level reviews of grievances involving an adverse determination

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving first level review of grievances involving an adverse determination in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier ensures that the first level review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the first level review decision.

To verify the independence and impartiality of individuals involved in making the first level review decision, verify that the health carrier does not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

Verify that, prior to issuing a decision regarding a first level review of a grievance involving an adverse determination, the health carrier provides free of charge to the covered person, or, if applicable, the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance, sufficiently in advance of the date the decision is required to be provided, to permit the covered person, or, if applicable, the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

Verify that, before the health carrier issues or provides notice of a final adverse determination in accordance with the time frames set forth in applicable state statutes, rules and regulations that is based on new or additional rationale, the health carrier provides the new or additional rationale to the covered person, or, if applicable, the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided, to permit the covered person, or, if applicable, the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

Verify that the health carrier's decision of a first level review of a grievance involving an adverse determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination;
    - Does not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75); and
- For a first level review decision that upholds the grievance:
    - The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial; and
    - Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The health carrier shall conduct expedited reviews of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: The provisions of this section apply to plan years (in the individual market, policy years) beginning on or after Sept. 23, 2010

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier grievance handling policies and procedures

_____ Sample of expedited appeals

_____ Health carrier grievance records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Carrier Grievance Procedure Model Act (#72)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving expedited review of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier's decision of an expedited review of urgent care requests of a grievance involving an adverse determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and
    - Does not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to applicable state statutes, rules and regulations equivalent to the *Uniform Health Carrier External Review Model Act* (#75); and
- If the decision involves a final adverse determination, the notice shall provide:
    - The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial; and
    - Notice of the covered person's, or, if applicable, the covered person's authorized representative's, right to contact the insurance commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Guaranteed Availability of Coverage (Individual and Group Market Health Insurance)***

CITATION: PHSA §2702

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual or group markets in a state must offer to any individual or employer in the applicable state all products approved for sale in the applicable market, and must accept any eligible individual or employer applying for any of those products.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual and group markets in a state must accept for coverage, in the applicable state, every individual and group employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Health carriers are permitted to limit enrollment to designated annual open and special enrollment periods.

This provision applies to all health carriers in the individual market and group employer plans. This provision applies to non-grandfathered group health plans. This provision also applies to grandfathered small group health plans, which were already required to comply with guaranteed availability of coverage requirements under HIPAA.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(INDIVIDUAL MARKET)

Standard 1
A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Apply to: All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of individual market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to plan applicants in compliance with final regulations established by HHS, the DOL and the Treasury and does not place unallowable conditions on such availability.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods, and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations. Verify that a carrier has complied with any requirements that would allow for continuous open enrollment based upon certain circumstances of failing to file rates and forms and have them approved prior to open enrollment period.

Individual Health Insurance Coverage—Open Enrollment Period
A health carrier in the individual market must allow an individual to purchase health insurance coverage during the annual open enrollment period described in 45 CFR §155.410(e).

Individual Health Insurance Coverage—Special Enrollment Periods
Verify that a health carrier allows enrollment during defined enrollment periods, including open enrollment periods, limited open enrollment periods and special enrollment periods, and provides those periods pursuant to 45 CFR §147.104 and §155.420, as well as in accordance with state-specific requirements.

Verify that a health carrier provides for a special enrollment period that is not less than 60 calendar days pursuant to 45 CFR §147.104 and §155.420 for qualified individuals (and their dependents, when applicable) in the following circumstances:

- Loss of minimum essential coverage (including employer plans, Medicaid, CHIP and COBRA coverage, as well as loss of coverage due to divorce, legal separation, loss of dependent status or death of the policyholder);
- Addition of a dependent through marriage, birth, adoption, placement for adoption or placement in foster care (including gaining a dependent through a child support order or other court order);
- Unintentional, inadvertent or erroneous enrollment in a plan that results from error, misrepresentation, misconduct or inaction of an officer, employee or agent of the exchange or HHS or its instrumentalities, or a non-exchange entity (including a health carrier or its representative) that provides enrollment assistance or conducts enrollment activities;
- Health carrier substantially violated a material provision of its contract in relation to the enrollee;
- Enrollee (or dependent of an enrollee) is determined newly eligible or ineligible for an advance premium tax credit or experiences a change in eligibility for cost-sharing reductions;
- A person terminates employer coverage as a result of being determined newly eligible for premium tax credits due to becoming ineligible for qualifying coverage in an eligible employer-sponsored plan;

- A person in a state that has not expanded Medicaid who was previously ineligible for premium tax credits due to having income below the federal poverty line experiences a change in household income that makes the person newly eligible for premium tax credits; or
- Permanent move that results in access to new individual market plans (including release from incarceration).

Verify that a health carrier that offers qualified health plans through an insurance exchange or marketplace serving the individual insurance market also provides for a special enrollment period that is not less than 60 days for qualified individuals in the following circumstances:

- Gain of status as a citizen, national or lawfully present individual;
- Status as federally recognized American Indian tribe or Alaska Native; or
- Person demonstrates to the exchange in the state, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the exchange may provide.

Verify that a health carrier provides for a special enrollment period with effective coverage dates that begin the first day of the month following enrollment if the plan is selected between the 1st and 15th of the month or the first day of the second month following enrollment if the plan is selected between the 16th and the last day of the month with the following exceptions:

- In the case of marriage, not later than the first day of the month following plan selection;
- In the case of a dependent's birth, adoption, placement for adoption, or placement in foster care, the date of the birth, adoption, placement for adoption, or placement in foster care; or
- For loss of minimum essential coverage, the first day of the month following the loss of previous coverage if the qualified health plan is selected before or on the day of the loss. If the plan is selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.

Note: In some circumstances, federal rules permit states or the marketplace in a state to implement alternative coverage effective dates. Examiners should verify that health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all individuals in the individual market in the applicable state—consistent with applicable state statutes, rules and regulations—and without regard to the claims experience of an individual and his or her dependents or any health status-related factor relating to such individual and his or her dependents.

With regard to a health carrier denying coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the individual market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer individual market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- To an individual, when the individual does not live or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to any additional individuals because of its obligations to existing enrollees.

Review health carrier underwriting files to verify that a health carrier, that cannot offer coverage for reason of lack of network capacity, does not offer coverage in the individual market in the applicable geographic service to new individuals or to any enrollees until the later of 180 days following each such refusal or the date on which the health carrier notifies the commissioner of the applicable state that it has regained capacity to deliver services.

Review health carrier underwriting files to verify that the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- The provisions set forth in the final regulations established by HHS, the DOL and the Treasury should not be construed to require that a health carrier offering group health benefit plans must offer health benefit plans in the individual market;
- A health carrier offering only student health insurance coverage is not required to otherwise offer coverage in the individual market so long as the health carrier is offering student health insurance coverage consistent with the HHS, DOL and the Treasury definition of "student health insurance coverage." In accordance with 45 CFR §147.145, student health insurance is exempt from the requirement to establish open enrollment periods and coverage effective dates based on a calendar policy year; and
- A health carrier, at the time of renewal, may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with applicable state statutes, rules and regulations and effective on a uniform basis among all individuals covered under the health benefit plan.

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to eligible plan applicants, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that a health carrier and its officials, employees, agents and representatives comply with any applicable statutes, rules and regulations regarding marketing by health carriers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminating based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed availability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed availability of individual market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment, when applicable.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(GROUP MARKET)

Standard 2
A health carrier offering group market health insurance coverage shall issue any applicable health benefit plan to any eligible employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with state and federal law.

Apply to: All group health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140. However, grandfathered small group health plans were already required to comply with guaranteed availability of coverage requirements under HIPAA

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of group market health insurance coverage in accordance with final regulations provided by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier makes group market health insurance coverage available on a guaranteed availability basis to eligible employers in compliance with final regulations provided by HHS, the DOL and the Treasury, and that the carrier does not place unallowable conditions on such availability.

Review health carrier underwriting policies and procedures to verify the health carrier:

- Offers coverage to all eligible employees of the eligible employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and
- Does not limit the offer of coverage to only certain individuals or dependents in the group or to only part of the group.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods.

<u>Group Plans—Special Enrollment Periods</u>
Verify that a health carrier offering coverage in the small group market provides for an annual open enrollment period from Nov. 15 through Dec. 15, during which time employers may enroll in coverage effective Jan. 1 of the subsequent year without meeting any minimum participation or minimum contribution requirements.

Verify that a health carrier offering coverage in the small group market permits employers to enroll at any time during the year, including outside of the annual group open enrollment period, and that the carrier does not place any unallowable enrollment restrictions on employers.

Verify that any enrollment restrictions that may be allowable outside of the annual group enrollment period (such as minimum participation and minimum contribution requirements) are applied by the carrier in a consistent manner to all employers seeking coverage.

Note: Different enrollment standards may apply depending on whether small group coverage is being offered within a small group exchange (also known as a SHOP marketplace) or in the small group market outside of an exchange or SHOP. For example, the minimum participation requirement may be calculated differently. Examiners should be aware of such differences and also of whether the carrier being examined is offering coverage within a SHOP, outside the SHOP, or both.

Verify that a health carrier permits an employee, or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of any health benefit package under the plan of the employer during a special enrollment period if:

- The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
- The employee's or dependent's coverage:
    - Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
    - Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated, or loss of coverage because an individual no longer resides, lives or works in the service area of HMO coverage;
- The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time; or
- Under the terms of the health benefit plan, the employee requests enrollment not later than 30 days after the triggering event.

Verify that the health carrier provides a special enrollment period to all covered employees that experience the following qualifying events that result in the loss of coverage of a qualified beneficiary pursuant to 29 USC §1163:

- The death of the covered employee;
- The termination (other than by reason of such employee's gross misconduct), or reduction of hours of the covered employee's employment;
- The divorce or legal separation of the covered employee from the employee's spouse;
- The covered employee becomes entitled to benefits under Title XVIII of the Social Security Act;
- A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; or
- A proceeding in a case under Title XI of the Social Security Act, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

Verify that if an employee requests enrollment, the health carrier provides for enrollment effective not later than the first day of the first calendar month beginning after the date the health carrier received the completed request for enrollment.

Verify that, with respect to dependents of employees, the health carrier provides for a dependent special enrollment period during which the dependent, and if not otherwise enrolled, the employee, may be enrolled under a health benefit plan, if a person becomes a dependent of the employee/participant through marriage, birth, adoption, or placement for adoption.

Verify that the health carrier's special enrollment period for qualified individuals provides a period of time not less than 30 days from the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available, at least 30 days after the date the plan makes dependent coverage generally available).

Verify that the health carrier, for an employee who seeks to enroll a dependent during a special enrollment period, provides for the coverage of the dependent effective upon:

- In the case of marriage, not later than the first day of the first month beginning after the health carrier receives the completed request for special enrollment;
- In the case of a dependent's birth, the date of the child's birth; and
- In the case of a dependent's adoption or placement for adoption, not later than the date of the adoption or placement for adoption.

Verify that the health carrier permits an employee or a dependent of the employee, who is eligible but not enrolled, to enroll in coverage under the terms of the health benefit plan if:

- The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under the state children's health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under the plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the plan not later than 60 days after the date of termination of such coverage; or
- The employee or dependent becomes eligible for assistance, with respect to coverage under the plan under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the plan not later than 60 days after the employee or dependent is determined to be eligible for such assistance.

Verify that the health carrier provides adequate written notice of special enrollment rights and the requirement furnished to an individual declining coverage (if the plan requires the reason for declining coverage to be in writing). 29 CFR §2590.701-6 includes model language for informing employees of their special enrollment rights.

Verify that the health carrier does not treat special enrollees as late enrollees and offers the same benefit package as is offered to similarly situated individuals who enroll when first eligible. Any differences in benefits or cost-sharing requirements for different individuals constitute a different benefit package, and a special enrollee cannot be required to pay more for coverage or to enroll in different coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

Verify that the health carrier is in compliance with 45 CFR §147.108 and 45 CFR §146.111, including the examples identified in federal regulations.

Review health carrier underwriting policies and procedures to verify the health carrier does not apply any waiting period (consistent with the HHS, DOL and Treasury definition of "waiting period") that exceeds 90 days.

Review the health carrier's underwriting files to verify the requirements used by a health carrier in determining whether to provide coverage to an employer are applied uniformly among all employers applying for coverage or receiving coverage from the health carrier.

In states that have adopted the *Small Group Market Health Insurance Coverage Model Act* (#106), review health carrier underwriting files to verify that any minimum participation level that a health carrier establishes for employers applying for coverage outside of the Nov. 15 through Dec. 15 group open enrollment period is not greater than:

- 100% of eligible employees working for groups of three or fewer employees; and
- 75% of eligible employees working for groups with more than three employees.

Minimum participation requirements are permitted outside the annual enrollment period from Nov. 15 through Dec. 15 to the extent permitted by state law. Examiners should review health carrier underwriting files to verify that any minimum participation rules applied by the health carrier comply with any state-specific requirements.

In states that have adopted the *Small Group Market Health Insurance Coverage Model Act* (#106), review health carrier underwriting files to verify the health carrier, in applying minimum participation requirements with respect to an employer, that applies for coverage outside of the Nov. 15 through Dec. 15 time period, does not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met.

"Creditable coverage" is defined in the *Small Group Market Health Insurance Coverage Model Act* (#106) as follows. "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(1) A group health plan;
(2) A health benefit plan;
(3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);
(5) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents. For purposes of Title 10, USC Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
(6) A medical care program of the Indian Health Service or of a tribal organization;
(7) A state health benefits risk pool;
(8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP);
(9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 USC 2504(e)); or
(11) Title XXI of the Social Security Act (State Children's Health Insurance Program).

In states that have not adopted the *Small Group Market Health Insurance Coverage Model Act* (#106), examiners need to be aware that HHS guidance regarding the applicability of group participation rules provide for different ways in which the state and/or health carrier may calculate minimum participation requirements, as such variations are deemed permissible by HHS.

In applying minimum participation requirements with respect to an employer, review health carrier underwriting files to verify the health carrier does not consider individuals eligible for coverage under a COBRA continuation provision as eligible employees in determining whether the applicable percentage of participation is met.

Review health carrier underwriting files to verify the health carrier does not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to an employer at any time after the employer has been accepted for coverage.

Examiners should verify that health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the health carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all employers in the group market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

With regard to a health carrier that denies coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the group market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer group market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- In an area outside of the health carrier's established geographic service area for such network plan;
- To an employee when the employee does not live, work or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group certificateholders and covered persons.

Review health carrier underwriting files to verify that a health carrier that cannot offer coverage for reason of lack of network capacity does not offer coverage in the group market in the applicable geographic service area to new cases of employer groups or to any employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services.

Review health carrier underwriting files to verify the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all employers without regard to the claims experience of the employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required by such regulations to provide group market health insurance coverage if the health carrier elects not to offer new coverage to group employers in the applicable state; and
- A health carrier that elects not to offer new coverage may be allowed, as determined by the commissioner, to maintain its existing policies in the applicable state;

Review health carrier underwriting files to verify that a health carrier that elects not to offer new coverage to employers in the applicable state has provided notice of its election to the commissioner and does not write new business in the group market in the applicable state for a period of 5 years beginning on the date the carrier ceased offering new coverage in the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to an eligible employer, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible employer that was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed availability of group market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed availability of group market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment, when applicable.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Guaranteed Renewability of Coverage (Individual and Small Group Market Health Insurance)***

CITATION: PHSA §2703

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual and small group market in a state is required to renew or continue in force the coverage at the option of the individual or small employer, as applicable.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual, small group or large group market is required to renew or continue in force the coverage at the option of the plan sponsor.

There are numerous exceptions to the guaranteed renewability requirements, such as failure to pay premiums or contributions, fraud, violation of participation or contribution rules, termination of the plan, enrollees' movement outside of the service area, ceasing of association membership, discontinuation of a particular product, or the discontinuance of all coverage.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
GUARANTEED RENEWABILITY OF COVERAGE

Standard 1
A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed renewability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed renewability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed renewability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed renewability of coverage

_____ Health carrier communication and educational materials related to guaranteed renewability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed renewability of individual market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed renewability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier renews, or continues in force, at the option of the policyholder, individual market health insurance coverage, in compliance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting files to verify that health carrier nonrenewal or discontinuance of coverage of a health benefit plan, subject to guaranteed renewability provisions established by HHS, the DOL and the Treasury final regulations, are performed only as follows:

- The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan, or the health carrier has not received timely premium payments;
- The policyholder or the policyholder's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;
- The health carrier elects to cease offering individual market health insurance coverage in the applicable state in accordance with HHS, the DOL and the Treasury final regulations and other applicable state law;
- In the case of a health carrier that offers coverage through a network plan, the policyholder no longer lives or resides within the health carrier's established geographic service area, and the health carrier would deny enrollment in the plan pursuant to lack of capacity as defined in final regulations established by HHS, the DOL and the Treasury.
- The commissioner, in accordance with state law:
    - Finds that the continuation of the coverage would not be in the best interests of the covered persons or would impair the health carrier's ability to meet its contractual obligations; and
    - Assists affected covered persons in finding replacement coverage (Note: Examiners need to be aware that health carriers that fail to renew coverage under this exception must do so in a nondiscriminatory fashion); or
- In the case of health benefit plans that are made available in the individual market only through one or more bona fide associations, the membership of a policyholder in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated for reason of lack of policyholder association membership uniformly, without regard to any health status-related factor related to any covered person.
- In the case of health benefit plans that are made available in the individual market as student health insurance coverage, the student policyholder covered under the coverage ceases to be a student at the institution of higher education through which the student health insurance coverage is offered, provided the coverage for reason of cessation of student status is terminated uniformly without regard to any health status-related factor related to any covered person; or

- The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the health carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state's individual market, only if the health carrier:
    - Provides advance notice of its decision to discontinue offering the obsolete health benefit plan to the commissioner in the applicable state in which it is licensed;
    - Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
        - All affected policyholders; and
        - The commissioner in the applicable state in which an affected policyholder is known to reside, provided the notice is sent to the commissioner at least three working days prior to the date the notice is sent to the affected policyholders;
    - Provides notice to each enrollee issued that particular type of health benefit plan (obsolete product form) that the policyholder has the option to purchase all other health benefit plans currently being offered by the health carrier in the individual market in the applicable state; and
    - In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage to purchase all other health benefit plans currently being offered by the health carrier in the individual market in the applicable state, acts uniformly, without regard to the claims experience of those covered persons or any other health status-related factor relating to any covered person who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier decides to discontinue offering a particular type of health benefit plan of individual market health insurance coverage, the health carrier discontinues coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:

- Provides advance notice of its decision to discontinue offering a health benefit plan to the commissioner in the applicable state in which it is licensed;
- Provides notice of the decision to nonrenew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:
    - All affected policyholders; and
    - The commissioner in the applicable state in which an affected policyholder is known to reside, provided the notice to the commissioner is sent at least three working days prior to the date the notice is sent to affected policyholders;
- Provides notice to each enrollee issued that particular type of health benefit plan that the policyholder has the option to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the health carrier in the applicable state; and
- In exercising the option to discontinue that particular type of health benefit plan and in offering the option of coverage to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the health carrier in the applicable state, acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any policyholder or dependent of a policyholder or new policyholders and their dependents who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier elects to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, in the applicable state, the health carrier discontinues such coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:

- Provides advance notice of its decision to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, to the commissioner in each state in which it is licensed; and

- Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
    - All affected policyholders; and
    - The commissioner in each state in which an affected policyholder is known to reside, provided the notice sent to the commissioner at least three working days prior to the date the notice is sent to affected policyholders.

Review health carrier underwriting files to verify that in the case of a discontinuance, the health carrier has ceased writing new business in the market in the applicable state for a period of five years beginning on the date the health carrier ceased offering new coverage in the applicable state. Depending upon the state, if a plan that is guaranteed renewable is modified by the health carrier, then that plan typically would need to have been reviewed and approved by the state insurance department.

Review health carrier underwriting files to verify that in the case of a discontinuance, the health carrier, as determined by the commissioner, may renew its existing business in the market in the applicable state or may be required to nonrenew all of its existing business in the market in the applicable state.

Note: Examiners need to be aware that, in the case of a health carrier doing business in one established geographic service area of the applicable state, the guaranteed renewability provisions established by HHS, the DOL and the Treasury shall apply only to the health carrier's operations in that service area. Examiners should also be aware of the rating areas and the service areas that have been approved by the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed renewability of coverage.

Review complaint records to verify that if the health carrier has improperly nonrenewed or discontinued a health benefit plan providing individual market health insurance coverage, the health carrier has taken appropriate corrective action/adjustments regarding renewal of coverage, or continuation of coverage, in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing individual market health insurance coverage was nonrenewed or discontinued.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds, prospective purchasers and policyholders by the health carrier provide complete and accurate information about guaranteed renewability of individual market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed renewability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed renewability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed renewability of individual market health insurance coverage.

Determine if the health carrier monitors producer-generated notices that nonrenew or discontinue coverage. Review producer records of such notices for compliance with the guaranteed renewability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
GUARANTEED RENEWABILITY OF COVERAGE

Standard 2
A health carrier offering small group market health insurance coverage shall renew or continue in force the coverage, at the option of the small employer subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All small group health products (non-grandfathered products) for plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed renewability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed renewability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed renewability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed renewability of coverage

_____ Health carrier communication and educational materials related to guaranteed renewability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed renewability of small group market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed renewability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier renews, or continues in force, at the option of the small employer, small group market health insurance coverage, in compliance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting files to verify that health carrier nonrenewal or discontinuance of coverage of a health benefit plan, subject to guaranteed renewability provisions established by HHS, the DOL and Treasury final regulations, are performed only as follows:

- The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan, or the health carrier has not received timely premium payments;
- The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;
- There has been noncompliance with the health carrier minimum participation requirements;
- There has been noncompliance with the health carrier's employer contribution requirements;
- The health carrier elects to cease offering small group market health insurance coverage in the applicable state in accordance with HHS, DOL and the Treasury final regulations and other applicable state law;
- In the case of a health carrier that offers coverage through a network plan, there is no longer any employee living, working or residing within the health carrier's established geographic service area, and the health carrier would deny enrollment in the plan pursuant to lack of capacity as set forth in HHS, DOL and Treasury final regulations;
- In the case of a health carrier that offers coverage in the small group market only through one or more bona fide associations, the membership of the small employer in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated for reason of lack of policyholder association membership uniformly, without regard to any health status-related factor relating to any covered person;
- The commissioner, in accordance with state law:
    - Finds that the continuation of the coverage would not be in the best interests of the certificateholders or would impair the health carrier's ability to meet its contractual obligations; and
    - Assists affected covered persons in finding replacement coverage (Note: Examiners need to be aware that health carriers that fail to renew coverage under this exception must do so in a nondiscriminatory fashion); or

- The commissioner finds that the product form is obsolete and is being replaced with comparable coverage, and the health carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state's small group market, if the health carrier:
    - Provides advance notice of its decision to discontinue offering that particular type of health benefit plan (obsolete product form) in the applicable state's small group market, to the commissioner, in the applicable state in which it is licensed;
    - Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
        - All affected plan sponsors and employees and their dependents; and
        - The commissioner in the applicable state in which an affected insured individual is known to reside, provided the notice is sent to the commissioner at least three working days prior to the date the notice is sent to the affected plan sponsors and employees and their dependents;
    - Provides notice to each plan sponsor issued that particular type of health benefit plan (obsolete product form) that the plan sponsor has the option to purchase all other health benefit plans currently being offered by the health carrier in the small group market in the applicable state; and
    - In exercising the option to discontinue that particular type of health benefit plan (obsolete product form), acts uniformly without regard to the claims experience of any small employer or any other health status-related factor relating to any employee or dependent of an employee or new employees and their dependents who may become eligible for coverage.

Note: Examiners need to be aware that a health carrier that elects to nonrenew small group market health insurance coverage under a health benefit plan because of the plan sponsor's fraud or intentional misrepresentation of material fact under the terms of coverage, may choose not to issue a health benefit plan to that plan sponsor for one year after the date of nonrenewal. This provision shall not be construed to affect guaranteed renewability requirements pertaining to other health carriers to issue coverage under any health benefit plan to the plan sponsor.

Review health carrier underwriting files to verify that if a health carrier decides to discontinue offering a particular type of health benefit plan of small group market health insurance coverage, the health carrier discontinues coverage only in accordance with applicable state statutes, rules and regulations and only if the health carrier:

- Provides advance notice of its decision to discontinue offering a particular type of health benefit plan of small group market health insurance coverage to the commissioner in each state in which it is licensed;
- Provides notice of the decision to nonrenew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:
    - All affected plan sponsors and employees and their dependents; and
    - The commissioner in the applicable state in which an affected insured individual is known to reside, provided the notice to the commissioner is sent at least three working days prior to the date the notice is sent to affected plan sponsors and employees and their dependents;
- Provides notice to each plan sponsor issued that particular type of health benefit plan that the plan sponsor has the option to purchase all other health benefit plans providing small group market health insurance coverage currently being offered by the health carrier in the applicable state; and
- In exercising the option to discontinue that particular type of health benefit plan, acts uniformly without regard to the claims experience of any small employer or any health status-related factor relating to any employee or dependent of an employee or new employees and their dependents who may become eligible for coverage.

Review health carrier underwriting files to verify that if a health carrier elects to discontinue offering small group market health insurance coverage in the small group market, or all markets, in the applicable state, the health carrier discontinues such coverage only in accordance with applicable state law and only if:

- The health carrier provides advance notice of its decision to discontinue offering small group market health insurance coverage in the small group market, or all markets, to the commissioner in each state in which it is licensed;
- Provides notice of the decision to nonrenew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
    - All affected plan sponsors and employees and their dependents; and
    - The commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the commissioner is sent at least three working days prior to the date the notice is sent to affected plan sponsors and employees and their dependents.
- In the case of a discontinuance, the health carrier shall be prohibited from writing new business in the market in the applicable state for a period of five years beginning on the date the health carrier ceased offering new coverage in the applicable state; and
- In the case of a discontinuance, the health carrier, as determined by the commissioner, may renew its existing business in the market in the applicable state or may be required to nonrenew all of its existing business in the market in the applicable state.

Review health carrier underwriting policies and procedures to verify that at the time of coverage renewal, a health carrier may modify the coverage for a product offered in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with applicable state law and effective on a uniform basis among small group health plans within that market.

Note: Examiners need to be that, in the case of a health carrier doing business in one established geographic service area of the applicable state, the guaranteed renewability provisions established by HHS, the DOL and the Treasury shall apply only to the health carrier's operations in that service area. Examiners should also be aware of the rating areas and the service areas that have been approved by the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed renewability of coverage.

Review complaint records to verify that if the health carrier has improperly nonrenewed, or discontinued a health benefit plan providing small group market health insurance coverage, the health carrier has taken appropriate corrective action/adjustments regarding renewal of coverage, or continuation of coverage, in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing small group market health insurance coverage was nonrenewed or discontinued.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds, prospective purchasers and policyholders by the health carrier provide complete and accurate information about guaranteed renewability of small group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed renewability of small group market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to guaranteed renewability of small group market health insurance coverage.

Review health carrier training materials to verify that information provided is complete and accurate with regard to guaranteed renewability of small group market health insurance coverage.

Determine if the health carrier monitors producer-generated notices that nonrenew or discontinue coverage.

Review producer records of such notices for compliance with the guaranteed renewability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Lifetime/Annual Benefit Limits***

CITATION: PHSA §2711

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual and small group market in a state is prohibited from establishing lifetime limits and annual limits on the dollar value of essential health benefits.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual market and small group market is prohibited from establishing lifetime limits and annual limits on the dollar value of essential health benefits.

Starting in 2014, the Affordable Care Act banned annual dollar limits. Until that time, annual limits were restricted under the Department of Health and Human Services (HHS) regulations published in June 2010. For plan years starting between Sept. 23, 2010 and Sept. 22, 2011, plans may not limit annual coverage of essential benefits such as hospital, physician and pharmacy benefits to less than $750,000. The restricted annual limit is $1.25 million for plan years starting on or after Sept. 23, 2011, and $2 million for plan years starting between Sept. 23, 2012 and Jan. 1, 2014. For plans issued or renewed beginning Jan. 1, 2014, all annual dollar limits on coverage of essential health benefits is prohibited.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to grandfathered and non-grandfathered group health plans, and non-grandfathered individual health benefit plans. This provision does not apply to grandfathered individual health insurance coverage.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
LIFETIME/ANNUAL BENEFIT LIMITS

Standard 1
A health carrier shall not establish any lifetime or annual limit on the dollar amount of essential health benefits (EHB)s for any individual, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Restriction on the dollar amount of lifetime limits applies to all group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010, and all individual health products (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Restriction on the dollar amount of annual limits applies to all group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014 and all individual health products (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Not applicable to grandfathered individual health insurance coverage

Documents to be Reviewed

_____ Health carrier complaint handling policy/procedures

_____ Health carrier complaint register/logs/files

_____ Complaint letter or email and health carrier's complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Health carrier correspondence

_____ Health carrier policyholder service policy/procedures

_____ Health carrier policy files

_____ Health carrier marketing materials

_____ Health carrier policy forms and filings

_____ Health carrier claim handling policies/procedures

_____ Claims training manuals

_____ Health carrier internal claims audit reports

_____ Claim bulletins

_____ Health carrier claim forms manual

_____ Health carrier claim files

_____ Health carrier grievance handling policies/procedures

_____ Health carrier grievance procedure training manuals

_____ Health carrier grievance register

_____ Health carrier grievance records/files

_____ Health carrier internal grievance audit reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written complaint handling policies and procedures regarding compliance with restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review complaint logs/files to verify that, when improper application of lifetime/annual limits on the dollar amount of essential health benefits upon an individual occurs, the health carrier has taken appropriate corrective action/adjustments a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notifications.

Verify that the health carrier has established and implemented written policyholder service policies and procedures regarding compliance with restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that, for plan or policy years beginning prior to Jan. 1, 2014, for any individual, the health carrier has established, for its health benefit plans, the following minimum annual limits on the dollar amount of benefits that are essential health benefits:

- $750,000, for a plan or policy year beginning on or after Sept. 22, 2010, but before Sept. 23, 2011;
- $1,250,000, for a plan or policy year beginning on or after Sept. 22, 2011, but before Sept. 23, 2012; and
- $2,000,000, for a plan or policy year beginning on or after Sept. 22, 2012, but before Jan. 1, 2014.

With regard to U.S. Department of Health and Human Services (HHS) waivers, examiners need to be aware that for plan or policy years beginning prior to Jan. 1, 2014, a health benefit plan is exempt from annual limit requirements if the plan is approved for a waiver from such requirements by the HHS, but such exemption only applies for the specified period of time that the HHS waiver is applicable.

Verify that, when a health benefit plan receives a waiver from the HHS, the health carrier notifies prospective applicants, affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.

Verify that, when an applicable HHS waiver expires or is otherwise no longer in effect, the health carrier notifies affected policyholders and the commissioner in each state where any affected insured is known to reside.

With regard to reinstatement of coverage, verify that the health carrier reinstates coverage for any individual:

- Whose coverage or benefits under a health benefit plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and
- Who becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the health benefit plan:
    - For group health insurance coverage, on the first day of the first plan year beginning on or after Sept. 23, 2010; or
    - For individual health insurance coverage, on the first day of the first policy year beginning on or after Sept. 23, 2010.

Note: Examiners need to be aware that, for individual health insurance coverage, an individual is not entitled to reinstatement under a health benefit plan if the individual has reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, the requirement for reinstatement of coverage does apply to a family member who has reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

With regard to reinstatement of coverage, if an individual is eligible for benefits or is required to become eligible for benefits under the health benefit plan, verify that the health carrier provides the individual with written notice that:

- The lifetime limit on the dollar value of all benefits no longer applies; and
- The individual, if still covered under the plan, is again eligible to receive benefits under the plan.

If an individual is not enrolled in the health benefit plan, or if an enrolled individual is eligible for, but not enrolled in any benefit package under a health benefit plan, verify that the health carrier provides an individual with an opportunity of at least 30 days to enroll in the health benefit plan.

Verify that the health carrier provides applicable notices and an enrollment opportunity beginning not later than:

- For group health insurance coverage, the first day of the first plan year beginning on or after Sept. 23, 2010; or
- For individual health insurance coverage, the first day of the first policy year beginning on or after Sept. 23, 2010.

Verify that the health carrier provides the notices as follows:

- For group health insurance coverage, to an employee on behalf of the employee's dependent;
- For individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent;
- For group health insurance coverage, the notices may be included with other enrollment materials that a health benefit plan distributes to employees, provided the statement is prominently displayed on the notice; and
- For group health insurance coverage, if a notice is provided to an individual, a health carrier's requirement to provide the notice with respect to that individual is satisfied.

For any individual, who is eligible for benefits or who is required to become eligible for benefits under the health benefit plan, that enrolls in a health benefit plan, verify that coverage provided by the health carrier under the plan takes effect not later than:

- For group health insurance coverage, the first day of the first plan year beginning on or after Sept. 23, 2010; or
- For individual health insurance coverage, the first day of the first policy year beginning on or after Sept. 23, 2010.

Examiners need to be aware that, with regard to reinstatement of coverage, an individual enrolling in a health benefit plan for group health insurance coverage is to be treated by the health carrier as if the individual were a special enrollee in the plan, as provided under federal regulations 45 CFR §146.117(d).

With regard to reinstatement of coverage, verify that the health carrier:

- Offers the individual all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and
- Does not require the individual to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

Examiners need to be aware that any difference in benefits or cost-sharing provided to the individual by the health carrier constitutes a different benefit package.

Verify that the health carrier's marketing materials provided to insureds and prospective insureds provides complete, accurate information about lifetime and annual limits.

Verify that the health carrier has established written claim handling policies and procedures regarding compliance with ACA-related restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier's system of ACA-related oversight is reasonably designed to:

- Detect improper application of lifetime/annual limits on the dollar amount of essential health benefits for any individual;
- Identify exceptions found;
- Set forth recommended next steps; and
- Provide for appropriate corrective action/adjustments to be performed by the health carrier regarding incorrectly applied lifetime/annual limits, in a timely and accurate manner.

Review claim handling files to verify that the health carrier properly applies lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review claim handling files to verify that the health carrier does not improperly establish a lifetime limit on the dollar amount of essential health benefits for any individual.

Examiners need to be aware that:

- A health carrier is not prohibited from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law; and
- The provisions of the final regulations established by HHS, the DOL and the Treasury do not prohibit a health carrier from excluding all benefits for a given condition. However, examiners need to be aware that other state/federal laws or regulations, such as state laws regarding mandatory coverage for certain conditions, may prohibit such exclusions of all benefits for a given condition and may have been adopted as part of a state's essential health benefit package.

Verify that the health carrier does not establish an annual limit on the dollar amount of essential health benefits for any individual, with the following exceptions:

- Health flexible spending arrangements (FSA), as defined in Section 106(a)(2)(i) of the Internal Revenue Code;
- Medical savings accounts (MSA), as defined in Section 220 of the Internal Revenue Code; and
- Health savings accounts (HSA), as defined in Section 223 of the Internal Revenue Code.

Verify that the health carrier has taken into account only essential health benefits, in determining whether an individual has received benefits that meet or exceed the allowable limits.

Verify that the health carrier has established written grievance handling policies and procedures regarding compliance with ACA-related restrictions on establishing lifetime/annual limits on the dollar amount of essential health benefits for any individual, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review grievance procedures files/records to verify that, when improper application of lifetime/annual limits on the dollar amount of essential health benefits upon an individual occurs, the health carrier has taken appropriate corrective action/adjustments a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notifications.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Network Adequacy***

CITATION: PHSA §2702 (45 CFR §156.230)

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The NAIC established network adequacy standards as set forth in the revised *Health Benefit Plan Network Access and Adequacy Model Act* (#74) for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility, transparency and quality of health care services offered under a network plan. In addition, provisions of the ACA established a requirement that a health carrier offering qualified health plans in the individual or group markets in a state must meet minimum criteria for the adequacy of provider networks delivering covered services to covered persons.

BACKGROUND: In Nov. 2015, the NAIC adopted a substantially revised network adequacy model, the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). The NAIC established standards for the creation and maintenance of networks by health carriers and assures the adequacy, accessibility, transparency and quality of health care services offered under a network plan. Based upon the Affordable Care Act, federal regulatory agencies, including the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) have issued regulations and associated regulatory guidance, including frequently asked questions (FAQs) that set forth minimum criteria for network adequacy that health carriers' network plans must meet in order to be certified as Qualified Health Plans (QHP's) and stand-alone dental plans (SADPs).

Pursuant to 45 CFR §156.230(a)(2), a health carrier which issues a QHP or SADP that uses a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." All health carriers applying for QHP certification need to attest that they meet this standard as part of the certification/recertification process.

Note: State regulators need to determine whether these examination standards are to apply to all health carriers in the individual market and to group plans, including non-grandfathered group health plans, or to only a subset of health insurance markets and policies, in accordance with state statute and regulations.

FAQs: See the HHS website for federal guidance.

NOTES: Examiners should obtain specific direction from the insurance commissioner ordering the examination as to whether there are provisions for which examiners are to apply federal statutes and regulations in addition to, or in place of, state statutes and regulations when applying these examination standards. Examiners should familiarize themselves with specific state and federal statutes and regulations as they pertain to network adequacy. States have considerable flexibility in determining how they want to address network adequacy issues, and the federal regulatory agencies have traditionally deferred to that inherent state authority. States may therefore require examiners to refer to specific state and federal law and regulations instead of the language found in the *Health Benefit Plan Network Access and Adequacy Model Act* (#74).

STANDARDS
NETWORK ADEQUACY

Standard 1
A health carrier offering individual and group market health insurance network plans shall develop and file an access plan with the insurance commissioner in accordance with requirements regarding content and filing of network access plans set forth in applicable state statutes, rules and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations, in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations and exchange requirements, addressing filing and approval of network adequacy or access plans

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved network access plan(s)

_____ Health carrier policies and procedures related to the implementation of access plans

_____ Health carrier policies and procedures related to filing of access plans and material changes to access plans

_____ Policies and/or incentives that restrict, or unduly burden an enrollee's access to network providers, including provider specialists

_____ Health carrier communication and educational materials related to access plans provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Health carrier employees' and appointed agent training materials

_____ State exchange filing requirements

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding the health carrier's filing of access plans at the time it files a newly offered provider network.

Verify that a health carrier has filed a network access plan in a compliant manner and form and obtained all necessary approvals from the appropriate state regulators prior to or at the same time it files a newly offered network.

Verify that the health carriers' network(s) comply(ies) with approved access plan(s). This verification can be performed by directly confirming active provider participation, "secret shopping," reviewing regulatory or health carrier customer service inquiries and/or complaints, surveying policyholders and enrollees, or by other tools generally employed or otherwise utilized by examiners to verify a health carrier's compliance with filings.

Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 2
A health carrier offering individual and group market health insurance network plans shall maintain a network that is sufficient in number and types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons will be accessible, without unreasonable travel or delay and that emergency services are accessible 24 hours per day, 7 days per week.

Apply to: Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing network adequacy and plan design

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan

_____ Health carrier policies and procedures related to implementing and maintaining network adequacy and access plans

_____ Health carrier correspondence with state regulators addressing issues related to maintaining network adequacy

_____ Health carrier policies and procedures related to filings for material changes to access plans

_____ Provider selection [tiering] criteria and supporting documentation regarding selection [tiering] criteria for maintaining network adequacy and access plans

_____ Documents related to recruitment and selection of providers, including following approval of network access plan

_____ Provider directory/ies

_____ Provider/member location reports (e.g. by ZIP code)

_____ List of providers by specialty

_____ Any policies or incentives that restrict access to subsets of network specialists

_____ Health carrier complaint records concerning network adequacy, plan design and out of network service denials (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures that reference to network adequacy and plan design

_____ Health carrier marketing and educational materials related to network adequacy and plan design created for insureds, beneficiaries and prospective purchasers including communications with producers

_____ Health carrier employee training materials related to network adequacy maintenance activities

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify the health carrier has maintained its provider network(s) in accordance with terms of the approved network access plan(s) and state [and federal] statutes and regulations, as applicable.

Verify the health carrier has implemented the administrative functions necessary to meet the size and performance requirements of its provider network(s), including any reasonable criteria in accordance with its approved access plan and state [and federal] statutes and regulations, as applicable.

Verify that the health carrier has established and implemented written policies and procedures regarding filings of amended access plans when necessitated by materials in its provider networks.

Verify as required by the approved access plan, and by state [and federal] statutes and regulations, that the health carrier's established network(s) address(es) at least the following:

- The use of telemedicine or telehealth or other technology to meet network access standards, if applicable; procedures for making and authorizing referrals within and outside its network, if applicable; factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;
- The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;
- The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary, due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:
    - For covered persons referred to specialty physicians; and
    - For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
- The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at the health carrier's participating hospitals.

Verify the health carrier monitors the performance of its provider network(s) in accordance with its approved access plan and state statutes and regulations, as applicable, and records such activities.

Verify the health carrier has implemented necessary provider network changes, including but not limited to contracting with additional or replacement providers for its provider network(s) required to maintain its provider network(s), as established within its approved access plan(s) and as required under applicable state [and federal] statutes and regulations.

Verify that the health carrier has notified the state insurance department [or other state regulator] of material changes to its access plan.

Verify the health carrier has received any required approvals necessitated by changes to the health carrier's provider network(s) or enrollment.

Verify the health carrier has implemented any requirements established by the state insurance department required by any changes to the access plan or the health carrier's enrolled policyholder and enrolled life membership counts, including any insured, beneficiary, prospective purchaser, or provider notice, education or other communication(s).

Review health carrier policies and procedures related to network adequacy and plan design to verify that the health carrier maintains a network that is sufficient in number and appropriate types of providers, including providers who serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults will be accessible without unreasonable travel or delay, and that emergency services are accessible 24 hours per day, 7 hours per week, in compliance with state [and federal] statutes and regulations.

Verify that the health carrier has established and implemented a process, including written policies and procedures, to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the insurance commissioner as required under state statutes and regulations.

Verify that the health carrier specifies and informs covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider and that such requests are documented, processed in a timely fashion and, for approved requests, that cost-sharing and out-of-pocket maximums are accurately applied, as required under state statutes and regulations.

Verify that the health carrier has a system in place that documents all requests to obtain a covered benefit from a non-participating provider and verify that the health carrier provides this information to the insurance commissioner of the applicable state upon request as required under state statutes and regulations.

Verify that that the health carrier monitors, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contractual covered benefits to covered persons.

Review complaint records to determine if the health carrier has not met minimum network adequacy standards contained within its access plan or required under applicable state [or federal] statutes and regulations or has improperly applied network adequacy standards and whether the health carrier has taken appropriate corrective action/adjustments for the covered person(s) in a timely and accurate manner.

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to a covered person, including website notifications, as applicable.

Verify that health carrier communication and educational and marketing materials provided to insureds, beneficiaries and prospective purchasers provide complete and accurate information about network adequacy.

Verify that the health carrier has established training programs designed to inform its employees and agents about applicable state [and federal] laws and regulations.

Review health carrier employee training materials to verify that information provided is complete and accurate with regard to network adequacy.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network adequacy.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 3
A health carrier's contractual arrangements with participating providers shall comply with requirements regarding health carrier/participating provider contractual requirements set forth in applicable state statutes and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's statutes and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to Qualified Health Plan products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing network adequacy and plan design

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan(s)

_____ Health carrier policies and procedures related to applicable contractual arrangements between health carriers and participating providers

_____ Health carrier contracts with providers

____ Health carrier complaint records relating to complaints or other disputes made by providers, policyholders or enrollees relating to network provider contractual matters

_____ Health carrier communication, education and training materials provided to participating providers

_____ Health carrier employee and agent training materials related to network provider contractual matters

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier's network provider contracts comply with state [and federal] statutes and regulations and with approved network access plan(s).

Review how the health carrier markets or represents its network plans to consumers, particularly for those health carriers that market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, review the health carrier's provider selection standards to verify that quality is actually being used to assess whether to include providers in the network.

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of health benefit network plans with state [and federal] requirements relating to health carrier/participating provider contractual arrangements. Review records related to the written policies and procedures for any instances, indicating health carrier performance, that did not comply with such policies and procedures.

Verify that the health carrier has established a process by which contracting network providers will be notified of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services, on an ongoing basis. Review process records to confirm that the health carrier in fact provides such notifications in a timely manner.

Verify that contracts between a health carrier and a participating provider set forth a hold harmless provision specifying protection for covered persons in the event of nonpayment or insolvency of the health carrier or its intermediary, as required under state statutes or regulations.

Verify that contracts between the health carrier and a participating provider set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue as required under state statutes or regulations.

Verify that the participating provider does not collect or attempt to collect from a covered person any money owed to the provider by the health carrier. Review the contract provisions within the health carrier/participating provider contract with regard to periodic reconciliation/audit of itemized bills related to claims to health carrier reimbursement amounts. Review explanation of benefits (EOB) documents to verify that the provider is collecting the appropriate amount from the covered person.

Verify that the health carrier has developed, for providers and each health care professional specialty, selection standards for selecting [and tiering], as applicable, of participating providers, as required under the health carrier's approved access plan and in accordance with state statutes and regulations. Verify that the health carrier uses the selection standards in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts.

Verify that the health carrier does not establish selection [and tiering] criteria in a manner:

- That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or
- That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

Verify that the health carrier's selection criteria do not discriminate, with respect to participation under the health benefit plan, against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations.

Verify that consistent with state statutes and regulations, the health carrier makes its standards for selection and tiering, as applicable, of participating providers for its network(s)available for review [and approval] by the insurance commissioner.

Verify, if applicable, that a description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, for its network providers is made available to the public.

Verify that the health carrier notifies participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

Review health carrier policies, procedures, programs, provider communications and other materials that may document or record health carrier activities related to provider networks, and policy provisions to identify if a health carrier offers an inducement to a provider that would encourage or otherwise incentivize the provider to deliver less than medically necessary services to a covered person.

Verify that the health carrier does not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the health carrier or a person contracting with the health carrier or in accordance with any rights or remedies available under applicable state [and federal] law and regulations. Examiners may need to review network provider contract forms and network provider communications, policies and other written materials. Review health carrier network provider records including communications that could contain complaints from network providers raising such concerns.

Verify that contracts between a health carrier and a participating provider require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.

Verify that the health carrier and participating provider provide the requisite advance written notice to each other as required under state [and federal] statutes and regulations before the provider is removed or leaves a network without cause.

Verify that the health carrier maintains network provider participation records, including records pertaining to former network providers, to include records documenting provider status, status notices, renewals and terminations as required by state statutes and regulations.

Verify that the health carrier makes a good faith effort to provide written notice of a provider's removal or leaving the network within state [and federal] statutory or regulatory time frames for health carrier notices to all persons entitled to such notice under state [and federal] statutes or regulations.

Verify that when a provider who is a primary care professional has been removed, or has left a provider network, the provider provides the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier, as required by the health carrier's contract with the participating provider. If the list is not provided to the health carrier by the primary care physician who has been removed or who has left a provider network, ascertain why the health carrier has not enforced the contractual provision regarding such notice.

Verify that when the provider being removed or leaving the network is a primary care professional, the health carrier provides notice related to the termination to all covered persons who are patients of that primary care professional.

When a covered person's provider leaves or is removed from the network, verify that the health carrier establishes reasonable procedures addressing those covered persons who are in an active course of treatment, including procedures to assist transitions to participating providers in a manner that provides for continuity of care, in accordance with applicable state [and federal] statutes or regulations.

Verify that the health carrier makes available to the covered person information concerning available participating providers in the same geographic area who are of the same provider type, and information about how the covered person may request continuity of care.

Verify that the health carrier's procedures outlining how a covered person may request continuity of care include all provisions required under state [and federal] statutes or regulations, including:

- Individuals eligible to request continuity of care on behalf of patients;
- Individuals eligible to receive continuity of care;
- The length of the continuity of care period;
- Health carrier decision-making processes on continuity of care requests; and
- Enrollee grievance and appeal rights regarding continuity of care decisions.

Verify that the health carrier's procedures for continuity of care ensure that providers agree in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract, and the provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.

Verify that health carrier contractual arrangements with participating providers ensure that the rights and responsibilities under a contract between a health carrier and a participating provider are not assigned or delegated by either party without the prior written consent of the other party.

Verify that the health carrier has written policies and procedures in place to ensure that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly-financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

Verify that the health carrier assumes responsibility for notifying participating providers (1) of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, and (2) of their obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

Verify that a health carrier does not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Verify that the health carrier has established a mechanism by which a participating provider may determine in a timely manner, at the time services are provided, whether or not an individual is a covered person or is within a grace period for payment of premium during which the health carrier may hold a claim for services rendered, pending receipt of payment of premium.

Verify that the health carrier has established written policies and procedures for resolution of administrative, payment or other disputes between providers and the health carrier for plans that use a provider network.

Review contractual arrangements between the health carrier and participating providers to ascertain if such contracts contain provisions that conflict with the provisions contained in the approved access plan(s) and/or the requirements of applicable state [and federal] statutes and regulations regarding network adequacy.

Verify that, at the time a contract is signed, the network provider receives a copy of or access to the network contract in a timely manner including all documents incorporated by reference. The provider contract shall define what is to be considered timely notice.

Verify that, while a provider contract is in force, the health carrier notifies a participating provider in a timely manner, of any changes to those provisions or documents that would result in material changes in the contract. The language of the contract shall define what is to be considered timely notice and what is to be considered a material change.

Verify that a health carrier informs a provider of the provider's network participation status, in a timely manner, on any health benefit plan in which the health carrier has included the provider as a participating provider.

Review complaint/dispute records to determine if the health carrier has not complied with the contractual provisions of the health carrier/participating provider contract, and whether the health carrier has provided appropriate corrective action/adjustments to the participating provider(s) in a timely and accurate manner.

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence related to any corrective action provided to a participating provider.

Verify that health carrier communication and educational materials provided to participating providers provide complete and accurate information about health carrier/participating provider contractual arrangements.

Review health carrier training materials to verify that information provided is complete and accurate with regard to health carrier/participating provider contractual arrangements and state [and federal] statutes and regulations.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 4
A health carrier offering individual and group market health insurance network plans shall comply with requirements regarding balance billing in accordance with applicable state statutes and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Note: Standard 4 is based on the section titled "Requirements for Participating Facilities with Non-Participating Facility-Based Providers" of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). In states that have not adopted this section of the Model Act, examiners should look at the state statutes and regulations that pertain to balance billing

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing balance billing within health carrier provider networks

_____ Approved health carrier network access plan(s)

_____ Health carrier policies and procedures related to balance billing, including contractual arrangements between health carriers and participating providers

_____ Health carrier policyholder service policies and procedures related to balance billing

_____ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc., within health carrier provider network plans

_____ Non-emergency out-of-network services written disclosures issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks

_____ Out-of-network emergency services billing notices issued by facility-based providers, if set forth in state statutes or regulations for health carrier provider networks

_____ Non-participating facility-based provider-issued payment responsibility notices/billing statements, if set forth in state statute or regulations for health carrier provider networks

_____ Health carrier's provider mediation processes, including policies and procedures, if set forth in state statutes or regulations for health carrier provider networks

_____ Records of open and completed provider mediations, if set forth in state statutes or regulations for health carrier provider network plans

_____ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response) for health carrier provider network plans

_____ Health carrier communication and educational materials related to balance billing provided to insureds, beneficiaries and prospective purchasers of health carrier provider network plans

_____ Employee training materials related to balance billing for health carrier provider network plans

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of network plans with requirements in approved provider networks and as set forth in applicable state statutes and regulations regarding balance billing.

Verify for non-emergency out-of-network services, at the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility provides the covered person with an out-of-network services written disclosure, in accordance with any requirements set forth in state statutes or regulations.

Verify that at the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, the facility provides a covered person with a written disclosure and obtains the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document before the time of admission.

Verify for out-of-network emergency services, a non-participating facility-based provider includes a statement on any billing notice sent to a covered person for services provided, informing the covered person that he or she is responsible for paying the applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under a provider mediation process as set forth in state statutes or regulations.

Verify that where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice includes the Payment Responsibility Notice as set forth in state statutes or regulations.

Verify that non-participating facility-based providers do not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process.

Verify that non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice may not balance bill the covered person.

Verify that for health carrier out-of-network facility-based provider payments, health carriers develop a program for payment of non-participating facility-based provider bills and may elect to pay non-participating facility-based provider bills as submitted, or the health carrier may pay in accordance with the benchmark for non-participating facility-based provider payments established in applicable state statutes and regulations, and that non-participating

facility-based providers who object to such payment(s) may elect the provider mediation process described in applicable state statutes and regulations. Payments to non-participating facility-based providers shall be presumed to be reasonable if a payment is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area.

Verify that the health carrier has established a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in applicable state statutes and regulations or that the health carrier otherwise complies with any state statutes and regulations regarding mediation or arbitration processes for payment of non-participating provider bills. The health carrier's provider mediation process shall be established in accordance with mediation standards as set forth under state statute and regulations.

Verify that following completion of the provider mediation process, the cost of mediation is split evenly and paid by the health carrier and the non-participating facility-based provider or that the health carrier otherwise follows any state statutes or regulations regarding its share of the cost for the process.

Verify that a health carrier provider mediation process is not used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

Verify that a health carrier maintains records on all requests for mediation and completed mediations during a calendar year and, upon request, submits a report to the insurance commissioner in the format specified by the insurance commissioner.

Review complaint records (including complaint records to other state agencies, if applicable) to verify that if a non-participating facility-based provider attempts to collect payment, excluding appropriate cost-sharing, from a covered person for health care services, the non-participating facility-based provider has taken appropriate corrective action/adjustments regarding the removal of the requirement of the covered person's payment for health care services, in a timely and accurate manner.

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to insureds, beneficiaries and prospective purchasers provide complete and accurate information about balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about state [and federal] statutes and regulations pertaining to balance billing.

Review health carrier training materials for its employees and appointed agents to verify that information provided is complete and accurate with regard to balance billing.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 5
A health carrier offering individual and group market health insurance network plans shall develop and issue written disclosures or notices to be provided to covered persons regarding balance billing, in accordance with applicable state statutes and regulations.

Apply to: Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Note: Standard 5 is based on the section titled "Disclosure and Notice Requirements" of the *Health Benefit Plan Network Access and Adequacy Model Act* (#74). In states that have not adopted this section of the Model Act, examiners should look at the state's statutes and regulations that pertain to written disclosures or notices regarding balance billing

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations addressing balance billing within health carrier provider networks

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan provisions related to written disclosures and notices regarding balance billing

_____ Provisions within health carrier contracts with network providers related to written disclosures and notices regarding balance billing

_____ Health carrier policyholder service policies and procedures related to written disclosures and notices of balance billing

_____ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.

_____ Written disclosures for out-of-network services provided by health carriers regarding balance billing

_____ If set forth in state statutes or regulations, written disclosures for non-emergency services provided by facility-based providers regarding balance billing

_____ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier communication and educational materials related to written disclosures/notices of balance billing provided to insureds, beneficiaries, prospective purchasers and producers

_____ Training materials for health carrier employees and appointed agents related to balance billing

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that, as set forth in state [or federal] statute or regulation, the health carrier develops a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification and other time frame(s) as set forth in state [or federal] statutes or regulations for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network, that there is the possibility that the covered person could be treated by a health care professional that is not in the same network as the covered person's network.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier has established and implemented written policies and procedures regarding the content and issuance of written disclosures or notices to covered persons regarding balance billing.

Verify, as set forth in state [and federal] statutes or regulations, that the health carrier's disclosure or notice indicates that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. Verify that the notice includes other content as set forth in state [or federal] statutes or regulations pertaining to the treatment of costs incurred due to care provided by out-of-network providers. Verify that the disclosure or notice also informs the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

Verify, as set forth in statutes or regulations, that for non-emergency services, as a requirement of its provider contract with a health carrier, a facility develops a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network as the covered person's network.

Verify that the health carrier has established processes to count the cost sharing paid by a covered person for an essential health benefit provided by an out-of-network provider in an in-network setting towards the enrollee's annual limitation on cost sharing in instances in which the carrier does not provide requisite notice to the covered person, as required under state [and federal] statutes and regulations.

Review complaint records to verify that if the health carrier has issued a written notice or disclosure of balance billing not in compliance with the content requirements of applicable state [and federal] statutes and regulations and the approved access plan has improperly issued such notice or has not issued such notice, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper written notice or disclosure to the covered person(s).

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains correspondence, records documenting corrective actions taken on behalf of a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to insureds, beneficiaries, prospective purchasers and producers provide complete and accurate information about content and issuance of written notices or disclosures pertaining to balance billing.

Verify that the health carrier has established training programs designed to inform its employees and appointed agents about state [and federal] and regulations regarding content and issuance of written notices or disclosures pertaining to balance billing. Review the health carrier's training materials to verify that the information provided is complete and accurate.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
NETWORK ADEQUACY

Standard 6
A health carrier offering individual and group market health insurance network plans shall comply with requirements set forth in applicable state statutes and regulations regarding content, accessibility, transparency, accuracy, and completeness of printed and electronic provider directories.

Apply to: Those individual and group health products and related provider networks as set forth in the state's laws and regulations. For state examinations being conducted in the absence of state statutes and regulations addressing ACA provisions, to all Qualified Health Plan products that use a provider network

Priority: Essential

Documents to be Reviewed

_____ State statutes and regulations related to network provider directories

_____ Federal statutes and regulations as they pertain to network adequacy

_____ Approved health carrier network access plan(s)

_____ Hard copies and web-based copies of network provider directories

_____ Provisions within health carrier network provider contract(s) entered into pursuant to the approved network access plan(s) addressing provider directories

_____ Health carrier policies and procedures related to network provider directories, including policies and procedures for maintaining accurate and timely directories

_____ Files and supporting documentation regarding frequency of network provider directory revisions and updates

_____ Health carrier self-audits of provider directories, in accordance with state statutes and regulations

_____ Health carrier complaint records concerning the accessibility, accuracy and completeness of network provider directories as well as supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response

_____ Health carrier marketing and sales policies and procedures that refer to provider directories and networks

_____ Health carrier marketing and educational materials related to provider directories and networks provided to insureds, beneficiaries and prospective purchasers, including communications with producers

_____ Health carrier training materials for employees and appointed agents

_____ Producer records related to network provider directories

Others Reviewed

_____ _____

_____ _____

NAIC References

Health Benefit Plan Network Access and Adequacy Model Act (#74)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of all network plans with provider directory requirements in accordance with state [and federal] requirements.

Verify that the health carrier posts electronically a current and accurate provider directory for each of its network plans, including specified information required under state [and federal] statutes and regulations for health care professionals, hospitals and other facilities. To the extent required under state statutes and regulations, verify that this information is available in a searchable format.

Verify for electronic provider directories for each network plan, that the health carrier makes available specified additional information required under state statutes or regulations for health care professionals, hospitals and other facilities.

Verify that in making a provider directory available electronically, the health carrier ensures that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

Verify that the health carrier makes it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in the applicable state.

Verify that the health carrier updates each network plan provider directory at least monthly or within the specified time frame stated under applicable state statutes or regulations.

Verify that the health carrier periodically audits at least a reasonable sample size of its provider directories for accuracy and retains documentation of such an audit to be made available to the insurance commissioner of the applicable state upon request or complies with any other provider directory audit requirements as applicable under state statutes or regulations.

Verify that the health carrier provides a print copy, or a print copy of the requested directory information, of a current provider directory with specified information for health care professionals, hospitals and other facilities, in accordance with state [and federal] statutes and regulations, upon request of a covered person or a prospective covered person.

Verify, via sample testing of the provider directory relative to network providers, that the network provider:

- Is still practicing;
- Is currently participating in the health carrier's network;
- Office is located at the address designated in the provider directory;
- Is practicing in accordance with the designation (i.e. pediatrics, nurse midwife, cardiology) as listed in the provider directory;

- Is currently accepting new patients;
- Has not been sanctioned or prohibited from participation in federal health care programs under Section 1128 or Section 1128A of the Social Security Act; and
- Has not had his/her license suspended or revoked by a state agency.

With regard to residential treatment facilities (mental health treatment and substance use disorder), verify that residential treatment facilities for mental health treatment and substance use disorder are included in the provider directory on the health carrier's website and in hardcopy.

Verify that for each network plan, a health carrier includes in plain language in both the electronic and print directory, general information, if applicable, describing the criteria the health carrier has used to build its provider network; describing the criteria the health carrier has used to tier providers; describing how the health carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and noting that authorization or referral may be required to access some providers.

Verify that the health carrier includes in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

Verify that for all of the pieces of information required to be included in a printed or electronic provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier makes available through the directory the source of the information and any limitations, if applicable.

Verify that the health carrier's provider directory, whether in electronic or print format, accommodates the communication needs of individuals with disabilities, and includes a link to or information regarding available assistance for persons with limited English proficiency, or otherwise complies with state statutes and regulations regarding accessibility.

Note: State regulators should be aware that a Qualified Health Plan (QHP) must comply with language accessibility requirements under federal regulations 45 CFR §155.205 in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

Verify that the health carrier makes available in print, upon request, specified information about health care professionals, hospitals and other facilities required under state statute and regulations, for the applicable network plan.

Verify that the health carrier includes a disclosure in the printed directory that the information included in the directory is accurate as of the date of printing and that insureds, beneficiaries, prospective purchasers and producers should consult the health carrier's electronic provider directory on its website or call the health carrier's customer service telephone number to obtain current provider directory information.

Review complaint register/logs and complaint files to identify complaints pertaining to accessibility, accuracy and completeness of provider directories.

Review complaint records to verify that if the health carrier has issued a provider directory not in compliance with the content requirements of applicable state [and federal] statutes and regulations, has improperly issued such a directory or has not issued such a directory, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper provider directory to covered person(s).

Ascertain if any examination adverse determination finding could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains correspondence documenting the corrective action taken on behalf of a covered person(s), including website notifications related to provider directories.

Verify that any marketing materials, communication and educational materials provided to insureds, beneficiaries and potential purchasers by the health carrier provide complete and accurate information about the network based on evaluation of the content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that the health carrier has established training programs designed to inform its employees and appointed agents about applicable state [and federal] statutes and regulations pertaining to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review health carrier training materials to verify that information provided is complete and accurate with regard to requirements for content, accessibility, transparency, accuracy, and completeness of provider directories.

Review producer records and health carrier communication with producers to verify that the provider directory information provided by producers to insureds, beneficiaries and prospective purchasers is complete and accurate with regard to provider networks.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Prohibition on Preexisting Condition Exclusions***

CITATION: PHSA §2704 and §1255

EFFECTIVE DATE: For grandfathered and non-grandfathered group health insurance coverage, plan years beginning on or after Jan. 1, 2014; grandfathered plans must also comply with other federal and state requirements related to preexisting condition exclusions, including HIPAA

For non-grandfathered individual health insurance coverage, policy years beginning, or applications denied on or after Jan. 1, 2014

For individuals under 19 years of age enrolled in transitional coverage, policy or plan years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) prohibit health carriers from denying coverage, limiting benefits or denying benefits to any individual, based upon a preexisting condition.

BACKGROUND: "Preexisting condition exclusion" means a limitation or exclusion on benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR §148), whether medical advice, diagnosis, care or treatment was recommended or received before that day.

A preexisting condition exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR §148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period).

Note: The standards for Section 2704 are closely related to other provisions of the ACA regarding guaranteed issue, waiting periods and nondiscrimination. For instance, health carriers are prohibited from denying eligibility for benefits or from charging more for coverage on the basis of health status-related factors, including health status, medical condition (both physical and mental illness) and claims experience, among other factors. It is important to review other areas of Chapter 24A for further guidance regarding other applicable health reform provisions.

Examiners should also refer to guidance provided by the U.S. Department of Health and Human Services (HHS) the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) final regulations, including FAQs and other guidance issued by HHS, the DOL and the Treasury with regard to the prohibition of preexisting condition exclusions and special enrollment period provisions.

FAQs: See the HHS website for federal guidance.

NOTES: For additional examination standards related to preexisting condition exclusions, please review the section of Chapter 24—Conducting the Health Examination in the *Market Regulation Handbook* related to HIPAA.

STANDARDS
PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS

Standard 1
A health carrier may not deny coverage to applicants/proposed insureds, based on any preexisting condition exclusion or preexisting condition limitation.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014. Grandfathered plans must also comply with other federal and state requirements related to preexisting condition exclusions, including HIPAA

All individual health products (non-grandfathered products) for policy years beginning, or applications denied on or after Jan. 1, 2014

All transitional products (non-grandfathered products) for policy or plan years beginning on or after Sept. 23, 2010 for individuals under age 19

This does not apply to individual health insurance coverage grandfathered health plans. However, other federal and state requirements related to preexisting condition exclusions, including HIPAA, may apply

Priority: Essential

Documents to be Reviewed

_____ Data request for all applications for coverage during the relevant period, including the underwriting and rating characteristics of the applicant and the outcome of the application

_____ Health carrier underwriting, policyholder service, and complaint handling policies and procedures related to eligibility and coverage for applicants/proposed insureds with preexisting conditions

_____ Underwriting files

_____ Policyholder service files and supporting documentation, letters, notices, telephone scripts, etc., regarding preexisting conditions

_____ Complaint register/logs/files

_____ Health carrier complaint records (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Applications for coverage and pre-enrollment questionnaires

_____ Questionnaires or assessments related to wellness or disease-management programs and health carrier policies and procedures for using this information

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to preexisting conditions

_____ Health carrier communication and educational materials related to preexisting conditions provided to applicants and enrollees, including communications with producers

_____ Any information that health carriers request before an individual is accepted for coverage, including, but not limited to, claims history, family history, genetic information and credit information

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Review health carrier underwriting, policyholder service and complaint handling policies and procedures for provisions addressing applicants/proposed insureds to verify that the health carrier has adequate and appropriate policies and procedures in place to ensure that coverage is not denied to applicants/proposed insureds on the basis of a preexisting condition. Such review should include examination of applications for coverage and pre-enrollment questionnaires, questionnaires or assessments related to wellness or disease-management programs, the collection of any other information that health carriers request before an individual is accepted for coverage, and health carrier policies and procedures for using this information.

Verify that the health carrier does not limit or exclude coverage under an individual or group health insurance benefit plan for an individual via the health carrier's issuance of a preexisting condition exclusion or preexisting condition limitation on that individual.

Note: HIPAA explicitly limits the use of preexisting condition exclusions and prohibits health carriers from denying eligibility for benefits or from charging more for coverage because of any health factor, including health status, medical condition (both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability. For additional examination standards related to these requirements, please review the section of Chapter 24—Conducting the Health Examination in the *Market Regulation Handbook*.

Review health carrier underwriting files/records for denials of coverage for applicants/proposed insureds on the basis of a preexisting condition.

Review health carrier policyholder service files to identify inquiries regarding coverage denials for applicants/proposed insureds on the basis of a preexisting condition.

Analyze data on applications and the outcome of applications to assess whether there are unusual frequencies related to denials of coverage and the reasons for denials. An unusual frequency for a certain type of denial could indicate failure to comply with the prohibition against preexisting condition exclusions or limitations.

Review health carrier enrollment policies and procedures to verify that the health carrier has adequate and appropriate policies and procedures in place regarding applications for coverage for individuals, to include provisions addressing open enrollments and renewals:

- Verify that during an open enrollment period, a health carrier does not deny or unreasonably delay the issuance of a policy, refuse to issue a policy or issue a policy with any preexisting condition exclusion rider or endorsement to an applicant or insured on the basis of a preexisting condition; and
- Verify that the coverage offered by the health carrier is effective for those applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

Verify that the health carrier:

- Provides prior prominent public notice on its Internet website and written notice of open enrollment rights for individuals to each of its policyholders at least 90 days before any open enrollment period; and
- Provides information as to how an individual may enroll in coverage with the health carrier during an open enrollment period.

Individual Health Insurance Coverage—Special Enrollment Periods

Verify that a health carrier that restricts enrollment to defined enrollment periods, including open enrollment periods, limited open enrollment periods and special enrollment periods, and provides those periods pursuant to 45 CFR §147.104 and §155.420, as well as in accordance with state-specific requirements.

Verify that a health carrier provides for a special enrollment period that is not less than 60 calendar days, pursuant to 45 CFR §147.104 and §155.420 for qualified individuals (and their dependents, when applicable) in the following circumstances:

- Loss of minimum essential coverage (including employer plans, Medicaid, CHIP and COBRA coverage, as well as loss of coverage due to divorce, legal separation, loss of dependent status or death of the policyholder);
- Addition of a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care (including gaining a dependent through a child support order or other court order);
- Unintentional, inadvertent, or erroneous enrollment in a plan that results from error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the exchange or HHS or its instrumentalities, or a non-exchange entity (including a health carrier or its representative) that provides enrollment assistance or conducts enrollment activities;
- Health carrier substantially violated a material provision of its contract in relation to the enrollee;
- Enrollee or dependent of an enrollee is determined newly eligible or ineligible for an advance premium tax credit or experiences a change in eligibility for cost-sharing reductions;
- A person terminates employer coverage as a result of being determined newly eligible for premium tax credits due to becoming ineligible for qualifying coverage in an eligible employer-sponsored plan;
- A person in a state that has not expanded Medicaid who was previously ineligible for premium tax credits due to having income below the federal poverty line experiences a change in household income that makes the person newly eligible for premium tax credits; or
- A permanent move that results in access to new individual market plans (including release from incarceration).

Verify that a health carrier that offers qualified health plans through an insurance exchange or marketplace serving the individual insurance market also provides for a special enrollment period that is not less than 60 days for qualified individuals in the following circumstances:

- Gain of status as a citizen, national, or lawfully present individual;
- Status as federally recognized American Indian tribe or Alaska Native; or
- Person demonstrates to the exchange in the state, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the exchange may provide.

Verify that a health carrier provides for a special enrollment period with effective coverage dates that begin the first day of the month following enrollment if the plan is selected between the 1st and 15th of the month or the first day of the second month following enrollment if the plan is selected between the 16th and the last day of the month with the following exceptions:

- In the case of marriage, not later than the first day of the month following plan selection;
- In the case of a dependent's birth, adoption, placement for adoption, or placement in foster care, the date of the birth, adoption, placement for adoption or placement in foster care; or
- For loss of minimum essential coverage, the first day of the month following the loss of previous coverage if the qualified health plan is selected before or on the day of the loss. If the plan is selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.

Note: In some circumstances, federal rules permit states or the marketplace in a state to implement alternative coverage effective dates. Examiners should verify that health carriers are complying with any state-specific requirements that may apply.

Note: Examiners should be aware that in some cases, individuals having prior group health plan coverage may be eligible for special enrollment in a health benefit plan if the individual was under a COBRA continuation provision and the coverage under such provision was exhausted or the individual was not under a COBRA continuation provision, but the coverage was terminated as a result of a COBRA qualifying event resulting in the loss of eligibility of coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or employer contributions toward such coverage were terminated.

Group Plans—Special Enrollment Periods

Verify that a health carrier offering coverage in the group market provides for an annual open enrollment period from Nov. 15 through Dec. 15, during which time employers may enroll in coverage without meeting any minimum participation or minimum contribution requirements.

Verify that a health carrier offering coverage in the group market permits employers to enroll at any time during the year, including outside of the annual group open enrollment period, and that the carrier does not place any unallowable enrollment restrictions on employers.

Verify that any enrollment restrictions that may be allowable outside of the annual group enrollment period (such as minimum participation and minimum contribution requirements) are applied by the carrier in a consistent manner to all employers seeking coverage.

Note: Different enrollment standards may apply depending on whether group coverage is being offered within a group exchange (also known as a SHOP marketplace) or in the group market outside of an exchange or SHOP. For example, the minimum participation requirement may be calculated differently. Examiners should be aware of such differences and also of whether the carrier being examined is offering coverage within a SHOP, outside the SHOP, or both.

Verify that a health carrier permits an employee, or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of any health benefit plan of the employer during a special enrollment period if:

- The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
- The employee's or dependent's coverage:
    - Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
    - Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, cessation of dependent status, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated, or loss of coverage because an individual no longer resides, lives or works in the service area of HMO coverage;
- The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time; and
- Under the terms of the health benefit plan, the employee requests enrollment not later than 30 days after the triggering event.

Verify that the health carrier provides a special enrollment period to all covered employees that experience the following qualifying events that result in the loss of coverage of a qualified beneficiary pursuant to 29 USC §1163:

- The death of the covered employee;
- The termination (other than by reason of such employee's gross misconduct) or reduction of hours of the covered employee's employment;
- The divorce or legal separation of the covered employee from the employee's spouse;
- The covered employee becomes entitled to benefits under Title XVIII of the Social Security Act;
- A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; or
- A proceeding in a case under Title XI of the Social Security Act, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

Verify that if an employee requests enrollment, the health carrier provides for enrollment effective not later than the first day of the first calendar month beginning after the date the health carrier received the completed request for enrollment.

Verify that, with respect to dependents of employees, the health carrier provides for a dependent special enrollment period during which the dependent, and if not otherwise enrolled, the employee, may be enrolled under a health benefit plan, if a person becomes a dependent of the employee/participant through marriage, birth adoption or placement for adoption.

Verify that the health carrier's special enrollment period for qualified individuals provides a period of time not less than 30 days from the date of the marriage, birth, adoption or placement for adoption (or, if dependent coverage is not generally made available, at least 30 days after the date the plan makes dependent coverage generally available).

Verify that the health carrier, for an employee who seeks to enroll a dependent during a special enrollment period, provides for the coverage of the dependent effective upon:

- In the case of marriage, not later than the first day of the first month beginning after the date the health carrier receives the completed request for special enrollment;
- In the case of a dependent's birth, as of the child's birth; and
- In the case of a dependent's adoption or placement for adoption, not later than the date of the adoption or placement for adoption.

Verify that the health carrier permits an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll in coverage under the terms of the health benefit plan of the employer during a special enrollment period if:

- The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under the plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the plan not later than 60 days after the date of termination of such coverage; or
- The employee or dependent becomes eligible for assistance, with respect to coverage under the plan under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the plan not later than 60 days after the employee or dependent is determined to be eligible for such assistance.

Verify that the health carrier provides adequate written notice of special enrollment rights and the requirement furnished to an individual declining coverage (if the plan requires the reason for declining coverage to be in writing). 29 CFR §2590.701-6 includes model language for informing employees of their special enrollment rights.

Verify that the health carrier does not treat special enrollees as late enrollees and offers the same benefit package as is offered to similarly situated individuals who enroll when first eligible. Any differences in benefits or cost-sharing requirements for different individuals constitute a different benefit package, and a special enrollee cannot be required to pay more for coverage or to enroll in different coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

Verify that the health carrier is in compliance with 45 CFR §147.108 and 45 CFR §146.111, including the examples identified in federal regulations.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction relating to the health carrier having imposed preexisting condition exclusions or preexisting condition limitations.

Review complaint records to verify that, when an applicant/proposed insured has been the subject of a restriction of health benefits coverage or has been denied health benefits coverage, due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an applicant/proposed insured for whom coverage of health benefits were inappropriately restricted or denied due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation.

Review policy form files to verify approval(s) from the applicable state and (if applicable) from the Marketplace, and compare against the issued certificate or policy provided in the sample.

Verify that any marketing materials provided to prospective purchasers by the health carrier provide complete and accurate information about the prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Verify that health carrier communication and educational materials provided to applicants and enrollees provide complete and accurate information about the prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Review health carrier training materials to verify that information provided is complete and accurate with regard to limitations and restrictions regarding the issuance of preexisting condition exclusions or preexisting condition limitations.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to limitations and restrictions regarding the issuance of preexisting condition exclusions or preexisting condition limitations and does not encourage the exclusion of applicants/proposed insureds on the basis of preexisting conditions.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS

Standard 2
A health carrier may not deny coverage to any insured, based on any preexisting condition exclusion or other preexisting condition limitation.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Jan. 1, 2014. Grandfathered plans must also comply with other federal and state requirements related to preexisting condition exclusions, including HIPAA

All individual health products (non-grandfathered products) for policy years beginning, or applications denied on or after Jan. 1, 2014

All transitional products (non-grandfathered products) for policy or plan years beginning on or after Sept. 23, 2010 for individuals under age 19

This does not apply to individual health insurance coverage grandfathered health plans. However, other federal and state requirements related to preexisting condition exclusions, including HIPAA, may apply

Priority: Essential

Documents to be Reviewed

_____ Data request for all claims presented by policyholders during the relevant period, including a description of the benefit requested and the outcome of the claim

_____ Health carrier policyholder service, complaint handling, claim handling and grievance policies and procedures related to coverage for insureds with preexisting conditions

_____ Policyholder service files, and supporting documentation, including claim denial letters and explanation of benefits, letters, notices, telephone scripts, etc., regarding preexisting conditions

_____ Complaint register/logs/files

_____ Health carrier complaint records (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claim files/register/logs

_____ Informal/formal grievances/register/logs

_____ Health carrier utilization management policies and procedures

_____ Applicable external appeals files/register/logs, external appeal resolutions and associated documentation

_____ Applications for coverage and pre-enrollment questionnaires

_____ Questionnaires or assessments related to wellness or disease-management programs and health carrier policies and procedures for using this information

_____ Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier communication and educational materials related to preexisting conditions provided to policyholders, certificateholders and beneficiaries, including communication with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation (#107)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Review health carrier policyholder service, complaint handling, utilization management policies and procedures, claim handling and grievance procedures policies and procedures for provisions addressing insureds, to verify that a health carrier has adequate and appropriate policies and procedures in place to ensure that coverage is not denied to insureds on the basis of a preexisting condition or preexisting condition limitation.

Verify that the health carrier does not limit or exclude coverage for any insured under an individual or group health insurance benefit plan via the health carrier's issuance of a preexisting condition exclusion or preexisting condition limitation on that individual.

Review health carrier policyholder service files/records for inquiries regarding denial of coverage to insureds on the basis of a preexisting condition.

Review health carrier complaint register/logs and complaint records to identify complaints relating to denial of coverage to insureds on the basis of a preexisting condition.

Review health carrier claim files/register/logs and formal and informal grievances to identify insureds for whom coverage of health benefits was improperly restricted or denied, due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation.

Review health carrier claim files/register and formal and informal grievances, as well as records of appeals of adverse utilization review determinations, to verify that when a health carrier has improperly applied limitations or exclusions of coverage through the issuance of a preexisting condition exclusion or preexisting condition limitation on any insured, the health carrier has taken appropriate corrective action/adjustments regarding the removal of the limitations/exclusions in a timely and accurate manner.

Analyze data on claims presented and claim outcomes to assess whether there are unusual frequencies related to denials of claims and the reasons for denials. An unusual frequency for a certain type of claim denial could indicate failure to comply with the prohibition against preexisting condition exclusions or limitations.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented any corrective actions, including remediation and interest payments. The examiner should include this information in the examination report. If it appears financial harm occurred to consumers and the health carrier did not provide remediation, the examiner should make a recommendation for remediation to all affected consumers in the examination report.

Verify that the health carrier maintains proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications.

Review of procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing improper denial/restriction of coverage due to the health carrier having imposed a preexisting condition exclusion or preexisting condition limitation on an insured.

Review policy form files to verify approval(s) from the applicable state and, (if applicable) from the Marketplace, and compare against the issued certificate or policy provided in the sample.

Note: Examiners need to be aware that other plan elements may result in the imposition of a preexisting condition exclusion or limitation on the insured or discourage the enrollment of individuals with significant health needs. These elements may include cost-sharing; narrow or tiered provider networks; drug formularies; restrictive medical necessity definitions; utilization management; waiting periods; and benefit substitution. Therefore, examiners should review the health carrier's health benefit plans to verify that these benefit design elements are consistent with reasonable medical management techniques and are not discriminatory.

Verify that health carrier communication and educational materials provided to policyholders, certificateholders and beneficiaries provide complete and accurate information about the prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to prohibition of the health carrier from imposing any preexisting condition exclusion or preexisting condition limitation.

Review health carrier training materials to verify that information provided is complete and accurate with regard to the prohibition of health carrier issuance of preexisting condition exclusions and preexisting condition limitations.

Review producer records and health carrier communications with producers to verify that information provided by producers to insureds and claimants is complete and accurate with regard to the prohibition of health carrier issuance of preexisting condition exclusions and preexisting condition limitations and does not encourage the exclusion of applicants/proposed insureds on the basis of preexisting conditions.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Preventive Health Services***

CITATION: PHSA §2713

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth a requirement that a health carrier that provides coverage in the individual and small group market in a state must provide a minimum level of preventive benefits. PHSA §2713 contains guidelines for determining what services are considered "preventive." A health carrier may not impose cost sharing requirements on preventive health services.

BACKGROUND: Under the Patient Protection and Affordable Care Act (ACA), covered persons are eligible for a variety of "preventive services," without cost-sharing, or at no additional cost to the covered person. These preventive health services are among those designed to help identify health problems earlier, manage those problems more effectively, and treat those problems before they develop into more complicated and serious illness.

The U.S. Department of Health and Human Services (HHS) has provided several lists of covered preventive health services for different groups, including evidence-based screening and counseling, preventive services for adults, preventive services for children and youth, and preventive services for women, including pregnant women.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision does not apply to grandfathered health insurance coverage.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
PREVENTIVE HEALTH SERVICES

Standard 1
A health carrier shall not impose cost sharing requirements upon preventive services, as defined in, and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All group health products (non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

Individual health products (non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Not applicable to grandfathered health insurance coverage

Priority: Essential

Documents to be Reviewed

_____ Health carrier complaint handling policy/procedures

_____ Health carrier complaint register/logs/files

_____ Health carrier complaint register

_____ Complaint letter or email and health carrier's complaint response

_____ Supporting documentation (claim files, underwriting files, etc.)

_____ Health carrier correspondence

_____ Health carrier policyholder service policy/procedures

_____ Health carrier policy files

_____ Health carrier marketing materials

_____ Health carrier policy forms and filings

_____ Health carrier claim handling policies/procedures

_____ Claims training manuals

_____ Health carrier internal claims audit reports

_____ Claim bulletins

_____ Health carrier claim forms manual

_____ Health carrier claim files

_____ Health carrier grievance handling policies/procedures

_____ Health carrier grievance procedure training manuals

_____ Health carrier grievance register

_____ Health carrier grievance records/files

_____ Health carrier internal grievance audit reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established written complaint handling policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost-sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review complaint logs/files to verify that, when improper assessment of cost-sharing upon insureds occurs, the health carrier has taken the appropriate corrective action/adjustments on the insured's policy deductibles, copayments, coinsurance and other cost-sharing mechanisms in a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notifications.

Verify that the health carrier has established written policyholder service policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost-sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that other provisions of state or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including Section §2715(d)(4) of the Public Health Services Act, which requires a health carrier to give 60 days' advance notice to a covered person before any material modification will become effective.

The USPSTF recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current. A health carrier would therefore not need to provide coverage in accordance with the November 2009 USPSTF guidelines. However, the examiner should check the USPSTF recommendations regarding breast cancer screening, mammography and prevention periodically to see if the recommendations have been updated.

Verify that the health carrier, at least annually at the beginning of each new plan year or policy year, whichever is applicable, revises the preventive services covered under its health benefit plans in accordance with final regulations established by HHS, the DOL and the Treasury and that are consistent with the recommendations of the USPSTF, the ACIP of the CDC and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings supported by the HRSA in effect at the time.

Verify that the health carrier's marketing materials provided to insureds and prospective insureds provides complete, accurate information about the restriction of cost-sharing methods the health carrier may impose on the insured for preventive items and services described in the final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier has established written claim handling policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost-sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier's system of ACA-related oversight is reasonably designed to:

- Detect improper assessment of cost-sharing upon insureds for preventive items and services;
- Identify exceptions found;
- Set forth recommended next steps; and
- Provide for appropriate corrective action/adjustments to be performed by the health carrier on the insured's policy deductibles, copayments, coinsurance and other cost sharing mechanisms in a timely and accurate manner.

Review claim handling files to verify that the health carrier properly applies deductibles, co-payments, coinsurance and other methods of cost-sharing on preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review claim handling files to verify that the health carrier does not improperly impose any cost-sharing requirements, such as a co-payment, coinsurance or deductible with respect to all of the following items or services:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force (USPSTF) as of Sept. 23, 2010, with respect to the insured;
- Note: Examiners need to be aware that the listing of recommended items/services in the USPSTF may change over time. Examiners need to review the health carrier's claims practices procedures to verify that the health carrier is utilizing the USPSTF recommendations in effect at the time that the items/services are rendered to the insured. The website for verification of the aforementioned is, as of May 2023, located at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
- Immunizations for routine use in children, adolescents and adult insureds that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation from the ACIP of the CDC is considered in effect after it has been adopted by the Director of the CDC, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the CDC. Note: The recommended immunizations for children, adolescents and adults referenced above can be found at *www.cdc.gov/vaccines/schedules*;
- With respect to infants, children and adolescent insureds, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to insured women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Examiners need to be aware that a health carrier may impose cost-sharing requirements with respect to an office visit, if an item or service described in final regulations established by HHS, the DOL and the Treasury is billed separately or is tracked as individual encounter data separately from the insured's office visit.

Review the health carrier's claim handling files to verify that the health carrier does not improperly impose any cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the insured's office visit is the delivery of the item or service.

If an item or service described in in final regulations established by HHS, the DOL and the Treasury is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service, then the carrier may impose cost sharing requirements.

Examiners need to be aware that with regard to preventive items and services delivered by out-of network providers:

- A health carrier that has a network of providers is not required to provide benefits for items and services described in final regulations established by HHS, the DOL and the Treasury that are delivered by an out-of-network provider; and
- A health carrier that has a network of providers is not precluded from imposing cost-sharing requirements for items or services described in final regulations established by HHS, the DOL and the Treasury that are delivered by an out-of-network provider.

Examiners need to be aware that nothing prevents a health carrier from using medical management techniques to determine frequency, method, treatment or setting described in final regulations established by HHS, the DOL and the Treasury to the extent not specified in the recommendation(s) or guideline(s).

Examiners need to be aware that with regard to additional services, a health carrier is not prohibited from providing coverage for items and services in addition to those recommended by the USPSTF or the ACIP of the CDC, or provided by guidelines supported by the HRSA, or from denying coverage for items and services that are not recommended by the USPSTF, the ACIP or the HRSA. A health carrier may impose cost-sharing requirements for a treatment not described in final regulations established by HHS, the DOL and the Treasury even if the treatment results from an item or service described in final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier has established written grievance handling policies and procedures regarding compliance with ACA-related restrictions on the assessment of cost-sharing upon insureds for preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review grievance procedures files/records to verify that, when improper assessment of cost-sharing upon insureds occurs, the health carrier has taken the appropriate corrective action/adjustments on the insured's policy deductibles, copayments, coinsurance and other cost-sharing mechanisms in a timely and accurate manner.

Verify that the health carrier maintains proper documentation for all correspondence supporting the corrective action provided to the insured, including website notifications.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Rescissions***

CITATION: PHSA §2712

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) prohibit health carriers from rescinding policies unless a rescission is based upon fraud or intentional misrepresentation of material fact.

BACKGROUND: Regulations and associated FAQs issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a rescission is a cancellation or discontinuance of coverage that has a retroactive effect; this includes a cancellation that treats a policy as void from the time of the group's enrollment or a cancellation that voids benefits paid up to one year before the cancellation. A rescission is not the cancellation or discontinuance of coverage that has only a prospective effect, nor the cancellation or discontinuance of coverage if effective retroactively to the extent it is based on a failure to timely pay required premiums or contributions towards the cost of coverage.

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to both grandfathered and non-grandfathered group health plans.

A group health benefit plan and a health carrier offering group or individual health insurance coverage may not rescind such plan or coverage with respect to a plan enrollee (in the individual market, primary subscriber) once the enrollee (plan subscriber) is covered under such plan or coverage, except that provision shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Such plan or coverage may not be cancelled except with prior notice to the plan enrollee (in the individual market, primary subscriber) and only as permitted under applicable sections of HHS, DOL and Treasury regulations.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
RESCISSIONS

Standard 1
A health carrier may not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to rescissions

_____ Underwriting files and supporting documentation regarding rescissions, including letters, notices, telephone scripts, etc.

_____ Rescinded policies

_____ Reformations/counteroffers

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning rescissions (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Claim files

_____ Internal appeals/grievances files

_____ Applicable external appeals based on rescissions, external appeal resolution and associated documentation

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to rescissions

_____ Health carrier communication and educational materials related to rescissions, provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding the prohibition of rescissions in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to rescissions to verify adequate and appropriate policies/procedures are in place to ensure rescissions issued by the health carrier are in compliance with final regulations established by HHS, the DOL and the Treasury.

Review rescinded policies to verify that the health carrier does not inappropriately rescind coverage.

Review reformations and/or counteroffers to determine if the reformation or counteroffer resulted in any inappropriate rescissions of coverage.

Note: Examiners need to be aware that carrier rescissions should be reviewed to ensure that carrier rescissions are not based on actions taken or statements made by enrollees on the basis of errors or misrepresentations on the part of carriers, exchanges, producers, navigators or assisters. (See the federal Centers for Medicare & Medicaid Services (CMS) guidance on errors and misrepresentations.)

Review rescission notices to verify that notices sent out clearly state the specific fraudulent act, practice, or omission or intentional misrepresentation of material fact on which the rescission is based, the terms of the plan or coverage that supports the rescission, and the factual basis for rescinding coverage.

Review complaint register/logs and complaint files to identify complaints pertaining to rescission.

Review complaint records to verify that when coverage has been rescinded inappropriately, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual whose coverage was inappropriately rescinded.

Review health carrier claim files to identify any coverage denials for claimants on inappropriately rescinded coverage.

Review health carrier internal appeals/grievance files to identify any coverage denials for individuals on inappropriately rescinded coverage.

Review procedures should also require review of any external appeal requests and of the conclusions of external appeals addressing rescissions.

Review policy form files to ensure approval(s) from the applicable state and (if applicable) from the Marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about rescissions.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about rescissions.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to rescissions.

Review health carrier training materials to verify that information provided is complete and accurate with regard to rescissions.

Determine if the health carrier monitors producer-generated rescissions. Review producer records of rescissions for compliance with final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
RESCISSIONS

Standard 2
A health carrier offering group or individual health insurance coverage shall provide at least 30 days' advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage may be rescinded.

Apply to: All group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2010

All individual health products (grandfathered and non-grandfathered products) for policy years beginning on or after Sept. 23, 2010

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to rescissions

_____ Underwriting files and supporting documentation regarding rescissions, including letters, notices, telephone scripts, etc.

_____ Rescinded policies

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning rescissions (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding providing advance notice of rescissions in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier's underwriting policies and procedures related to advance written notice of rescissions to verify that adequate and appropriate policies/procedures are in place to ensure the health carrier issues advance written notice of rescissions in compliance with final regulations established by HHS, the DOL and the Treasury.

Review rescinded policies to verify that the health carrier provides 30-day advance written notice to a plan enrollee or, in the individual market, a primary subscriber.

Review complaint register/logs and complaint files to identify complaints pertaining to improper advance written notice of rescission.

Review complaint records to verify that when 30 days' advance written notice of rescission has not been provided, the health carrier has taken appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual where advance written notice of rescission was inappropriately performed.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, DOL and Treasury provisions and final regulations pertaining to advance written notice of rescissions.

Review health carrier training materials to verify that information provided is complete and accurate with regard to advance written notice of rescissions.

Determine if the health carrier monitors producer-generated rescissions. Review producer records of rescissions for compliance with advance written notice provisions set forth in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Summary of Benefits and Coverage (SBC) and Uniform Glossary***

CITATION: PHSA §2715

EFFECTIVE DATE: Policy years beginning on or after Sept. 23, 2012

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that the U.S. Department of Health and Human Services (HHS) develop standards—for use by a group health plan and a health carrier offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, policyholders or certificateholders and beneficiaries a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. HHS was also directed to develop standards for definitions for commonly used insurance-related and medical terms and such other terms that will help consumers understand and compare the terms of coverage and the extent of medical benefits (including any exceptions and limitations).

Regulations issued by HHS, the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) established a framework for the production and distribution of SBCs, which include coverage examples and a uniform glossary of health insurance and medical definitions. These documents are designed to provide consumers—both individuals who purchase their own coverage and those who obtain coverage through their place of work—with consistent, understandable and comparable information regarding both available health coverage options and purchased or elected coverage.

BACKGROUND: The SBC and the uniform glossary are designed to provide consumers—both individuals who purchase their own coverage and those who obtain coverage through their place of work—with consistent, understandable and comparable information regarding health coverage options. While HHS interim regulations appear to require strict compliance with SBC format—including approved font, wording, and document layout and length—subsequent final regulations by HHS, the DOL and the Treasury have established a number of enforcement safe harbors for insurance carriers that are working diligently and in good faith to understand and come into compliance with health reform law.

With regard to compliance, "[t]he Departments' [HHS, DOL, and Treasury] basic approach to health reform implementation, as stated in associated HHS, DOL and Treasury FAQs, is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law."

In addition, federal guidance is set forth in associated FAQs that "[t]o the extent a plan's terms do not reasonably correspond to these instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms."

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
SUMMARY OF BENEFITS AND COVERAGE (SBC) AND UNIFORM GLOSSARY

Standard 1
The appearance, language, form and content of a summary of benefits and coverage (SBC) and uniform glossary issued by a health carrier shall be in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All individual health and group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2012

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service and new business-related policies and procedures related to SBCs and uniform glossaries

_____ Health carrier SBC and uniform glossary implementation plan (first review year)

_____ Health carrier SBC template

_____ Health carrier documentation for SBC template variations

_____ Health carrier SBC-related communication and education materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Samples of SBC forms, uniform glossaries and related forms, including the applicable health plans, policy forms, certificates and coverage endorsements

_____ Health carrier complaint handling policies and procedures related to incomplete, inaccurate and out-of-date SBC forms and uniform glossaries

_____ Health carrier complaint records regarding SBCs and uniform glossaries (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures related to SBCs

_____ Producer records

_____ Training materials

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established policies and procedures regarding the appearance, language, form and content of SBCs and uniform glossaries in accordance with final regulations provided by HHS, the DOL and the Treasury.

Review the health carrier's policyholder service and new business-related policies and procedures to verify that the health carrier has adequate and appropriate policies and procedures in place to ensure that the appearance, language, form and content of SBCs and uniform glossaries is in compliance with final regulations provided by HHS, the DOL and the Treasury.

For both group health plans and individual health plans, review SBCs and copies of uniform glossaries issued by a health carrier, together with the applicable health plan, policy forms, certificates and coverage documents for consistency and accuracy of the SBC in describing the benefits and coverage of the plan.

For both group health plans and individual health plans, review SBCs and copies of uniform glossaries issued by a health carrier for compliance with HHS, the DOL and the Treasury requirements, in the following areas:

- Length of document limited to eight sides or four sheets;
- Twelve-point font size;
- Language (culturally and linguistically appropriate and understandable language);
- Content (required content elements and coverage examples); and
- Health carrier contact information.

Note: Examiners need to be aware that HHS guidance permits carriers to exceed the four-page length limit if the carrier determines it is necessary to allow for the accurate portrayal of required information.

Review health carrier's SBCs and uniform glossaries for compliance with HHS, the DOL and the Treasury safe-harbor requirements.

In instances where a health carrier has issued an SBC that is at variance with applicable health carrier instructions, review health carrier documentation for SBC variations to obtain an explanation for the variance.

Review complaint records to verify that when an SBC or uniform glossary is provided in error, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a revised SBC and/or uniform glossary in a timely and accurate manner.

Ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to the recipient of an SBC and/or a uniform glossary, including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about SBCs and uniform glossaries.

Review the health carrier's training materials to verify that information provided is complete and accurate with regard to the appearance, language, form and content of SBCs and uniform glossaries.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
SUMMARY OF BENEFITS AND COVERAGE (SBC) AND UNIFORM GLOSSARY

Standard 2
A health carrier shall make a summary of benefits and coverage (SBC) available in compliance with final regulations issued by the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: All individual health and group health products (grandfathered and non-grandfathered products) for plan years beginning on or after Sept. 23, 2012

Priority: Essential

Documents to be Reviewed

_____ Health carrier policyholder service and new business-related policies and procedures related to SBCs and uniform glossaries

_____ Health carrier SBC and uniform glossary implementation plan (first review year)

_____ Health carrier SBC-related communication and education materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

_____ Consumer SBC requests and health carrier delivery logs or other related information or protocols

_____ Samples of SBC forms, uniform glossaries including any web-based forms

_____ Health carrier complaint handling policies and procedures related to incorrectly issued and/or missing SBC forms and uniform glossaries

_____ Health carrier complaint records regarding SBCs and uniform glossaries (supporting documentation including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier marketing and sales policies and procedures related to SBCs

_____ Producer records

_____ Training materials

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)
Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established policies and procedures regarding the availability of SBCs and uniform glossaries in accordance with final regulations provided by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that an SBC must be provided in several different circumstances, such as upon application for coverage, by the first day of coverage (if information in the SBC has materially changed), upon renewal or re-issuance, and upon request. Health carrier requirements regarding availability and method of delivery of the SBC and uniform glossary vary based upon HHS, DOL and Treasury final regulations regarding group (initial enrollment and renewals) or individual health insurance coverage. Review HHS, DOL and Treasury final regulations for requirements pertaining to health carrier production, issuance and delivery of SBCs and uniform glossaries to applicants, enrollees, policyholders or certificateholders, and beneficiaries.

Note: Examiners need to be aware that HHS/DOL/Treasury rules permit carriers to establish procedures designed to prevent the delivery of multiple identical SBCs to covered individuals residing at the same location.

Verify that the health carrier makes SBCs available without cost to consumers, when "shopping," upon application for insurance or during a plan or policy year.

Review complaint records to: 1) verify that when a health carrier has not made available or has improperly issued an SBC and/or a uniform glossary, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner; and 2) ascertain if any health carrier error could be the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier has implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to the recipient of an SBC and/or a uniform glossary, including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete, accurate and current information about the availability of SBCs and uniform glossaries.

Review the health carrier's training materials to verify that information provided is complete and accurate with regard to the availability of SBCs and uniform glossaries.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

PROVISION TITLE: ***Utilization Review***

CITATION: PHSA §2719

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Sept. 23, 2010

PROVISION: The provisions of the federal Affordable Care Act (ACA) set forth requirements with respect to internal claims and appeals and external review processes for group health plans and health carriers that are not grandfathered health plans under 45 CFR §147.140.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirements with respect to internal claims and appeals and external review processes for health carriers offering health insurance coverage in the individual and small group market.

Paragraph (b) of 45 CFR §147.136 provides requirements for internal claims and appeals processes. Paragraph (c) of 45 CFR §147.136 sets forth rules governing the applicability of state external review processes. Paragraph (d) of 45 CFR §147.136 sets forth a federal external review process for plans and issuers not subject to an applicable state external review process. Paragraph (e) of 45 CFR §147.136 prescribes requirements for ensuring that notices required to be provided under this section are provided in a culturally and linguistically appropriate manner. Paragraph (f) of this section describes the authority of HHS to deem certain external review processes in existence on March 23, 2010 as in compliance with paragraph (c) or (d) of 45 CFR §147.136. Paragraph (g) of 45 CFR §147.136 sets forth the applicability date for this section.

PHSA §2719 and the interim final regulations implementing §2719 require that group health plans and health carriers offering coverage in the group and individual markets comply with a state's external review process, if that process includes, at a minimum, the consumer protections set forth in the *Uniform Health Carrier External Review Model Act* (#75). The *Uniform Health Carrier External Review Model Act* (#75) references the procedures and time frames in the *Utilization Review and Benefit Determination Model Act* (#73). The *Health Carrier Grievance Procedure Model Act* (#72) sets out a process, including time frames, for covered persons to file a grievance requesting a review of an adverse determination made by a health carrier made under the *Utilization Review and Benefit Determination Model Act* (#73).

This provision applies to all health carriers in the individual market and to small group employer plans. This provision applies to non-grandfathered group health plans.

FAQs: See the HHS website for federal guidance.

NOTES:

STANDARDS
UTILIZATION REVIEW

Standard 1
The health carrier shall operate its utilization review program in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Form letters

_____ Activity reports

_____ Provider manual

_____ Files with utilization review requests (Verify all levels of authorized, appealed and disapproved requests are reviewed)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding the operation of its utilization review program, in accordance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to be aware that whenever a health carrier fails to adhere to the requirements set forth in applicable state statutes, rules and regulations with respect to making standard or expedited utilization review and benefit determinations of a benefit request or claim, the covered person, or, if applicable, the covered person's authorized representative, shall be deemed to have exhausted the provisions of applicable state statutes, rules and regulations equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) and may take action as outlined in applicable state statutes, rules and regulations relating to the *Uniform Health Carrier External Review Model Act* (#76).

The provisions of applicable state statutes, rules and regulations regarding standard or expedited utilization review and benefit determinations shall not be deemed exhausted based on a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person, or, if applicable, the covered person's authorized representative.

The exception noted above does not apply if the violation is part of a pattern or practice of violations by the health carrier.

A covered person, or, if applicable, the covered person's authorized representative, may request a written explanation of the violation from the health carrier. Verify that the health carrier has:

- Provided the written explanation within 10 days of receiving the request; and
- Included in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of applicable state statutes, rules and regulations to be exhausted.

Note: Examiners need to be aware that if an independent reviewer or a court of competent jurisdiction rejects the benefit request or claim for immediate review on the basis that the health carrier met the requirements of the exception outlined above, the covered person, or, if applicable, the covered person's authorized representative, has the right to resubmit and, as appropriate, pursue a review of the benefit request or claim under applicable state statutes, rules and regulations equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) or file a grievance pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

In this case, verify that the health carrier has provided to the covered person, or, if applicable, the covered person's authorized representative, notice, within a reasonable period of time, but not to exceed 10 days after the independent reviewer or the court rejects the benefit request or claim for immediate review, of the opportunity to resubmit and, as appropriate, pursue a review of the benefit request or claim under applicable state statutes, rules and regulations equivalent to the *Utilization Review and Benefit Determination Model Act* (#73) or file a grievance pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72).

For purposes of calculating the time period for refiling the benefit request or claim, verify that the health carrier calculates the time period shall begin upon the covered person's, or, if applicable, the covered person's authorized representative's, receipt of the notice of opportunity to resubmit.

Verify that the health carrier, in conducting utilization review, ensures that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

Verify that the health carrier, in ensuring the independence and impartiality of individuals involved in making the utilization review or benefit determination, does not make decisions regarding hiring compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

STANDARDS
UTILIZATION REVIEW

Standard 2
The health carrier shall provide written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Form letters

_____ Utilization review files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures in regard to providing written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier issues notification of an adverse determination in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the benefit request, or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination;
    - Does not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
    - The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim; and
    - A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

If the adverse determination is a rescission, verify that the health carrier provides in the advance notice of the rescission determination required to be provided under applicable state statutes, rules and regulations related to the advance notice requirement of a proposed rescission, in addition to any applicable disclosures required pursuant to other applicable state statutes, rules and regulations:

- Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;
- Notice that the covered person, or, if applicable, the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
- A description of the health carrier's grievance procedures established pursuant to state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), including any time limits applicable to those procedures; and
- The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

Standard 3
The health carrier shall conduct expedited utilization review and benefit determinations, in a timely manner and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Form letters

_____ Utilization review files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving expedited review of utilization review and benefit determinations, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier notification of an adverse determination pursuant to an expedited utilization review and benefit determination is set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative, to include all of the following:

- Information sufficient to identify the benefit request, or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;

- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. Verify that the health carrier:
    - Provides to the covered person, or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination;
    - Does not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to applicable state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72);
    - The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim; and
    - A statement explaining the availability of and the right of the covered person, or, if applicable, the covered person's authorized representative, as appropriate, to contact the insurance commissioner's office or ombudsman's office at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under state statutes, rules and regulations equivalent to the *Health Carrier Grievance Procedure Model Act* (#72), to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the insurance commissioner's office or ombudsman's office.

Verify that the health carrier provides the notice in a culturally and linguistically appropriate manner in accordance with federal regulations.

Verify that the health carrier:

- Provides oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health carrier.

With respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

If the adverse determination is a rescission, verify that the health carrier provides, in addition to any applicable disclosures required pursuant to applicable state statutes, rules and regulations:

- Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;
- The date the health carrier made the decision to rescind the coverage; and
- The date when the advance notice of the health carrier's decision to rescind the coverage ends.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

Standard 4
The health carrier shall conduct utilization reviews or make benefit determinations for emergency services in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

Apply to: Health carriers offering a health benefit plan providing or performing utilization review services

This provision does not apply to grandfathered health plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier utilization review policies and procedures

_____ Member materials

_____ Files of emergency services

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Utilization Review and Benefit Determination Model Act (#73)

Other References

_____ Federal regulations, including FAQs and other regulatory guidance

Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding receiving and resolving utilization reviews or making benefit determinations for emergency services, in accordance with final regulations established by HHS, the DOL and the Treasury.

When conducting utilization review or making a benefit determination for emergency services, verify that a health carrier providing benefits for services in an emergency department of a hospital follows provisions set forth in applicable statutes, rules and regulations.

Verify that a health carrier covers emergency services to screen and stabilize a covered person in the following manner:

- Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;
- Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;
- If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;
- If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of applicable state statutes, rules and regulations; and
- Without regard to any other term or condition of coverage, other than:
    - The exclusion of or coordination of benefits;
    - An affiliation or waiting period as permitted under PHSA §2704; or
    - Applicable cost-sharing, as provided in applicable state statutes, rules and regulations.

For in-network emergency services, verify that the health carrier provides coverage of emergency services subject to applicable copayments, coinsurance and deductibles.

For out-of-network emergency services, verify that the health carrier's cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person does not exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

Note: Examiners need to be aware that a health carrier may require a covered person to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay.

Verify that the health carrier provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

- The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person (Note: This provision does not apply for capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers If a health benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount is the median of these negotiated amounts);
- The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or
- The amount that would be paid under Medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

A health carrier may impose any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.

A health carrier may impose a deductible with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits.

If a health carrier's out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network maximum must apply to out-of-network emergency services.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes and regulations, especially where state statutes and regulations add state-specific requirements, and should seek advice and assistance from the state insurance department.

Chapter 24B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

Introduction
The purpose of this chapter, Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination, is to provide guidance for examiners when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group and large group insurance markets. The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health carriers that may or may not include offering mental health and/or substance use disorder coverage. Chapter 24, Section G. Claims, Standard 3 applies to examinations related to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 found at 42 U.S.C. § 300gg-26.

The guidance found in this chapter recognizes that when developing an examination or review plan related to MHPAEA compliance, it is important to consider examination standards as applicable from Chapter 24 and Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination, as well as Chapter 20.

Regardless of which chapter is used in the *Market Regulation Handbook,* the examiner will also need to reference Chapter 20—General Examination Standards for general examination standards that apply to all insurers.

A. Mental Health and Substance Use Disorder Parity

1. Purpose

Mental health and substance use disorder parity compliance examinations should be designed to ensure that all health carriers are in compliance with all the requirements of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (as amended by the Consolidated Appropriations Act of 2021) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

These standards require health carriers to demonstrate compliance in terms of defining mental health or substance use disorder benefits, classifying benefits, financial requirements, quantitative treatment limitations (QTLs), nonquantitative treatment limitations (NQTLs), required disclosures and vendor coordination.

2. Definitions

For purposes of this chapter, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate Lifetime Dollar Limit means a dollar limitation on the total amount of specified benefits that may be paid under a health plan (45 CFR § 146.136(a)).

Annual Dollar Limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health plan (45 CFR § 146.136(a)).

Classifications of benefits used for applying parity rules:

(1) Inpatient, In-network. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage (45 CFR § 146.136(c)(2)(ii)(A)(1)). See special rule for plans with multiple network tiers in paragraph (c)(3)(iii)(B) of 45 CFR§146.136.

a. If a plan provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits for MH/SUD benefits. After the tiers are established, the plan may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

(2) Inpatient, Out-of-network. Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(2)).

(3) Outpatient, In-network. Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage. See special rules for office visits and plans with multiple network tiers in paragraphs (c)(3)(iii)(C) and (c)(3)(iii)(B) of 45 CFR §146.136.

a. A plan may divide its benefits furnished on an outpatient basis into two subclassifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules.

b. If a plan provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD benefits. After the tiers are established the plan may not impose any financial requirements or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

(4) Outpatient, Out-of-network. Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(4)). See special rule for office visits in paragraph (c)(3)(iii)(C) of 45 CFR § 146.136.

a. A plan may divide its benefits furnished on an outpatient basis into two subclassifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules.

(5) Emergency Care. Benefits for emergency care (45 CFR § 146.136(c)(2)(ii)(A)(5)).

(6) Prescription Drugs. Benefits for prescription drugs (45 CFR § 146.136(c)(2)(ii)(A)(6)).

Coverage Unit refers to the way in which a plan (or health insurance coverage) groups individuals for purposes of determining benefits, premiums, or contributions. For example, different coverage units include self-only, family, and employee plus spouse (45 CFR § 146.136(a)).

Cumulative Financial Requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements) (45 CFR § 146.136(a)).

Cumulative Quantitative Treatment Limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits (45 CFR § 146.136(a)).

Expected Plan Payments are payments expected to be paid under the plan for the plan year (45 CFR § 146.136(c)(3)(i)(C)). Any reasonable method may be used to determine the dollar amount expected to be paid under the plan for medical/surgical benefits subject to a financial requirement or QTL (45 CFR § 146.136(c)(3)(i)(E).

Plan Payment is the dollar amount of plan payments and is based on the amount the plan allows (before enrollee cost sharing) rather than the amount the plan pays (after enrollee cost sharing) because payment based on the allowed amount covers the full scope of the benefits being provided (45 CFR § 146.136(c)(3)(i)(D)).

Financial Requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits (45 CFR § 146.136(a)).

Medical/Surgical Benefits mean benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but do not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *International Classification of Diseases* (ICD) or state guidelines) (45 CFR § 146.136(a)).

Mental Health Benefits mean benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the most current version of the ICD, or state guidelines) (45 CFR § 146.136(a)).

Substance Use Disorder Benefits mean benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines) (45 CFR § 146.136(a)).

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

To evaluate compliance with MHPAEA, examiners must request that the carrier submit the analyses and other underlying documentation that it has performed to determine that it meets all of the standards of MHPAEA. There must be specific documentation of how mental health conditions, substance use disorders and medical/surgical conditions were defined and how they were assigned to benefit classifications. There are specific mathematical analyses that the carrier must have performed in order to determine that it satisfies the MHPAEA requirements for financial requirements and QTLs. There are separate analyses the carrier must have performed in order to determine that it satisfies the MHPAEA requirement for NQTLs, which entail analyses for the "as written" component and analyses for the "in operation" component.

4. Standards and the Regulatory Tests

The mental health and substance use disorder parity review includes, but is not limited to, the following standards related to MHPAEA. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE

Standard 1
The health carrier shall define all covered services as mental health or substance use disorder benefits or as medical or surgical benefits. Mental health benefits or substance use disorder benefits must be defined to mean items or services for the treatment of a mental health condition or substance use disorder, as defined by the terms of the health plan and applicable state and federal law. Any definition of a condition or disorder as being or as not being a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice or state guidelines. (45 CFR § 146.136(a)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ Type of generally recognized independent standards of current medical practice, state law or guidance, used to define mental health conditions, substance use disorders and medical/surgical conditions (e.g., the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or the *International Statistical Classification of Diseases and Related Health Problems* (ICD code), etc.)

_____ List of specific mental health conditions or substance use disorders by diagnosis excluded from coverage as stated in the policy documents

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders (supporting documentation, including, but not limited to: written and phone records of inquiries, call center scripts, complaints, complainant correspondence and health carrier response)

_____ Internal department appeals/grievance files

_____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation

Other References

Enforcement of the federal Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the federal Public Health Services Act
42 U.S. Code § 300gg–23

Federal Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self-Compliance Tool: *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf*

U.S. Department of Labor Frequently Asked Questions Guidance: *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity*

Review Procedures and Criteria

Review definitions in the health carrier's policy forms and/or certificates of coverage for compliance with the definitions in 45 CFR § 146.136(a) and included in the definitions section of this chapter.

Review the health carrier's description of the independent standards it used to define mental health conditions, substance use disorders and medical/surgical conditions. These independent standards must be generally recognized independent standards of current medical practice such as the *Diagnostic and Statistical Manual* (DSM) or the *International Classification of Diseases* (ICD), or state guidelines.

Review exclusions in the health carrier's policy forms and/or certificates of coverage to identify those that involve a mental health or substance use disorder condition or diagnosis and compare it to the list of mental health and substance use disorder conditions excluded from coverage provided by the health carrier.

Verify that exclusions in the health carrier's policy forms and/or certificates of coverage identified as not a mental health or substance use disorder condition comply with state law and are consistent with generally recognized independent standards such as the *International Classification of Diseases* (ICD) or the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Review any attestations required by the state and submitted by the health carrier.

For services the health carrier has determined are both medical/surgical and mental health/substance use disorders, review the explanation of how they determine the correct expected dollar amount for these services (e.g., nutritional counseling, occupational therapy).

STANDARDS
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE

Standard 2
The health carrier must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits in determining the classification in which a particular benefit belongs (or applicable sub-classification) (45 CFR § 146.136(c)(2)(ii)(A)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ All policy documents (e.g., if group or association, request master policy and a sample of each certificate type issued during the examination scope)

_____ Documentation as to how the carrier demonstrates assignment to the six classifications of benefits (and applicable sub-classifications) and the standard used

_____ Company and vendor claim procedure manuals and bulletins/communications (if a carrier uses a behavioral health claims vendor for processing MH/SUD claims or for providing utilization management services)

_____ Internal company claim audit reports for both mental health or substance use disorders and medical/surgical services

_____ Provider contracts, instructions, communications and similar documents regarding coding instructions, code changes, etc.

_____ Utilization review and managed care guidelines and procedure manuals

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Mental health and/or substance use disorder and medical/surgical complaint and grievance files

Other References

Enforcement of the federal Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the federal Public Health Services Act
42 U.S. Code § 300gg–23

Federal Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self-Compliance Tool: *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf*

U.S. Department of Labor Frequently Asked Questions Guidance: *https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity*

Review Procedures and Criteria

Review the health carrier's list that specified the classification or sub-classification to which each benefit was assigned.

Determine whether the health carrier uses permissible sub-classifications for any benefits.

Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); and outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A)).

Review the standard used by the health carrier to determine which classification of benefits (or applicable sub-classification) a particular benefit was assigned to and verify that the same standards were used for assigning medical/surgical benefits and mental health or substance use disorder benefits.

Review the health carrier's documentation that demonstrates that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

STANDARDS
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE

Standard 3
The health carrier shall not apply any financial requirement on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant financial requirement of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ Health carrier list of all financial requirements applied to mental health or substance use disorder benefits and medical/surgical benefits in each classification (or applicable sub-classification). (This will include schedules of benefits and other policy documents)

_____ Health carrier documentation of the reasonable method used to determine expected plan payments for medical/surgical benefits within each classification of benefits (or applicable sub-classification), including documentation and communications with vendors engaged to provide assistance with analyses

_____ Documentation demonstrating the predominant and substantially tests performed by the health carrier for each applicable financial requirement applied to all benefits

_____ Internal company claim audit reports specific to mental health or substance use disorders

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Health carrier complaint records concerning mental health and/or substance use disorder (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal department appeals/grievance files concerning mental health and/or substance use disorders

_____ Applicable external appeals register/logs/files related to concerning mental health and/or substance use disorder, external appeal resolution and associated documentation

Other References

Enforcement of the federal Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the federal Public Health Services Act
42 U.S. Code § 300gg–23

Federal Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self-Compliance Tool: *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf*

Review Procedures and Criteria

Financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximums (45 CFR § 146.136(c)(1)(ii)). A financial requirement is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification (45 CFR § 146.136(c)(3)(i)(A)). The level of the financial requirement that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement (45 CFR § 146.136(c)(3)(i)(B)). The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement (or subject to any level of a financial requirement) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement) (45 CFR § 146.136(c)(3)(i)(C)).

Review the health carrier's methodology for performing its analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. Note: A health carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ASOP) (ACA FAQ 34 Q3).

Review the health carrier's documentation that demonstrates that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). Note: If the financial requirement applies to all medical/surgical benefits in the classification, no cost analysis is required. No financial requirements shall apply only to mental health or substance use disorder benefits.

Determine whether the health carrier's documentation supports that the level of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is comparable and no more restrictive than the level of financial requirement that applies to more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)).

If no single level of the financial requirement applies to more than one-half of medical/surgical benefits in the classification, determine whether the health carrier can demonstrate that it has satisfied this test (45 CFR § 146.136(c)(3)(i)(B)(2)).

STANDARDS
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE

Standard 4
The health carrier shall not apply any quantitative treatment limitation (QTL) on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant QTL of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ Health carrier list of all QTLs applied to mental health or substance use disorder benefits and medical/surgical benefits in each classification (or applicable sub-classification) (this will include schedules of benefits and other policy documents)

_____ Health carrier documentation of the reasonable method used to determine expected plan payments for medical/surgical benefits within each classification of benefits (or applicable sub-classification), including documentation and communications with vendors engaged to provide assistance with analyses

_____ Documentation demonstrating the predominant and substantially tests performed by the health carrier for each applicable financial requirement applied to all benefits

_____ Internal company claim audit reports

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Health carrier complaint, grievance and appeals records (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, call center scripts, complainant correspondence and health carrier response)

Other References

Enforcement of the federal Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the federal Public Health Services Act
42 U.S. Code § 300gg–23

Federal Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self-Compliance Tool: *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf*

Review Procedures and Criteria

QTLs include annual, episode, and lifetime day and visit limits. (45 CFR § 146.136(c)(1)(ii)). A QTL is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification (45 CFR § 146.136(c)(3)(i)(A)). The level of the QTL that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the QTL (45 CFR § 146.136(c)(3)(i)(B)). The determination of the portion of medical/surgical benefits in a classification of benefits subject to a quantitative treatment limitation (or subject to any level of a quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the QTL) (45 CFR § 146.136(c)(3)(i)(C)).

Review the health carrier's methodology for performing its analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. Note: A health carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ASOP) (ACA FAQ 34 Q3).

Review the health carrier's documentation that demonstrates that any type of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). Note: If the QTL applies to all medical/surgical benefits within the classification, no cost analysis is required. No QTLs shall apply only to mental health or substance use disorder benefits.

Determine whether the health carrier's documentation supports that the level of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of QTL that applies to more than one-half of expected plan payments that are subject to the QTL within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)).

If no single level applies to more than one-half of medical/surgical benefits in the classification, determine whether the health carrier can demonstrate that it has satisfied this test (45 CFR § 146.136(c)(3)(i)(B)(2)).

STANDARDS
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE

Standard 5
The health carrier shall apply non-quantitative treatment limitations (NQTLs) to mental health or substance use disorder benefits within a classification of benefits (or applicable sub-classification) so that any processes, strategies, evidentiary standards, or other factors used to apply a limitation, 1) as written and 2) in operation, are comparable to the processes, strategies, evidentiary standards, or other factors used to apply the limitation to medical/surgical benefits within the classification (or applicable sub-classification) (45 CFR § 146.136(c)(i)). The health carrier shall perform and document comparative analyses of the design and application of NQTLs in accordance with 42 U.S.C. § 300gg-26(a)(8)(A).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage.

Priority: Recommended

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ A list of all NQTLs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTLs. A state may focus its review on a subset of NQTLs rather than all NQTLs. (See reference link to the DOL Self-Compliance Tool for a non-exhaustive list) Note: Due to the significant number of potential NQTLs, it is advised that the examiner selects a targeted subset or sample of NQTLs based on examination resources, state specific concerns, company common practices, etc. to avoid the review of hundreds of service variations. Additional NQTLs can be phased into the review as appropriate

_____ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchies for performing utilization review; case management referral criteria; initial screening scripts and algorithms; policies relating to reviewer discretion; and processes for identifying and evaluating clinical issues and utilizing performance goals

_____ Notes and/or logs kept during utilization review, such as those describing: peer clinical review; telephonic consultations with attending providers; consultations with expert reviewers; clinical rationale used in approving or denying benefits; the selection of information deemed reasonably necessary to make a medical necessity determination; adherence to utilization review criteria and criteria hierarchy; professional judgment used in lieu of utilization review criteria; and actions taken when incomplete information is received from attending providers

_____ Company claim procedure manuals and bulletins/communications

_____ Claims processor and customer services' MHPAEA training materials

_____ Company fraud, waste, and abuse policies and procedures

_____ Internal company claim audit reports

_____ Prescription drug formulary for each product/plan design

_____ Prescription drug utilization management documentation

_____ Fail-first policies or step therapy protocols

_____ Network development/contracting policies and procedures

_____ Standards for provider admission to participate in a network, including credentialing requirements

_____ Standards for determining provider reimbursement rates

_____ Samples of provider/facility contracts in use during the exam period

_____ Plan methods for determining usual, customary and reasonable charges for each product/plan design

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Mental health and/or substance use disorder and medical/surgical utilization review procedures

_____ Complaint files, logs and disposition notes

_____ Documentation, including but not limited to comparative analyses, demonstrating that within each of the six classifications of benefits (and applicable sub-classifications), the as written and in operation processes, strategies, evidentiary standards, or other factors used in applying an NQTL are comparable to and applied no more stringently to mental health or substance disorder benefits than to medical/surgical benefits in the classification

Other References

Enforcement of the federal Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the federal Public Health Services Act
42 U.S. Code § 300gg–23

Federal Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self-Compliance Tool: *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf*

FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (ACA FAQ 45): *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf*

Review Procedures and Criteria

Review the list of all NQTLs imposed on mental health/substance use disorders and choose a sample.

Review the health carrier's comparative analyses to verify that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or substance disorder benefits are comparable to, and are applied no more stringently than those used in applying the limitation with respect to medical/surgical benefits in the classification. The comparative analyses shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A)):

- The specific coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which such NQTL applies in each respective benefits classification;
- The factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits;
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification; and
- The specific findings and conclusions reached by the health carrier with respect to the health insurance coverage, including any results of the analyses described in 42 USC 300gg-26(a)(8)(A) that indicate that the health carrier is or is not in compliance with 45 CFR 146.136(c)(4).

The health carrier's analyses must contain the following, at a minimum (ACA FAQ 45 Q2):

1. A clear description of the specific NQTL, plan terms and policies at issue;
2. Identification of the specific mental health or substance use disorder and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical/surgical;
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination;
4. To the extent the health carrier defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources;
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the health carrier between mental health or substance use disorder and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation;
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the health carrier should identify the nature of the decisions, the decision maker(s), the timing of the decisions and the qualifications of the decision maker(s);
7. If the health carrier's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the health carrier ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical/surgical benefits;
8. A reasoned discussion of the health carrier's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the health carrier is or is not in compliance with MHPAEA; and
9. The date of the analyses and the name, title and position of the person or persons who performed or participated in the comparative analyses.

The health carrier shall avoid the following practices and procedures when responding to a request for comparative analyses (ACA FAQ 45 Q3):

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards and strategies without a clear explanation of how they were defined and applied in practice;
5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; and
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

STANDARDS
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE

Standard 6
The health carrier shall ensure that it complies with all availability of plan information and related disclosure obligations regarding: 1) criteria for medical necessity determinations; 2) reasons for denial of services; 3) information relevant to medical/surgical, mental health and substance use disorder benefits; 4) rules regarding claims and appeals, including the right of claimants to free reasonable access to and copies of documents, records and other information including information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan, including any analyses performed by the carrier as to how the NQTL complies with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Plan policies and procedures for responding to participant requests for medical necessity criteria for either or both mental health and substance use disorder services and medical/surgical services

_____ Plan policies and procedures for responding to requests for information on the processes, strategies, evidentiary standards and other factors used to apply an NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan

_____ Sample adverse benefit determination letters

_____ Sample letters responding to disclosure requests for medical necessity criteria and information on NQTLs

_____ Policies and procedures for classifying denials as administrative or medical necessity

_____ Internal and external appeals files for mental health and substance use disorder services adverse benefit determinations

_____ Log of disclosure requests, including date requested, date responses were provided, and samples of documents sent in response

Other References

45 CFR § 146.136(d)
ERISA 104
29 CFR § 2520.104b-1
29 CFR § 2560.503-1
29 CFR § 2590.715-2719

Review Procedures and Criteria

Review the health carrier's method for providing to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder determinations (45 CFR § 146.136(d)(1)).

Review the health carrier's letters providing the reason for any denial of reimbursement for mental health or substance use disorder benefits and verify that the letters are dated within 30 days of the request (45 CFR § 146.136(d)(2)).

Review the health carrier's policy & procedure for responding promptly to requests for all documents, records and other information relevant to an adverse benefit determination, including medical necessity criteria and the comparative analysis required under (42 USC 300gg-26(a)(8)(A)), disclosures referenced above (45 CFR § 146.136(d)(3)) as referenced in ACA FAQ 45-Q6.

Document that the health carrier's claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations (45 CFR § 147.136).

STANDARDS
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE

Standard 7
The health carrier as the entity is responsible for parity compliance. The health carrier shall ensure that management of mental health and substance use disorder benefits coverage, as a whole, complies with the applicable provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA), including any vendor relationships. The carrier shall provide or require sufficient information in terms of plan structure and benefits to or from any vendor to ensure that the mental health and substance use disorder benefits are coordinated with the medical/surgical benefits for purposes of compliance with the requirements of MHPAEA.

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Priority: Recommended

Documents to be Reviewed

_____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities

_____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA

_____ A narrative summary outlining how the vendor and the carrier coordinate benefit design and application to ensure compliance with MHPAEA

_____ Select written communications relevant to mental health and substance use disorder benefits between the carrier and the vendor

Other References

29 CFR § 2590.712(e)
75 FR § 5426
78 FR § 68250

Review Procedures and Criteria

Review the contractual agreements between the health carrier and any vendors providing administrative, claims and/or medical management responsibilities.

Review the health carrier's protocols and procedures to document that any contracted vendors are collaborating with the health carriers to satisfy compliance with MHPAEA. This shall include an explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

Review any audits the health carrier has completed of its vendors to ensure compliance with MHPAEA.

Chapter 25—Conducting the Medicare Supplement Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a format for conducting Medicare supplement insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of Medicare supplement insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Grievance Procedures
I. Network Adequacy
J. Provider Credentialing
K. Quality Assessment and Improvement
L. Utilization Review

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

Examiners should note that some of the following market conduct standards may apply to all Medicare supplement insurance carriers, while others apply only to Medicare Select (managed care) carriers.

Examiners should also note that states may require, by law or regulation, that health plans receive certification by specific private accreditation organizations in order to obtain licensing. Other states may recognize accreditation as meeting specific state requirements. To the extent an examiner may take into account accreditation for specific operational areas (such as quality assessment and improvement, credential verification, utilization review, grievance processes or utilization management), when planning the examination and setting review priorities, the examiner should become familiar with the standards applied by the accrediting entity. Individual jurisdictions may have procedures in place for communicating deviations from such standards to the applicable accrediting entity in addition to administrative procedures.

A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the entity is and how it operates. Normally, it is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate financial examination review, but is important in providing the market conduct examiner with an understanding of the examined entity. Many troubled insurance companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. In addition to the general categories, examiners should also review Section J Provider Credentialing (Medicare Select carriers only) of this chapter.

a. Provider Credentialing

Examiners should determine that a Medicare Select carrier has established documented verification programs to ensure that participating health care professionals meet minimum specific professional qualifications, both initially and on an ongoing basis.

Additional introductory material is located in Chapter 20—General Examination Standards.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The Medicare Select carrier's plan of operation complies with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operations

_____ Information to enrollees

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Ascertain that the plan of operation has been filed with the insurance commissioner.

Review the plan of operation for compliance with applicable statutes, rules and regulations.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 2
The entity reports to the insurance department on an annual basis, each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Reporting Medicare supplement policies form

_____ Records of issued Medicare supplement policies/certificates

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 9.2 and 22

Review Procedures and Criteria

Ascertain that the reporting Medicare supplement policies form has been filed with the insurance commissioner.

Review policy and certificate records to ascertain whether multiple sales of policies or certificates to individual enrollees have been made.

Review the reporting Medicare supplement policies form and compare with multiple sales findings during the examination to ensure that the entity has accurately reported multiple sales.

Verify plans after Jan. 1, 2020 are in compliance with Section 9.2 of Model # 651.

Verify the Benefit Chart of Medicare Supplement Plans Sold on or after Jan. 1, 2020 is correct pursuant to Model #651.

Verify the information provided by the carrier on Plan F or High Deductible F is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

Verify the information provided by the carrier on Plan G or High Deductible G is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 3
The entity certifies compliance with standards for claims payments on the Medicare supplement insurance experience reporting form.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Medicare supplement insurance experience reporting form

_____ Claims payment procedures manuals

_____ Claims training manuals

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Ascertain that the Medicare supplement insurance experience reporting form has been filed with the insurance commissioner.

Review the procedures and claims training manuals to ascertain whether the entity's standards for claim payments are in compliance with applicable statutes, rules and regulations.

Compare the entity's procedures and claims training manuals with the entity's Medicare supplement insurance experience reporting form. Discuss any discrepancies with the entity.

Standard 4
The entity does not provide producer compensation that encourages replacement sales.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Producer manuals

_____ Producer compensation agreements

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 16

Review Procedures and Criteria

Review procedures, producer compensation agreements and producer manuals to ascertain whether the entity's standards for producer compensation are in compliance with applicable statutes, rules and regulations concerning replacement sales.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the entity about its product(s). Typically, it is not based on sampling techniques, but sampling may be used as a review tool. The areas to be considered in this kind of review include all documented, verbal and electronic advertising and sales materials. The entity's website that informs about Medicare supplement availability and/or benefits, would be considered advertising and should be reviewed for accuracy.

2. Techniques

This area of review should include all advertising and sales material, including Internet advertising, and all producer sales training materials to determine compliance with applicable statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of the information provided or to obtain additional information. The examiner should be familiar with outlines of coverage and replacement regulations. Policyholder records are a good source for detection of multiple issues of Medicare supplement policies. Suitability should be considered in reviewing the entity's sales and marketing practices.

The entity must have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of its advertisements. All advertisements maintained by, or for, and authorized by the entity are the responsibility of the entity.

The same statutes, rules and regulations (such as the *Unfair Trade Practices Act* (#880)) that apply to conventional advertising also apply to Internet advertising. When the examiner is reviewing an entity's Internet advertisements, it is important to also review the safeguards implemented by the entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear to avoid deception. The advertisement must not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive must be determined when reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence with the segment of the public to which the advertisement is directed.

Ensure that the entity actively offers all its Medicare supplement products to eligible individuals. The company should not engage in marketing practices such as discriminatory commission levels or references to health conditions that discourage individuals with less favorable risk characteristics from seeking or obtaining coverage.

Determine whether producer training materials require the producer to report all sales of Medicare supplement policies and/or certificates.

Ascertain that the entity has procedures for distributing to producers and other company personnel any bulletins issued by state or federal regulators.

Ensure that the entity prohibits the sale of Medicare supplement policies or certificates to people enrolled in a Medicare Advantage or private fee-for-service plans.

Ensure that the entity prohibits the sale of a Medicare supplement policy/certificate to an individual already covered under such a policy, unless the new policy/certificate is a replacement policy/certificate.

Ensure that producer commission schedules do not encourage replacement sales or sales of more than one Medicare supplement policy/certificate to an individual, or discourage eligible individuals with unfavorable risk characteristics.

Ensure that the entity offers to all eligible individuals all the Medicare supplement products it sells.

Determine whether individuals in the state have been eligible for guaranteed issue because of termination of Medicare business by managed care organizations, and review company practices with respect to eligible individuals.

Determine whether individuals in the state have been eligible for guaranteed issue for other situations as described in the *Model References Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651), Section 12.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed issue rights.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate the priority of the standard.

STANDARDS
MARKETING AND SALES

Standard 1
Entity rules concerning replacement are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Bulletins, newsletters and memos

_____ Replacement register

_____ Underwriting guidelines and files

_____ Replacement comparison forms (if external replacement)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)

Review Procedures and Criteria

Review replacement register to see if it is cross-indexed by producer and entity to determine if the entity has been targeted for replacements by a producer (internal or external).

Ensure that the application or other form asks whether the policy or certificate is intended to replace or add to any coverage currently in force.

Ensure that the application or other form asks all the questions required by state law to be asked.

Determine if the entity permits multiple sales of Medicare supplement policies to the same person.

Using a random selection of policyholders, have the entity run a policyholder/certificateholder history to identify the number of policies or certificates sold to those individuals.

Determine if underwriting guidelines place limitations on multiple sales; i.e. limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Ensure that the entity, when determining whether a sale involves replacement, furnishes to the applicant prior to policy/certificate issue, or at the time of issue in the case of a direct response sale, the required notice concerning replacement of Medicare supplement coverage, obtains the signatures required by state law, and maintains one copy of the signed notice on file.

Determine whether marketing materials encourage multiple issues of policies, for example, use of existing policyholder/certificateholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the entity has a system to discourage "over-insurance," as defined in the entity's underwriting requirements, of policyholders/certificateholders.

Determine whether individuals in the state have been eligible for guaranteed issue because of terminations of Medicare business by managed care organizations, and review entity practices with respect to eligible individuals.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed issue rights.

Determine that the regulated entity, upon replacement, does not impose any waiting periods, elimination periods or probationary periods in their replacement policies unless the replaced individual had not satisfied their six-month preexisting condition period under their prior coverage.

STANDARDS
MARKETING AND SALES

Standard 2
Outlines of coverage are in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17

Review Procedures and Criteria

Look for verification that outlines of coverage used have been approved by appropriate persons within the entity, and are authorized by the entity.

Ensure that outlines of coverage conform to the requirements of state law for format.

Determine whether mandated benefits, benefit limitations and premiums are completely and accurately described, and can be compared with other Medicare supplement policies or certificates offered by the entity and with other Medicare Select policies and certificates. The outline of coverage includes:

- A description of the principal benefits and coverage provided in the policy;
- A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's/certificateholder's age; and
- A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

STANDARDS
MARKETING AND SALES

Standard 3
The entity obtains receipts from applicants verifying that the outline of coverage has been received and that it is the outline of the policy for which the applicant has applied.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17

Review Procedures and Criteria

Verify through signed receipts that outlines of coverage have been provided to applicants prior to the sale of a policy or certificate.

Verify that the outline of coverage provided reflects the benefits of the policy for which the applicant applied, and, if not, that the applicant has been provided with a copy of the correct outline of coverage and the required disclosure concerning the substitution.

STANDARDS
MARKETING AND SALES

Standard 4
The *Guide to Health Insurance for People with Medicare* is provided to the applicant within the time frame required by law and is in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Underwriting files

_____ *Guide to Health Insurance for People with Medicare*

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17

Review Procedures and Criteria

Verify that the *Guide to Health Insurance for People with Medicare* was received by the applicant, by ensuring that the receipt for the guide contains the signature of the applicant.

Ensure that the applicant was provided with a copy of the guide prior to policy issuance or at the time of issuance, as required by state law.

Ensure that the guide was provided to the applicant within the time frame specified by state law.

Ensure that the guide is provided in the required format.

STANDARDS
MARKETING AND SALES

Standard 5
The entity maintains a system of control over the content, form and method of dissemination of all of its Medicare supplement advertisements.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ *Guide to Health Insurance for People with Medicare*

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660)

Review Procedures and Criteria

Ensure that the entity retains responsibility for all advertisements (as the term "advertisement" is defined by state law) regardless of by whom documented, created, designed, or presented.

STANDARDS
MARKETING AND SALES

Standard 6
Each advertisement of a Medicare supplement product is identified by form number or other means unique to that product and is labeled "insurance policy."

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ *Guide to Health Insurance for People with Medicare*

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660)

Review Procedures and Criteria

Ensure that all advertisements are identified by form number or other means of identification that distinguishes that advertisement from all others.

Ensure that advertisements clearly state that an advertised Medicare supplement policy is an "insurance policy."

STANDARDS
MARKETING AND SALES

Standard 7
Advertisements that are invitations to join an association, trust or discretionary group—and that are also solicitations of insurance—contain a separate and distinct application for membership of the group and another for the insurance coverage.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 6

Review Procedures and Criteria

Ensure that advertisements containing applications provide applications for membership in an association, trust or other group, separate from the application for the Medicare supplement coverage.

Standard 8
Advertisements truthfully represent the Medicare supplement coverage being marketed.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ *Guide to Health Insurance for People with Medicare*

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Sections 6 and 7
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy pays all that Medicare doesn't" or similar words or phrases in a manner that exaggerates any benefit beyond the terms of the policy.

Advertisements that are invitations to contract should:

- Disclose exceptions, reductions and limitations affecting the basic provisions of the policy;
- If a preexisting conditions limitation applies, ask a question immediately above the signature line concerning the applicant's understanding of the limitation; and
- Disclose renewability, modification, cancellability, termination, losses covered and premium changes due to age or other reasons in a manner that does not minimize or obscure the qualifying conditions.

Ensure that if the policy is not guaranteed issue or if a preexisting conditions limitation applies, the advertisement does not state or imply that health history will not affect the issuance of the policy or payment of a claim under the policy.

Ensure that provisions that are negative in nature, such as a preexisting conditions limitation, are presented in a negative light and that if the advertisement is an invitation to contract, the term "preexisting conditions limitation," if used, is defined.

Ensure that advertisements do not state or imply that claim settlements are "liberal" or "generous," or words of similar import, and do not mislead by quoting unusual claims that may have been paid.

STANDARDS
MARKETING AND SALES

Standard 9
Testimonials comply with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines, Section 8 (#660)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that testimonials used in advertising are genuine, represent the current opinion of the author, are applicable to the policy advertised, are accurately reproduced, and otherwise comply with all provisions of state law concerning the use of testimonials.

Ensure that the use of a spokesperson complies with all provisions of state law concerning disclosure of the interests of the spokesperson.

STANDARDS
MARKETING AND SALES

Standard 10
Advertisements that employ statistics accurately represent all relevant facts.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 9

Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751)

Review Procedures and Criteria

Ensure that advertisements containing statistical data accurately represent all relevant facts.

Advertisements should state the source of all statistics used in the advertisement.

STANDARDS
MARKETING AND SALES

Standard 11
Advertisements do not disparage competitors or their policies, services or business methods.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 10
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not directly or indirectly disparage competitors.

Standard 12
Advertisements do not imply licensing of the entity beyond the jurisdiction in which the entity is licensed or imply a status with any governmental entity.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ *Guide to Health Insurance for People with Medicare*

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 11
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not imply that the entity is licensed in jurisdictions other than that in which it is licensed.

Ensure that advertisements do not imply that the entity's products are approved, endorsed, or accredited, or connected with any governmental entity.

STANDARDS
MARKETING AND SALES

Standard 13
Advertisements state the name of the insurer and all other pertinent information required by applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ *Guide to Health Insurance for People with Medicare*

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 12
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that the entity's name appears in all advertisements. The entity should not use the name of the parent entity, a group designation or any other designation, without disclosing the name of the actual insurer.

Ensure that advertisements—including stationery, envelopes, etc., do not use any word, symbol, etc., that may confuse or mislead applicants into believing that the solicitation is connected with any government agency. The advertisement must contain a statement that the advertisement is not connected with or endorsed by the U.S. government or the federal Medicare program.

Producers who contact the consumer through a lead-generating device must disclose that fact to the consumer in the initial contact with the consumer.

STANDARDS
MARKETING AND SALES

Standard 14
Advertisements do not state or imply that prospective insureds become group or quasi-group members under a group policy and, as such, will enjoy special rates or underwriting privileges, unless it is a fact.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 13
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not state or imply that an applicant will become a member of a group, and therefore, enjoy special rating or underwriting privileges, unless it is a fact.

Ensure that advertisements do not solicit a particular class, such as governmental employees, and imply that their occupational status gives them group privileges, when the policy advertised is sold only on an individual basis at regular rates.

Standard 15
Advertisements should not use incentives to purchase that mislead the prospective insured.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 14
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements for individual policies do not directly or indirectly represent that the policy offering is introductory or special, and that the advantages will not be available at a later date, unless it is a fact.

Ensure that advertisements for individual policies do not describe an enrollment period as special or limited, or use words of similar import, when the insurer uses such enrollment periods as the usual method of advertising.

Ensure that if an enrollment period is used for policies sold on an individual basis, that the lapse between enrollment periods is not less than that provided for by state law, and that the advertisement states the period specified by state law in which the application must be mailed.

Ensure that advertisements do not state that only a specific number of policies will be sold, or that a time is fixed for discontinuance of the sale of a particular policy because of its special advantages, unless it is a fact.

Ensure that advertisements do not advertise a reduced initial premium more frequently or more prominently than the renewal premium, and that the two premiums are stated in juxtaposition.

STANDARDS
MARKETING AND SALES

Standard 16
Advertisements do not contain statements about the entity that are untrue or misleading.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers' advertising and sales materials

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 15
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain statements that are untrue or misleading about the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business.

Ensure that advertisements do not contain recommendations by commercial rating systems, unless the advertisements clearly indicate the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

H. Grievance Procedures

1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the Medicare Select carrier handles grievances.

A "grievance" means dissatisfaction in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network provider.

Note that these definitions may not include all documented communications that the company tracks as "complaints" under the definition of complaint.

The examiner should review the company procedures for processing grievances. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

2. Techniques

A review of grievance procedures should incorporate consumer and provider appeals, consumer direct grievances to the company and those grievances filed with the insurance department. The company should reconcile the company grievance register with a list of grievances from the insurance department. A random sample of grievances and appeals should be selected for review from the company's grievance register.

The company's documented grievance procedures should be reviewed. Determine how those procedures are communicated to plan members within membership materials and upon receipt of appeals and grievances.

The examiner should review the frequency of similar grievances and be aware of any pattern of specific types of grievance. Should the type of grievance noted be cause for unusual concern, specific measures should be instituted to investigate other areas of a company's operation. This may include modifying the scope of examination to examine specific company behavior.

3. Tests and Standards

The grievance handling review includes, but is not limited to, the following standards addressing various aspects of a company's operations. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
GRIEVANCE PROCEDURES

Standard 1
The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Sample documents and files, including electronic correspondence

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Contracts

_____ Grievance procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Review the contracts, outlines of coverage, grievance procedures, sample grievance files and disclosures to determine if the company is correctly defining "grievance."

STANDARDS
GRIEVANCE PROCEDURES

Standard 2
The entity develops documented grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures manuals

_____ Policies and/or certificates of coverage

_____ Outlines of coverage

_____ All forms used to process a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Determine if the entity provides grievance registration information to the policyholder at the time of the issuance of a policy or certificate.

Determine if the entity has procedures to ensure that a copy of its grievance procedures is provided to any enrollee or prospective enrollee upon request.

Determine if the entity includes a copy of its grievance procedures in its policies, certificates (if applicable) and outlines of coverage.

Review the disclosure form(s) to determine if a description of the entity's grievances procedures is included.

Review the entity's grievance procedures to ensure that the procedures are aimed at mutual agreement for settlement and that, if applicable, any arbitration procedures are disclosed.

STANDARDS
GRIEVANCE PROCEDURES

Standard 3
The entity documents, resolves and records grievances in compliance with applicable statutes, rules and regulations, and their contract language.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Entity's grievance handling policies and procedures

_____ Sample of grievance files

_____ Outlines of coverage

_____ Policies and/or certificates of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The entity maintains a grievance register that documents all grievances received during the calendar year.

The entity reports all grievances to the insurance commissioner annually, with the information and in the format required by law.

The entity complies with its documented procedures when receiving and resolving grievances.

The entity considers grievances in a timely manner and transmits grievances to appropriate decision-makers.

The entity takes corrective action promptly on valid grievances.

The entity promptly notifies concerned parties of the results of a grievance review.

STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the insurance department, if applicable.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Grievance forms and other information provided to an enrollee at the time the enrollee files a grievance

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Review the entity's procedures for processing a grievance to determine if the required disclosures are provided.

Review the entity's procedures to determine if, when required by state law, the enrollee is advised of the right to contact the insurance department.

Review the grievance procedures to ensure that a provision is made for grievance registration information to be provided at the time of issue and upon request.

As grievances are detected throughout the entire examination, ensure that they have been handled and recorded properly.

STANDARDS
GRIEVANCE PROCEDURES

Standard 5
The company reports its grievance procedures to the insurance commissioner on an annual basis.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances

_____ Procedures for annually reporting grievances to the insurance commissioner

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The examiner should determine whether the entity has procedures in place for recording and reporting grievances to the insurance commissioner.

The examiner should ensure that the entity has reported on an annual basis and in the format prescribed by the insurance commissioner, the number of grievances filed in the previous year and a summary of the subject, nature and resolution of such grievances.

I. Network Adequacy

1. Purpose

The network adequacy portion of the examination is designed to ensure that companies offering Medicare Select plans maintain service networks that are sufficient to ensure that all services are accessible without unreasonable delay. The standards require companies to ensure the adequacy, accessibility and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include the company's plan of operation and measures used by the company to analyze network sufficiency, contracts with participating providers and intermediaries, and ongoing oversight and assessment of access issues.

2. Techniques

To evaluate network adequacy standards, it is necessary for examiners to request from the company a statement or map that reasonably describes the service area. Additional items for review include a list and description by specialty of network providers and facilities. The examiner should determine whether the company has conducted studies to measure waiting times for appointments and other studies that measure the sufficiency and adequacy of the network. The examiner should also determine how the company arranges for covered services that cannot be provided within the network. Examiners should request the carrier's documented selection standards for providers and review the plan of operation. Using the list of providers and facilities, examiners should request a sample of specific provider contracts. The review of provider contracts should include an evaluation of compliance with filing requirements and adherence to patient-protection requirements. In addition to direct contracts with providers and facilities, examiners should review the documented guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Examiners should obtain verification that accurate provider directories are provided upon enrollment, are updated and dispersed periodically, and that the company has filed its updated list of network providers with the insurance commissioner on a quarterly basis. Another area for review includes grievances related to provider access issues.

3. Tests and Standards

The network adequacy review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider network. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
NETWORK ADEQUACY

Standard 1
The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Selection criteria

_____ Documents related to physician recruitment

_____ Provider directory

_____ List of providers by specialty

_____ Reports of out-of-network service denials

_____ Company policy for in-network/out-of-network coverage levels

_____ Provider/enrollee location reports by geographic location

_____ Any policies or incentives that restrict access to subsets of network specialists

_____ Computer tools used to assess the network's adequacy

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5
Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:

- Ratios of providers (primary care providers and specialty providers) to enrollees;
- Geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of enrollees;
- Waiting times for appointments;

- Hours of operation; and
- Volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

The company develops and complies with documented policies and procedures specifying when the company will pay for out-of-area and out-of-network services that are covered by the policy, or as are required by state law. In any case where the company is required to cover services and it has an insufficient number or type of participating providers to provide a covered benefit, the company shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit were obtained from participating providers or shall make other arrangements acceptable to the insurance commissioner.

The company establishes and maintains adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees. In determining whether a company has complied with this provision, the insurance commissioner shall give due consideration to the relative availability of health care providers in the enrollees' service area.

The company demonstrates that it monitors, on an ongoing basis, its providers, provider groups and intermediaries with which it contracts to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees. There are standards pertinent to provider licensing in Section J. Provider Credentialing of this chapter.

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
NETWORK ADEQUACY

Standard 2
The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The plan of operation contains evidence of at least the following:

- Covered services are available and accessible though network providers;
- Either the number of network providers in the service area is sufficient to deliver adequately all services, or that the company makes appropriate referrals for provision of such services outside its network;
- There are documented agreements with network providers describing specific responsibilities;
- Emergency care is available 24 hours per day, 7 days per week;
- The provider agreements prohibit the provider from billing or otherwise seeking reimbursement from enrollees, other than for coinsurance, copayments or supplemental charges;
- A description or map of the service area;
- A description of the company's grievance procedures;
- A description of the quality assurance program, including the formal organizational structure, the criteria for selection, retention and removal of network providers and the procedures for evaluating quality of care and taking corrective action when warranted;
- A list and description of network providers, by specialty; and
- Any other information requested by the insurance commissioner.

STANDARDS
NETWORK ADEQUACY

Standard 3
The company ensures that enrollees have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Policy forms

_____ Plan of operation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Within the network, the company operates or contracts with facilities to provide enrollees with access to emergency and urgently needed services on a 24 hours per day, 7 day per week basis.

The company covers in full, emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers.

STANDARDS
NETWORK ADEQUACY

Standard 4
The company files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals

_____ Sample of provider contracts

_____ Credentialing file

_____ Directory of providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Determine if the provider contracts and endorsements have been filed (if required by state law).

Review provider contracts to determine if the provider is listed in the directory and to determine if credentialing is up to date.

STANDARDS
NETWORK ADEQUACY

Standard 5
The company executes with each participating provider documented agreements that are in compliance with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals, contracts and intermediary subcontracts

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Every contract between a Medicare Select carrier and a participating provider or provider group contains a "hold harmless" provision specifying protection for enrollees from being billed by providers for other than coinsurance, copayments or supplemental charges.

The contract provides an extension of benefits beyond the period during which the policy was in force if the enrollee suffers continuous total disability after contract termination.

STANDARDS
NETWORK ADEQUACY

Standard 6
The company's arrangements with participating providers comply with applicable statutes, rules and regulations.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider manuals and contracts

_____ Credentialing and re-credentialing procedures

_____ Complaints made by providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Benefit Plan Network Access and Network Adequacy Model Act (#74), Section 6

Review Procedures and Criteria

When required by state law, the company complies with the following:

- The company establishes a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services;
- The company develops selection standards for primary care professionals and each health care professional specialty. The standards are used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts;
- The company makes its selection standards for participating providers available for review by the insurance commissioner;
- The company notifies participating providers of the providers' responsibilities with respect to the carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable state insurance law;
- The company does not offer inducements to providers to provide less than medically necessary services to enrollees;
- The company does not prohibit a participating provider from discussing treatment options with enrollees, regardless of the health carrier's position on the treatment options, or from advocating on behalf of enrollees within the utilization review or grievance processes established by the carrier or a person contracting with the carrier;

- The company requires a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of enrollees, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records;
- The company and the participating provider terminate provider contracts according to contract provisions and as provided by law;
- The company notifies participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from enrollees pursuant to policy or certificate provisions, or of the providers' obligations, if any, to notify enrollees of their personal financial obligations for non-covered services;
- The company does not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare;
- The company establishes a mechanism by which participating providers may determine in a timely manner whether a person is covered by the carrier; and
- The company establishes procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

STANDARDS
NETWORK ADEQUACY

Standard 7
The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider directory and updates

_____ Provider contracts

_____ Credentialing and re-credentialing documentation

_____ Internet directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Request information regarding the carrier's frequency of updates to the provider directory.

Verify that the company is providing directory updates to enrollees and to the insurance commissioner at the frequency required by state law.

Review how provider data is maintained. If the provider directory is not produced from the same system(s) that handles the administration functions, determine if the data is maintained consistently between systems.

If the provider directory is made available on the carrier's website, verify that a paper version can be requested, as an option, by the enrollee.

J. Provider Credentialing

1. Purpose

The provider credentialing portion of the examination is designed to ensure that companies offering Medicare Select plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

The areas to be considered in this kind of review include the company's documented credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy and the oversight of any delegated verification functions.

2. Techniques

Prior to reviewing records for specific providers, examiners should request all documented credentialing procedures from the company. Examiners should determine the composition of the carrier's credentialing committee. Examiners should use the company's provider directory to select a sample of specific provider credential files, drawing from a variety of provider types and facilities. For each provider selected, the examiner should request:

a. The provider application;
b. Credentialing verification materials, including materials obtained through primary and secondary sources;
c. Updates to credentialing information; and
d. Copies of correspondence to providers that relates to the credentialing process.

Examiners should determine how the credentialing committee permits providers to correct information and provide additional information for reconsideration. In the event the credentialing process is subcontracted, examiners should determine whether the contracting entity is following applicable standards.

3. Tests and Standards

The provider credentialing review includes, but is not limited to, the following standards related to the adequacy of the health carrier's provider credentialing and contracting processes. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PROVIDER CREDENTIALING

Standard 1
The company establishes and maintains a program for credentialing and re-credentialing of providers in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Credentialing plan

_____ Credentialing policies and procedures

_____ Minutes of the credentialing committee

_____ Credentialing plan evaluation reports (if any)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

The company establishes documented policies and procedures for credentialing and re-credentialing of all health care professionals with whom the company contracts and applies those standards consistently.

The company ensures that the carrier's medical director or other designated health care professional has the responsibility for, and participates in, the health care professional credentialing verification process.

The company establishes a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents in order to make decisions regarding credentialing verification.

The company makes all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.

The company keeps confidential all information obtained in the credentialing verification process, except as otherwise provided by state law.

The company retains all records and documents relating to a health care professional's credentialing verification process for at least the number of years required by state law.

The company's policies and procedures for credentialing and re-credentialing of providers are in compliance with state law.

STANDARDS
PROVIDER CREDENTIALING

Standard 2
The company verifies the credentials of a health care provider before entering into a contract with that health care provider.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing files

_____ Provider contracts

_____ Provider credentialing policies and procedures

_____ Provider directory

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

Ensure that the company verifies that providers are properly credentialed, prior to entering into a contract with the provider and placing the provider name in the provider directory. This can be achieved by comparing the effective date of the provider's contract with the date of credentialing and the date the provider's name is entered in the provider directory.

STANDARDS
PROVIDER CREDENTIALING

Standard 3
The company obtains primary verification of the information required by state law relating to provider credentialing.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Checklist for credentialing

_____ Checklists and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

If required by state law, the company verifies the following:

- Current license, certificate of authority or registration to practice his or her particular profession in the state and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable);
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable);
- Graduation in his or her specialty from an accredited school;
- Completion of post-graduate training (if applicable);
- The provider's license history in all states;
- The provider's malpractice history (if applicable); and
- The provider's practice history.

STANDARDS
PROVIDER CREDENTIALING

Standard 4
The company obtains, at the interval provided for by state law, primary verification of the information required by state law relating to provider credentialing.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Checklist for credentialing

_____ Checklists and forms for site visits (if any)

_____ Reports made from site visits (if any)

_____ Sample of credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

The company verifies the following:

- Current license, certificate of authority or registration to practice his or her particular profession in the state and history of licensure;
- Current level of professional liability coverage (if applicable);
- Status of hospital privileges (if applicable);
- Specialty board certification status (if applicable); and
- Current Drug Enforcement Agency (DEA) registration certificate (if applicable).

STANDARDS
PROVIDER CREDENTIALING

Standard 5
The company requires all participating providers to notify the individual designated by the company of changes in the status of any provider information that is required to be verified by the company.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Credentialing policies and procedures

_____ Provider contracts

_____ Credentialing files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 6

Review Procedures and Criteria

The company identifies for participating providers the individual to whom they should report changes in the status of provider information required to be verified by the company.

STANDARDS
PROVIDER CREDENTIALING

Standard 6
The company provides the provider with the opportunity to review and correct information submitted in support of the provider's credentialing verification.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Credentialing policies and procedures

_____ Provider manual

_____ Listing of active and terminated providers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 7

Review Procedures and Criteria

The company makes available to each provider who is subject to the credentialing verification process, the information and the source of the information obtained by the company to satisfy the company's credentialing process.

The company notifies the provider of any information obtained during the company's credentialing verification process that does not meet the company's credentialing verification standards or that varies substantially from the information provided to the company by the provider, if the information is required to be verified by state law, unless such disclosure is prohibited by law.

The company permits the provider to correct any incorrect information and request a reconsideration of the provider's credentialing verification application through a formal process by which the provider may submit supplemental or corrected information to the company's credentialing verification committee or the entity delegated to perform credentialing.

STANDARDS
PROVIDER CREDENTIALING

Standard 7
The company monitors the activities of the providers and provider entities with which it contracts and ensures that the requirements of state law are met.

Apply to: All Medicare Select plans

Priority: Essential

Documents to be Reviewed

_____ Provider credentialing and re-credentialing policies and procedures

_____ Intermediary contracts

_____ Periodic reports from intermediaries

_____ Reports of entity reviews and audits (if any) of credentialing activities by the company

_____ Minutes of the credentialing committee

_____ Minutes of the board of directors

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70)

Review Procedures and Criteria

The company ensures that providers and provider entities with which it contracts meet the requirements of state law applicable to such providers and provider entities.

K. Quality Assessment and Improvement

1. Purpose

The quality assessment portion of the examination is designed to ensure that companies offering Medicare Select plans have quality assessment programs in place that enable the company to evaluate, maintain and, when required by state law, improve the quality of health care services provided to enrollees. For Medicare Select plans that limit access to health care services to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals.

The areas to be considered in this kind of review include the company's documented quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with members about the program and oversight of delegated quality-related functions.

2. Techniques

In some jurisdictions, the quality assessment and improvement function may be monitored jointly by the Department of Insurance and Department of Health (or similar agency). To evaluate quality assessment and improvement activities, examiners should request information relative to the composition of the quality assessment and improvement committee. Examiners should also determine frequency of quality assessment and improvement meetings. To obtain an accurate assessment of a company's quality assessment and improvement program, it is advisable to review quality assessment and improvement committee meeting minutes for all meetings conducted during the examination period. Ascertain whether the quality assessment program reasonably encompasses all aspects of the covered health care services. Determine whether the carrier has obtained certification from a nationally recognized accreditation entity. Determine which standards will be met by virtue of the certification process. Examiners should evaluate the process by which quality assessment and improvement information and directives are communicated to network providers. Review procedures such as peer review, for including network providers in the quality assessment and improvement process. Ascertain whether outcome-based goals and objectives are being monitored and met.

3. Tests and Standards

The quality assessment and improvement review includes, but is not limited to, the following standards related to the assessment and improvement activities conducted by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 1
The company develops and maintains a quality assessment program that is in compliance with state law to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment policies and procedures

_____ Quality assessment plan (if any)

_____ Minutes of the quality assessment committee

_____ Minutes of the board of directors

_____ Evaluations of the quality assessment program

_____ Job descriptions of the chief medical officer or clinical director

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality assessment program and procedures to ensure effective corporate oversight of the program.

The company develops and maintains the infrastructure and disclosure systems necessary to measure the quality of health care services provided to enrollees on a regular basis and appropriate to the types of plans offered by the company.

The company establishes a system designed to assess the quality of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements.

The company communicates findings in a timely manner to applicable regulatory agencies, providers and consumers as provided for by state law.

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality assessment activities carried out by, or on behalf of, the company (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the documented quality assessment program, periodically reviews and revises the program documents and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality assessment programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 2
The company develops and maintains a quality improvement program that is in compliance with applicable statutes, rules and regulations to evaluate, maintain and improve the quality of health services provided to enrollees.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality improvement policies and procedures

_____ Quality improvement plan

_____ Minutes of the quality improvement committee

_____ Minutes of the board of directors

_____ Evaluations of the quality improvement program

_____ Job descriptions of the chief medical officer or clinical director

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company develops a quality improvement program and procedures to ensure effective corporate oversight of the program (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company develops and maintains the infrastructure and disclosure systems necessary to measure, on a regular basis, the quality of health care services provided to covered persons and appropriate to the types of plans offered by the company.

The company establishes a system designed to improve the quality and outcomes of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements (*Quality Assessment and Improvement Model Act* (#71), Section 6C).

The company has a documented quality improvement plan that includes:

- A statement of the objectives, lines of authority and accountability, evaluation tools, data collection responsibilities, performance improvement activities and annual effectiveness review of the program;
- Intent to analyze processes and outcomes of care to discern the causes of variation;
- Identification of the targeted diagnoses and treatments to be reviewed each year;
- Methods to analyze quality, including collection and analysis of information on:
    - Over- or under-utilization of services;
    - Evaluation of courses of treatment and outcome of care; and
    - Collection and analysis of information specific to an enrollee or provider gathered from multiple sources and documentation of both the satisfaction and grievances of the enrollee(s);
- A method to compare program findings with past performance and internal goals and external standards;
- Methods for:
    - Measuring the performance of participating providers;
    - Conducting peer review activities to identify practices that do not meet the company's standards;
    - Taking action to correct deficiencies;
    - Monitoring participating providers to determine whether they have implemented corrective action; and
    - Taking appropriate action when they have not;
- A plan to utilize treatment protocols and practice parameters developed with clinical input and using evaluations described above or acquired treatment protocols and providing participating providers with sufficient information about the protocols to meet the standards; and
- Evaluating access to care for covered persons according to the state's standards, and a strategy for integrating public health goals with services offered under the plan, including a description of good faith efforts to communicate with public health agencies.

The company establishes an internal system to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns and foster an environment of continuous quality improvement (*Quality Assessment and Improvement Model Act* (#71), Section 6A).

The company ensures that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system (*Quality Assessment and Improvement Model Act* (#71), Section 6D).

The company provides enrollees with the opportunity to comment on the quality improvement process (*Quality Assessment and Improvement Model Act* (#71), Section 6E).

The company uses the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the health care delivered to enrollees (*Quality Assessment and Improvement Model Act* (#71), Section 6B).

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality improvement activities carried out by, or on behalf of, the health carrier (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The chief medical officer or clinical director approves the documented quality improvement program, periodically reviews and revises the program document and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (*Quality Assessment and Improvement Model Act* (#71), Section 7).

The company has an appropriate documented policy to ensure the confidentiality of an enrollee's health information used in the company's quality improvement programs (*Quality Assessment and Improvement Model Act* (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 3
The company files with the insurance commissioner a documented description, in the prescribed format, of the quality assessment program, which includes a signed certification by a corporate officer of the company that the filing meets the requirements of applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Documented description of the quality assessment program

_____ Signed certification by a corporate officer

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5D

Review Procedures and Criteria

Determine if the forms have been filed.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 4
The company monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable statutes, rules and regulations are met.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Contracts with entities

_____ Minutes of the quality assessment and improvement committees

_____ Minutes of the board of directors

_____ Evaluations of the quality improvement program

_____ Reports of entity reviews and audits (if any) by the company

_____ Periodic reports from the entity

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71)

Review Procedures and Criteria

The company establishes, implements and enforces a policy to address effective methods of accomplishing oversight of each delegated activity.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 5
The company reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the company to terminate or suspend contractual arrangements with the provider.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Reports made to the licensing authority

_____ Files of terminated and suspended provider contracts

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 5C

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

Ascertain whether applicable terminated and suspended contract files reflect compliance with reporting requirements. Examiners should note that some terminated and suspended contracts will involve issues that are not necessary to report.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 6
The company documents and communicates information about its quality assessment program and its quality improvement program to enrollees and providers.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Quality assessment and improvement policies and procedures

_____ Enrollee materials (e.g., enrollee newsletters and advertisements, etc.)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8

Review Procedures and Criteria

The company includes a summary of its quality assessment and quality improvement programs in marketing materials.

The company includes a description of its quality assessment and quality improvement programs, in addition to a statement of patient rights and responsibilities with respect to those programs, in the certificate of coverage or handbook provided to new enrollees.

The company makes available annually to providers and covered persons, findings from its quality assessment and quality improvement programs, as well as information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions may have affected the findings.

STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

Standard 7
The company annually certifies to the insurance commissioner that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, meets applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Certification filings

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Quality Assessment and Improvement Model Act (#71), Section 8

Review Procedures and Criteria

The company makes the certified materials available for review by the public upon request, subject to a reasonable fee (except for those materials subject to confidentiality requirements and materials that are proprietary to the health plan).

The company retains all certified materials for at least 3 years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

L. Utilization Review

Check state-specific laws to determine if utilization review is applicable to Medicare supplement insurance within a state.

Chapter 26—Conducting the Long-Term Care Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter applies to all long-term care insurance (LTCI) policies, including qualified LTCI contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement LTCI. This chapter does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

This chapter provides a format for conducting LTCI examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of LTCI operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Appeal of Benefit Trigger Adverse Determination
G. Underwriting and Rating
H. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

HIPAA—Federal Minimum Requirements
Examiners should be aware that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 7702B of the Internal Revenue Code impose minimum requirements for health insurance coverage in certain areas and prohibits the application of any state law to the extent that it prevents the application of a HIPAA requirement. However, states that have laws in these areas that extend beyond HIPAA's minimum requirements may enforce those laws.

Group and individual LTCI issues affected by HIPAA include minimum standards for tax-qualified LTC policies.

LTCI
Two sections of HIPAA (7702B and 4980C) establish requirements for qualified LTCI contracts and companies issuing those contracts. For the purposes of HIPAA requirements, the following definitions apply: "Qualified LTC services" are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services; and "maintenance or personal care services" are services required by a chronically ill individual that are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Under HIPAA, qualified LTCI contracts and issuers of those contracts are required to satisfy certain requirements of the *Long-Term Care Insurance Model Act* (#640) and *Long-Term Care Insurance Model Regulation* (#641).

Many states have requirements that impose more consumer protection requirements on carriers than HIPAA, in which case the state's requirements should be enforced. (For example, a state may include a group of 1 in its definition of "group" or "small group.")

IIPRC-Approved Products
When conducting an exam that includes LTCI products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (Compact) on behalf of a compacting state, it is important to keep in mind the uniform standards, and not state-specific statutes, rules and regulations, are applicable to the content and approval of the product. The Compact website is *www.insurancecompact.org* and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rates and Forms Filing (SERFF) to product filings submitted to the Compact for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each Compact-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The Compact office should be included when a compacting state(s) is concerned that a Compact-approved product constitutes a violation of the provisions, standards or requirements of the Compact (including the uniform standards). Under the uniform standards, an LTCI product approved by the Compact can be used in a compacting state's partnership program provided the company has obtained the necessary approval from the compacting state or made the necessary certification to the compacting state, as applicable. Please note that the company must still comply with a compacting state's laws for minimum daily benefit amounts, minimum benefit periods and maximum elimination periods when selling an LTCI product approved by the Compact.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.

Apply to: All long-term care companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of reports and certifications made by the entity

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Each insurer should file with the insurance commissioner, prior to offering group LTCI to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory LTCI requirements substantially similar to those adopted in the state of issue. (Note: Section 21 of the *Long-Term Care Model Regulation* (#641)) requires an evidentiary filing only from discretionary groups. Review individual state statutes, rules and regulations to determine the extent of the state's jurisdiction over coverage sold to state residents under an out-of-state group policy.)

Each insurer should file with the insurance commissioner a copy of any LTCI advertising intended for use in the state—whether through written, radio or television medium—for review or approval to the extent required by state law. All advertisements should be retained for at least three years from the date of first use.

Determine if replacement/lapse reporting is submitted by the entity as required. Items to be reported are:

- Top 10 percent of producers with the highest percentage of replacements and lapses; and
- Number of lapsed policies as a percentage of annual sales and policies in force at the end of the previous calendar year.

Determine that the entity complies with filing and certification requirements set forth by statutes, rules and regulations for associations endorsing or selling LTCI. Generally, these requirements are imposed on an association group meeting the definition of a professional/trade/occupational association found in Section 4E(2) of the *Long-Term Care Insurance Model Act* (#640).

Ensure that the insurer has filed all requested advertising with the insurance department regarding association sold or endorsed LTCI, as may be requested by the insurance department. Any such advertising must disclose:

- The specific nature and amount of compensation that the association receives from the endorsement or sale of the policy or certificate to its members; and
- A brief description of the process under which the policies and the issuing insurer were selected.

Determine that the entity submits suitability and rescission information as required by applicable statutes, rules and regulations.

Determine the regulated entity has proper procedures in place to ensure its producers are properly trained and that the training meets the minimum standards established by the applicable laws and regulations.

Insurers subject to the *Long-Term Care Insurance Model Act* (#640) shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A of the *Long-Term Care Insurance Model Act* (#640) and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of LTC, including Medicaid, in a state. These records shall be maintained in accordance with state record retention requirements and shall be made available to the commissioner upon request.

Most states have a LTC partnership forms certification process in order for LTC partnership forms to be sold in their state.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
The entity has suitability standards for its products, when required by applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

_____ Underwriting/Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine whether the entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have the entity run a policyholder history to identify the number of policies sold to those individuals.

Determine if entity guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Ensure that the entity has developed and uses suitability standards for the purchase or replacement of LTCI, including, but not limited to:

- Presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet" and any other suitability-related information requested by the insurer;
- Presentation, at the same time as the personal worksheet, of the disclosure form titled "Things You Should Know Before You Buy Long-Term Care Insurance";
- Confirm that a completed personal worksheet was returned to the issuer prior to the consideration of the applicant for coverage, except that the personal worksheet need not be returned for sales of employer group LTCI to employees and their spouses; and

- If the issuer has determined that the applicant did not meet its financial suitability standards, confirmation that the insurer informed the applicant that the policy may not be suitable and obtained the applicant's written verification to proceed with the transaction prior to issuance of coverage (using a letter similar to Appendix D of the *Long-Term Care Insurance Model Regulation* #641). If the applicant has declined to provide financial information, confirm that the insurer verified the applicant's intent to purchase the coverage by either written verification (using a letter similar to Appendix D of Model #641) or alternative means. If an alternative method of verification was used for those who declined to provide financial information, confirm that the insurer has a record of the alternative method used.

Note: Pursuant to Section 24A of the *Long-Term Care Insurance Model Regulation* (#641), suitability standards do not apply to life insurance policies or riders that accelerate benefits for LTC as defined in the *Long-Term Care Model Act* (#640), Section 4A.

Determine whether the personal worksheet and disclosure form are in the form, content and text prescribed by applicable statutes, rules and regulations.

Determine whether the required personal worksheet and disclosure forms are retained as required by applicable statutes, rules and regulations.

Determine if the insurer is reporting suitability information to the insurance commissioner as required by applicable statutes, rules and regulations.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used by the entity.

Ensure the entity maintains a written statement specifying the standards of suitability used by the insurer and provides the standards to its producers, and that both follow the standards. The standards should specify that no recommendation should be made and/or no policy issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant (based on information known to the insurer or producer making the recommendation).

STANDARDS
MARKETING AND SALES

Standard 2
Policy forms provide required disclosure material regarding standards for benefit triggers.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Claim procedure/Underwriting manuals

_____ Claim files

_____ Policy forms

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Ensure the policy conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living (ADLs) and cognitive impairment.

Ensure that the policy contains the definition of ADLs, cognitive impairment and other key terms as required by statutes, rules and regulations.

Determine that the eligibility for payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the ADLs or the presence of cognitive impairment. Ensure that payment of benefits is not more restrictive than those allowed by statutes, rules and regulations.

Ensure that the policy contains a clear description of the process for appealing and resolving benefit determinations.

Standard 3
Marketing for long-term care products complies with applicable statutes, rules and regulations.

Apply to: Long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Required reports filed with the insurance department

_____ Marketing materials filed with the insurance department

_____ Underwriting files or other files containing proof of issuance of outline of coverage

_____ Review state statutes, rules and regulations to determine if state LTC requirements apply to annuity products with an LTC element. If so, then the applicable *Annuity Disclosure Model Regulation* (#245) would apply

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Life Insurance Disclosure Model Regulation (#580)
Life Insurance Illustrations Model Regulation (#582)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity uses applications for LTCI policies or certificates containing clear and unambiguous questions designed to ascertain the health condition of the applicant. (In most cases, application forms should have been reviewed by the insurance department's rates and forms division.)

Verify that the entity complies with right to return/"free look" requirements.

Verify that the outline of coverage is delivered to the applicant at time of initial solicitation through means that prominently directs the attention of the recipient to the document and its purpose.

Verify that at the time of policy delivery the insurer has delivered a policy summary for an individual life insurance policy that provides LTC benefits within the policy or by rider. In the case of direct response solicitations, verify that the insurer has delivered the policy summary upon the applicant's request, but regardless of the request has made delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, ensure that the summary also includes:

- An explanation of how the LTC benefit interacts with other components of the policy, including deductions from death benefits;
- An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person;
- Any exclusions, reductions and limitations on benefits of LTC; and
- A statement that any LTC inflation protection option required by the applicable state's statutes, rules and regulations regarding inflation protection option requirements comparable to Section 13 of the *Long-Term Care Insurance Model Regulation* (#641) is not available under this policy.

In addition to the above, if applicable to the policy type, ensure that the summary includes the following:

- A disclosure of the effects of exercising other rights under the policy;
- A disclosure of guarantees related to LTC costs of insurance charges; and
- Current and projected maximum lifetime benefits.

The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with the applicable state's basic illustration requirements comparable to Sections 7 and 8 of the *Life Insurance Illustrations Model Regulation* (#582) or into the life insurance policy summary, which is required to be delivered in accordance with the applicable state's life insurance policy summary requirements comparable to Section 5 of the *Life Insurance Disclosure Model Regulation* (#580).

Verify that the entity complies with records maintenance and reporting requirements:

- Entity must maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of LTCI policies sold by the producer as a percentage of the producer's total annual sales;
- Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements;
- Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year;
- Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year; and
- Every insurer shall report annually by June 30, for qualified LTCI contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

Standard 4
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for advertisements approved by the Compact)

_____ All company advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Policy forms, including any required buyer's guides, outline of coverage, LTCI personal worksheets and disclosure forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either at least three years from the date the advertisement was first used or later if required by state statutes, rules and regulations.

Review advertising materials in conjunction with the appropriate policy form. Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead prospective buyers to believe that they are purchasing an investment or savings plan. Problematic terminology may include the following terms: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required," if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is a fact. Enrollment periods may not be described in terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in the advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact; and
- Misrepresent any policy as being shares of stock.

Materials should:

- Clearly disclose the name and address of the insurer;
- If using a trade name, disclose the name of the insurer, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to the policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed; and
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact. Any proprietary relationship or payment for the testimonial must be disclosed.

Determine if the company approves producer sales materials and advertising. Ensure that copies of sales material other than company-approved materials, if permitted, are maintained in a central file. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as an insurance producer. Improper terms may include "financial planner," "investment advisor," "financial consultant" or "financial counseling," if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Review the use of the words "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy, unless it is a fact. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for an LTCI policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

Determine that company procedures and materials relative to LTC products comply with right to return/"free look" requirements.

Review the company and producer's Internet sites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised products are (or are not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?
- For the review of Internet advertisements:

- Run an inquiry with the company's name;
- Review the company's home page;
- Identify all lines of business referenced on the company's home page;
- Research the ability to request more information about a particular product and verify that the information provided is accurate; and
- Review the company's procedures related to producers' advertising on the Internet and ensure that the company requires prior approval of the producers' web pages, if the company name is used.

STANDARDS
MARKETING AND SALES

Standard 5
Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Policy/Underwriting file

_____ Loan and surrender files, if applicable

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Review policy/underwriting files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm applicant's receipt of replacement notice.

Review replacement disclosure forms for completeness and signatures as required.

STANDARDS
MARKETING AND SALES

Standard 6
Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Agency sales/Lapse records

_____ Company systems manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the company has advised its producers of its replacement policy.

Determine if the company has separate commission schedules for replacement business, pursuant to applicable state statutes, rules and regulations. Note: Some states limit the compensation payable on replacement business to no more than that payable on renewal policies.

Determine if the company has provided timely notice to the existing insurers of the replacement.

Examine the company system of identifying undisclosed replacements for effectiveness.

Determine if the company has the capacity to produce the data required by replacement regulation to assess producer replacement activity.

Determine if the company has issued letters in a timely manner to policyholders advising of the effects of preexisting conditions on covered benefits.

Review policy/underwriting files to determine if the company is retaining required records for required time frames.

Examine company procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the company provides required credit for preexisting conditions or probationary periods on replacements.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Policy renewals are applied consistently and in accordance with policy provisions.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review renewal business to determine if the entity's procedures for handling renewals are in accordance with applicable statutes, rules and regulations.

Ensure that individual policies or certificates do not contain renewal provisions other than "guaranteed renewable" or "noncancellable," and that these terms are adequately defined in the policy or certificate.

Review the underwriting/policy file to determine if premium notices were sent in a timely and accurate manner.

Review mailroom records for billings sent by the entity to ensure they were sent in a timely manner.

STANDARDS
POLICYHOLDER SERVICE

Standard 2
Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Administrative files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the required notification of lapse or termination is sent to the proper addressee(s), within the required time frames and that the required information is provided, per applicable statutes, rules and regulations.

Ensure that the entity receives designation of a person(s), other than the insured, to receive notice of lapse or termination of the policy or certificate for nonpayment of premiums or a written waiver by the insured not to designate an additional person(s) to receive notice.

Ensure that the insurer notifies existing insureds of their right to change their written designation at least once every two years, or as specified by state statutes, rules and regulations.

Verify that nonforfeiture and reinstatement provisions were applied consistently and in a non-discriminatory manner. Nonforfeiture provisions upon lapse and reinstatements should be applied per policy provisions and in accordance with applicable statutes, rules and regulations.

Ensure that the policy includes a provision that provides for reinstatement of coverage in the event of lapse, if the entity has provided evidence that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option should be made available to the insured for a period of 5 months after the date of termination.

STANDARDS
POLICYHOLDER SERVICE

Standard 3
Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.

Apply to: All long-term care products, except life insurance policies or riders containing accelerated benefits as defined in Section 4A of the *Long-Term Care Insurance Model Act* (#640)

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Administrative file

_____ Entity procedures manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the entity offers applicants the opportunity to purchase an LTC policy that includes a nonforfeiture benefit, as required by applicable statutes, rules and regulations.

If the applicant declines the nonforfeiture benefit, ensure that the entity provides a contingent benefit upon lapse of the policy for a specified period following a substantial increase in premium rates, as required and defined by applicable statutes, rules and regulations.

Ensure that a policy offered with nonforfeiture benefits contains the same coverage elements, eligibility, benefit triggers and benefit length as a policy without the nonforfeiture benefit.

Determine if the entity provides notice as required by applicable statutes, rules and regulations prior to the due date of the premium reflecting a substantial premium increase.

Ensure that the entity offers the proper nonforfeiture benefit, nonforfeiture credit and attained age rating, as required by applicable statutes, rules and regulations.

Determine if the policy contains the proper time frames for nonforfeiture benefit and the contingent benefit upon lapse, as required by applicable statutes, rules and regulations.

Determine if the correct nonforfeiture option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to nonforfeiture values, refer to applicable statutes, rules and regulations regarding the calculation of nonforfeiture values.

Review the entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Ensure that the entity notifies policyowners of material changes to any nonforfeiture benefits in accordance with applicable statutes, rules and regulations.

STANDARDS
POLICYHOLDER SERVICE

Standard 4
Policyholder service for long-term care products complies with applicable statutes, rules and regulations.

Apply to: Long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedures manuals

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity issues monthly reports to policyholders, when the LTC benefit is funded through a life insurance vehicle by the acceleration of the death benefit and is in benefit payment status.

Verify that the entity offers nonforfeiture benefits.

F. Appeal of Benefit Trigger Adverse Determination

Use the standard set forth below.

STANDARDS
APPEAL OF BENEFIT TRIGGER ADVERSE DETERMINATION

Standard 1
Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.

Apply to: All long-term care insurers

Priority: Essential

Documents to be Reviewed

_____ Company's written procedures explaining administration of appeals process and template denial letters

_____ Internal company procedures which describe the appeals process

_____ Applicable statutes, rules and regulations

_____ Request copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Ask insurer how it describes its appeal procedures to the insured.

Ask for copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective.

In the event the insurer has determined that the benefit trigger of an LTCI policy has not been met, verify that the insurer has provided a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

- The reason that the insurer determined that the insured's benefit trigger had not been met;
- The insured's right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request within 120 calendar days of receipt of the notice; and
- The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process.

Ensure that the individual or individuals making the internal appeal decision are not the same individual or individuals who made the initial benefit determination.

Verify that the insurer, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made, has completed and sent written notice of the internal appeal decision to the insured and the insured's authorized representative, if applicable.

If the insurer's original determination is upheld upon internal appeal, ensure that the notice of the internal appeal decision describes any additional internal appeal rights offered by the insurer.

If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, verify that the insurer has provided a written description of the insured's right to request an independent review of the benefit determination to the insured and the insured's authorized representative, if applicable.

As part of the written description of the insured's right to request an independent review, verify that the insurer has included in the written description of the insured's right to request an independent review of benefit determination the following, or substantially equivalent, language:

> "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy] [certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."

Examiners should be aware that not all jurisdictions maintain a list of independent review organizations qualified to review LTC benefit trigger decisions, and the language of the above paragraph may have been modified in accordance with state statutes, rules and regulations.

In the event that the insurer has not considered a benefit trigger decision eligible for independent review, verify that the insurer has informed the insured and the insured's authorized representative, if applicable, and the commissioner in writing and has included in the notice the reasons for its determination of independent review ineligibility.

Verify that the cost of independent review is borne solely by the insurer.

Verify that the insurer refers requests to the independent review organization that the insured or the insured's authorized representative has chosen within five business days of receiving a written request for independent review. If the insured or the insured's authorized representative has not chosen an approved independent review organization to perform the review, verify that the insurer has chosen an independent review organization approved or certified by the state. Verify that the insurer varies its selection of authorized independent review organizations on a rotating basis.

Verify that the insurer refers requests for independent review of a benefit trigger determination to an independent review organization, which may include, but not be limited to the following provisions, subject to applicable state statutes, rules and regulations:

- An independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified LTCI independent review organization; and
- Independent review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, ensure that such information is considered first in the internal review process:

- Verify that the insurer completes its review of the information and provides written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five business days of the insurer's receipt of such new or additional information; and
- If the insurer maintains its denial after such review, the independent review organization shall continue its review. If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

Verify that the insurer acknowledges in writing to the insured and the insured's authorized representative, if applicable, and the commissioner that a request for independent review was received, accepted and forwarded to an independent review organization for review. Ensure that the notice includes the name and address of the independent review organization.

Verify that if any new or additional information not previously provided to the insurer is submitted by the insured or the insured's authorized representative, the insurer either (1) considers and affirms or (2) overturns its benefit trigger determination. In the event that the insurer affirms its benefit trigger determination, verify that the insurer promptly provides such new or additional information to the independent review organization for its review, along with the insurer's analysis of such information.

If the insurer overturns its benefit trigger determination, verify that the insurer has provided notice to the independent review organization and the insured and the insured's authorized representative, if applicable, and the commissioner of its decision. Verify that the independent review process ceased immediately upon receipt of such notice.

Verify that the insurer abides by the decision of the independent review organization with respect to whether the insured met the benefit trigger.

Ensure that the insurer has not in any way restricted the insured's right to submit a new request for benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.

G. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- Rating practices;
- Underwriting practices;
- Use of correct and properly filed and approved forms and endorsements;
- Termination practices;
- Unfair discrimination;
- Use of proper disclosures, outlines of coverage and delivery receipts;
- Reinsurance; and
- Marketing and sales materials.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Individual and group issued and renewed policy files;
- Policy summaries;
- Replacement and conservation materials;
- Documentation of required disclosures and delivery receipts;
- Individual and group canceled policy files and certificates;
- Documentation of premium refund upon election of "free look" period;
- Recessions occurring prior to a claim;
- Policy forms, endorsements and applications, along with appropriate filings;
- Producer licensing information;
- Producer compensation agreements, where applicable;
- Premium statements and billing statements;
- Group trust arrangements, where applicable;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;
- Reinsurer policies/treaties; and
- Reinsurer guidelines and manuals.

For the purposes of this chapter, "underwriting file" means the file or files containing the new business application, renewal application, certificates or evidences of coverage, including binders, rate calculation sheets, billings, medical information, credit information, inspection or interview reports, all underwriting information obtained or developed, policy summary page, endorsements, cancellation or reinstatement notices, correspondence and any other documentation supporting selection, classification, rating or termination of the policy.

In selecting samples for testing, individual policies should generally not be combined with group policies. Because these two areas are generally not homogeneous, any conclusions or inferences made from the results of sampling may not be valid if combined. The examiner should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies, endorsements and premium statements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice of the examination.

Next, determine the entity's policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain that the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for entity judgment.

a. Rating Practices

   It is necessary to determine if the entity is in compliance with rating systems that have been filed with and, in some cases, approved by the insurance department. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by an entity might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that an entity is engaged in unfair competitive practices. Inconsistent application of rates or classifications can result in unfair discrimination.

   If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the use of improperly worded, vague or obsolete rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

   Occasionally, the examiner may need to review loss statistics to determine if premiums are fair and reasonable in relation to the associated claims experience. When possible, the examination team should make use of audit software to verify the correct application of specific rating components and the consistent use of rates. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

   The rating practices for renewal policies and newly issued policies should be reviewed. The examination team should also review premium notices and billing statements. The examiner should ensure the proper application of rate increases or rate decreases.

   The examiner should also ensure that the underwriting files contain sufficient information to support the rates that have been developed.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the entity's underwriting manuals, underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and entity minutes that may furnish evidence of anti-competitive behavior may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the entity's compliance with its own manuals and guidelines. The examiner should confirm that the entity's underwriters and producers consistently apply the entity guidelines for all business selected or rejected. The examination team should verify that the entity has correctly classified insured individuals.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the entity's management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of the business. Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each applicable field office.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to the insurance department's counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Termination Practices

The examination team should review the entity's policy cancellation and reinstatement practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the entity's own rules, guidelines and policy provisions.

Cancellation and lapsed policy processing should include a formal notice to the insured, including secondary addressees, where elected by the insured. Adherence to policy provisions for renewal language and for applicable grace periods should be reviewed.

The examination team should verify that premium refunds upon election of "free look" provisions are handled correctly, uniformly and in a timely manner.

The examination team should review reinstatement offers and determine what the entity's practice is for offering reinstatement. In addition, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Unfair Discrimination

The examination team should be mindful of entity underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional, yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

f. Use of Proper Disclosures, Buyer's Guides and Outlines of Coverage

The examination team should review the entity's use of required disclosure forms, buyer's guides, policy summaries, replacement notices, "free look" periods and outlines of coverage. In addition to the use of such required items, the examiner may wish to verify that the above items contain the correct content and are in the correct format.

g. Reinsurance

Most state statutes include a feature that for many lines of business the entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files.

Adherence to the requirement is easy to test, but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It also may reflect on the care that the entity's management places on its selection of business, and represent a danger to the financial health of the entity. Errors in this area should be forwarded to the appropriate state financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

h. Marketing and Sales Materials

It is recommended that a review of all forms and materials be conducted by reviewing the marketing and sales standards simultaneously during the underwriting and rating review.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the various standards.

STANDARDS
UNDERWRITING AND RATING

Standard 1
All mandated definitions and requirements for group long-term care insurance are followed in accordance with applicable statutes, rules and regulations.

Apply to: All group long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Rating/Quote information provided electronically

____ Marketing materials

____ Correspondence to producers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

If a group policy is issued to an employer or labor organization or association, determine if the group meets the required criteria to qualify the association or organization as a bona fide organization established for the benefits of its members.

Determine if all group LTC policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group LTC policy standard provisions that are applicable in the examining jurisdiction are incorporated into the group policy. These provisions include, but are not limited to, grace periods, periods of incontestability, required copies of applications, deemers of representations and not warranties, medical or other evidence of insurability, provision for a certificate of insurance and conversion to an individual policy in the event of termination or total disability.

Ensure that when a group long-term disability policy is replaced by another policy, the succeeding carrier offers coverage to all persons covered under the previous group policy on its date of termination and that the coverage and premium amounts meet the requirements of applicable statutes, rules and regulations.

STANDARDS
UNDERWRITING AND RATING

Standard 2
Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and inflation protection options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Determine if the application complies with applicable statutes, rules and regulations regarding form and content.

STANDARDS
UNDERWRITING AND RATING

Standard 3
The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Applications and related disclosure and consent forms

_____ Health questionnaires for applicants

_____ Medical underwriting guidelines

_____ Entity guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure the entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional.

Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test, and should be a part of the underwriting file. Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

Questions may ask if the applicant has been diagnosed with AIDS or ARC, if they are designed to establish the existence of the condition, but are not to be used as a proxy to establish sexual orientation of the applicant.

Ensure the entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation a factor in the determination of insurability.

Review a sample of underwriting files for denied applications in order to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the entity guidelines (e.g., based on the amount of insurance).

Neither the marital status, the living arrangements, the occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

STANDARDS
UNDERWRITING AND RATING

Standard 4
Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Administration file

_____ Policies, riders, amendments, endorsements, applications and certificates of coverage

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the policy contains the required terms and definition of such terms per applicable statutes, rules and regulations, including, but not limited to:

- Guaranteed renewable and noncancellable;
- Activities of daily living, acute condition, adult day care, bathing, cognitive impairment, continence, dressing, eating, hands-on assistance, home health care services, Medicare, mental or nervous disorder, personal care, skilled nursing care, toileting and transferring; and
- Reasonable and customary/usual and customary.

Determine if riders and endorsements added after the original date of issue, at reinstatement or renewal that reduce or eliminate benefits or coverage (except as requested by the insured) require signed acceptance by the insured.

Ensure that the entity has not established a new waiting period in the event existing coverage is converted or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the individual or group policyholder.

Ensure that the entity does not apply preexisting condition provisions more restrictive than "…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person," unless the insurance commissioner has extended limitation periods.

An LTCI policy or certificate, other than a policy or certificate issued to a defined group, may not exclude coverage for a loss or confinement that is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

An LTCI insurance policy or certificate may not exclude or use riders or waivers to exclude, limit or reduce benefits for specifically named or described preexisting conditions or physical conditions beyond the defined waiting period.

Determine if the policy meets the requirements under applicable statutes, rules and regulations with regard to prior hospitalization/institutionalization. The policy may not:

- Condition eligibility of any benefits on a prior hospitalization requirement, or, in the case of benefits provided in an institutional care setting, on the receipt of a higher level of institutional care;
- Condition eligibility for benefits (other than waiver of premium, post-confinement, post-acute care or recuperative benefits) on a prior institutionalization requirement;
- Condition eligibility of non-institutional benefits based on the prior receipt of institutional care on a prior institutional stay of more than 30 days; and
- Condition the receipt of benefits following institutionalization upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge.

A policy or rider containing post-confinement, post-acute care or recuperative benefit shall contain in a separate paragraph titled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

Determine if the policy contains any limitations regarding preexisting conditions, and, if so, ensure that they are outlined in a separate paragraph titled "Preexisting Condition Limitations."

Ensure that the policy measures the need for LTC on the activities of daily living (ADLs) and cognitive impairment, and that they are described—along with any additional benefit triggers, benefits and entity-required certification of functional dependency—in a separate paragraph titled "Eligibility for the Payment of Benefits."

If an LTC policy provides benefits for home health care or community care services, ensure that it meets the required minimum standards required by applicable statutes, rules and regulations.

STANDARDS
UNDERWRITING AND RATING

Standard 5
Underwriting and rating for long-term care products complies with applicable statutes, rules and regulations.

Apply to: Long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Insurance department approval of forms

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Entity cancellation/nonrenewal guidelines

_____ Certificate of mailing

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Long-Term Care Insurance Model Act (#640)
Long-Term Care Insurance Model Regulation (#641)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and applicable statutes, rules and regulations.

Review entity procedures for cancellation/nonrenewal to determine if the entity is following its own guidelines.

Review cancellation and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the forms, if necessary, were approved by the insurance department.

In addition to other applicable review procedures, verify the following:

- The entity has not cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;
- The entity has not established a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
- The entity does not provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; and
- The entity does not apply preexisting condition provisions more restrictive than "…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person," unless limitation periods have been extended by the insurance commissioner.

Verify that standards for incontestability periods are no more restrictive than as follows:

- Within 6 months, misrepresentations must be material;
- Within 2 years and more than 6 months, misrepresentation must be material and pertain to the condition for which benefits are sought; and
- After 2 years, benefits are contestable only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

Verify that the entity's underwriting practices reflect minimum requirements related to guaranteed renewability, noncancellability and continuation or conversion.

Replacement of a group LTC policy with another group LTC policy shall offer coverage to all persons covered under the previous group policy on its date of termination, with no preexisting condition exclusions that would have been covered on the prior policy and shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of LTC services.

Verify that the entity provides notice to the designated person, in addition to the applicant, for termination of a policy or certificate for nonpayment of premium.

Verify that the entity allows for reinstatement of coverage in the event of lapse if provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

Verify that prior to issuance of an LTC policy or certificate to an applicant age 80 or older, the insurer obtains one of the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician's statement; or
- Copies of medical records.

Verify that the entity delivers a copy of the completed application or enrollment form (whichever is applicable) to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

Verify that the entity maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. The entity shall annually furnish this information to the insurance commissioner in the format prescribed by applicable statutes, rules and regulations.

Verify that the premium charged does not increase due to increase of age beyond 65 or the duration the insured has been covered under the policy.

STANDARDS
UNDERWRITING AND RATING

Standard 6
The company's underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Company underwriting guidelines and bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Riders or extensions of coverage

_____ Interoffice memoranda and company minutes

_____ Policy specifications page

_____ Underwriter's file or notes on a system log

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Long-Term Care Insurance Model Act (#641)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness (#888)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Ensure the file documentation adequately supports the decisions made:

- The application should be complete and signed;
- Determine when, and under what conditions the company requires motor vehicle reports, inspection reports, credit reports, Medical Information Bureau (MIB) or other medical physician reports or other underwriting information to confirm exposure or premium basis;
- Determine if the file contains the necessary information to support the classification, rating and selection decision made; and
- Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable statutes, rules and regulations.

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

Determine if the company is following its underwriting guidelines, and that the guidelines conform to applicable statutes, rules and regulations, including, but not limited to:

- The insurer shall obtain one of the following prior to issuance of a policy or certificate to an applicant aged 80 or older:
    - A report of physical examination;
    - An assessment of functional capacity;
    - An attending physician's statement; or
    - Copies of medical records.
- All applications for LTC, except policies issued on a guaranteed-issue basis, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant; and
- If an application for LTC coverage contains a question regarding whether the applicant has had medication prescribed by a physician, the company shall also ask the applicant to list the medication.

Determine if the company underwriting guidelines have been filed, where applicable.

Review interoffice memoranda for evidence of anti-competitive behavior, collusive practices or improper replacement tactics.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each office being examined.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination. Companies may not permit discrimination between individuals of the same class and equal health status.

Ensure that underwriting requirements are not applied in an unfairly discriminatory manner.

Review guaranteed issue criteria to ensure correct handling.

Review policy provisions for skilled nursing care to ensure that no restrictions are placed on the proper level of care; i.e., the company does not provide only skilled nursing care or does not provide more coverage for skilled care in a facility than coverage for lower levels of care.

Verify that the questions on applications are sufficiently clear and applicable to the coverage being requested.

Verify that Medical Information Bureau (MIB) information is not used as the sole basis for an underwriting decision.

Companies may not refuse to insure, continue to insure or limit coverage based on:

- Sex;
- Marital status;
- Race;
- Religion;
- National origin;
- Physical or mental impairment (except where based on sound actuarial principles or actual or reasonably anticipated experience);
- Blindness or partial blindness only* (however, all other conditions, including the underlying cause of the blindness or partial blindness, are subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person); and
- Abuse status.

*Note: Review individual state statutes, rules and regulations that may provide that an insurer may not refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness.

Many jurisdictions have enacted legislation regarding subjects of abuse. Examiners should be familiar with their statutes, rules and regulations in this area.

Examine new business applications for the required fraud statement.

H. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
CLAIMS

Standard 1
Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.

Apply to: All long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Claim bulletins and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Long-Term Care Insurance Model Act (#640)
Unfair Claims Settlement Practices Act (#900)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether standards comply with state statutes. Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner.

Determine if claim handling meets applicable statutes, rules and regulations, including:

- Correct payees and addresses; and
- Correct benefit amounts.

Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

If a claim under an LTCI contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

- Provide a written explanation of the reasons for the denial; and
- Make available all information directly related to the denial.

Determine if the insurer is in compliance with proper payment of "clean claims," as defined in applicable state statutes, rules and regulations. Verify that the insurer pays clean claims within 30 business days after receipt of a clean claim. For claims that do not fall within the category of a clean claim, verify that the insurer has sent a written notice acknowledging the date of receipt of the claim and containing one of the following provisions within 30 business days:

- The insurer has declined to pay all or part of the claim and the specific reason(s) for denial; or
- That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

Verify that the insurer has paid clean claims within 30 business days after receipt of all requested additional information, or has sent a written notice that the insurer has declined to pay all or part of the claim within 30 days. The notice should specify the specific reason(s) for denial.

If, upon review of insurer clean claim payment practices, an examiner determines that an insurer has failed to comply with clean claim requirements, verify that the insurer has paid interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the receipt of the claim or, in the event the insurer has requested additional information, upon receipt of all requested additional information.

Verify that the insurer has included interest payable in any late reimbursement without requiring the individual who filed the original claim to make any additional claim for such interest.

It is an unfair practice to settle, or attempt to settle, a claim on the basis of an application that was materially altered without the consent of the insured.

Confirm that a monthly report is issued to the policyholder whenever LTC benefits are issued through acceleration of death benefit provisions of a life insurance product.

Confirm that mandatory nonforfeiture benefits are offered.

Determine that eligibility for the payment of benefits is based on a deficiency in the ability to perform not more than 3 of the activities of daily living (ADLs) or the presence of cognitive impairment.

Ensure that determination of deficiency is not more restrictive than:

- Requiring the hands-on assistance of another person to perform the prescribed ADLs; and
- For a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

Ensure that licensed or certified professionals, such as physicians, nurses or social workers, perform assessments of ADLs and cognitive impairment.

Chapter 26A—Conducting the Limited Long-Term Care Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter applies to limited long-term care insurance (LTCI) policies. This chapter does not apply to qualified LTCI contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement limited LTCI. This chapter also does not apply to life insurance contracts that accelerate benefits in the form of a lump sum payment, in anticipation of death or some other specified occurrence.

This chapter provides a format for conducting limited LTCI examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of limited LTCI operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Appeal of Benefit Trigger Adverse Determination
G. Underwriting and Rating
H. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the entity is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

IIPRC-Approved Products
When conducting an exam that includes limited LTCI products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (Compact) on behalf of a compacting state, it is important to keep in mind the uniform standards, and not state-specific statutes, rules and regulations, are applicable to the content and approval of the product. The Compact website is *www.insurancecompact.org* and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rates and Forms Filing (SERFF) to product filings submitted to the Compact for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each Compact-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The Compact office should be included when a compacting

state(s) is concerned that a Compact-approved product constitutes a violation of the provisions, standards or requirements of the Compact (including the uniform standards). Under the uniform standards, a limited LTCI product approved by the Compact can be used in a compacting state's partnership program provided the company has obtained the necessary approval from the compacting state or made the necessary certification to the compacting state, as applicable. Please note that the company must still comply with a compacting state's laws for minimum daily benefit amounts, minimum benefit periods and maximum elimination periods when selling a limited LTCI product approved by the Compact.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The entity files all reports and certifications with the insurance department as required by applicable statutes, rules and regulations.

Apply to: All limited long-term care companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department records of reports and certifications made by the entity

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Each insurer shall file with the insurance commissioner, prior to offering group limited LTCI to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory limited LTCI requirements substantially similar to those adopted in the state of issue. (Model #643 Section 20 & Model #642 Section 5). (Note: Section 20 of the *Limited Long-Term Care Model Regulation* (#643) requires an evidentiary filing only from discretionary groups.)

Each insurer should file with the insurance commissioner a copy of any limited LTCI advertising intended for use in the state—whether through written, radio or television medium—for review or approval to the extent required by state law. All advertisements should be retained for at least three years from the date of first use.

Determine if replacement/lapse reporting is submitted by the entity as required. Items to be reported are:

- Top 10 percent of producers with the highest percentage of replacements and lapses; and
- Number of lapsed policies as a percentage of annual sales and policies in force at the end of the previous calendar year.

Determine that the entity complies with filing and certification requirements set forth by statutes, rules and regulations for associations endorsing or selling limited LTCI. Generally, these requirements are imposed on an association group meeting the definition of a professional/trade/occupational association found in Section 4E(2) of the *Limited Long-Term Care Insurance Model Act* (#642).

Ensure that the insurer has filed all requested advertising with the insurance department regarding association sold or endorsed limited LTCI, as may be requested by the insurance department. Any such advertising must disclose:

- The specific nature and amount of compensation that the association receives from the endorsement or sale of the policy or certificate to its members; and
- A brief description of the process under which the policies and the issuing insurer were selected.

Determine that the entity submits suitability and rescission information as required by applicable statutes, rules and regulations.

Determine the regulated entity has proper procedures in place to ensure its producers are properly trained and that the training meets the minimum standards established by the applicable laws and regulations.

Insurers subject to the *Limited Long-Term Care Insurance Model Act* (#642) shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in Subsection B(2)(a) as required by Subsection A of the *Long-Term Care Insurance Model Act* (#640) and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of limited LTC, including Medicaid, in a state. These records shall be maintained in accordance with state record retention requirements and shall be made available to the commissioner upon request. Pursuant to Model #642, Section 9 producer training requirements are optional.

Most states have a limited LTC partnership policy forms in order for limited LTC partnership forms to be sold in their state.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
The entity has suitability standards for its products, where required by applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Producer records

_____ Training materials

_____ Procedure manuals

_____ Underwriting/Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine whether the entity makes multiple sales to individuals of the same product. Use random selection of policyholders and have the entity run a policyholder history to identify the number of policies sold to those individuals.

Determine if entity guidelines place limitations on multiple sales; i.e., limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Determine if the entity has developed and uses suitability standards and procedures to determine whether the purchase or replacement of limited LTCI is appropriate for the needs of the applicant. Suitability standards and procedures should include:

- Consideration of the advantages and disadvantages of insurant to meet the needs of the applicant;
- Discussion with applicants of how the benefits and costs of limited LTCI compare with LTCI;
- Agent training in its suitability standards and procedures; and
- Maintain a copy of suitability standards and procedures and make them available for inspection upon request by the commissioner.

If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternate method of verification shall be made a part of the applicant's file.

Note: Pursuant to Section 25H of the *Limited Long-Term Care Insurance Model Regulation* (#643), suitability standards do not apply to life insurance policies or riders that accelerate benefits for limited LTC as defined in the *Limited Long-Term Care Model Act*, Section (# 642), Section 4(D).

Determine if the insurer is reporting suitability information to the insurance commissioner as required by applicable statutes, rules and regulations.

Determine whether marketing materials encourage multiple issues of policies; for example, use of existing policyholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used by the entity.

Ensure the entity maintains a written statement specifying the standards of suitability used by the insurer and provides the standards to its producers, and that both follow the standards. The standards should specify that no recommendation should be made and/or no policy issued in the absence of reasonable grounds to believe that the purchase of the policy is not unsuitable for the applicant (based on information known to the insurer or producer making the recommendation).

Standard 2
Policy forms provide required disclosure material regarding standards for benefit triggers.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Claim procedure/Underwriting manuals

_____ Claim files

_____ Policy forms

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ensure the policy conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living (ADLs) and cognitive impairment.

Ensure that the policy contains the definition of ADLs, cognitive impairment and other key terms as required by statutes, rules and regulations.

Determine that the eligibility for payment of benefits is not more restrictive than requiring either a deficiency in the ability to perform not more than 3 of the ADLs or the presence of cognitive impairment. Ensure that payment of benefits is not more restrictive than those allowed by statutes, rules and regulations.

Ensure that the policy contains a clear description of the process for appealing and resolving benefit determinations.

Standard 3
Marketing for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Required reports filed with the insurance department

_____ Marketing materials filed with the insurance department

_____ Underwriting files or other files containing proof of issuance of outline of coverage

_____ Review state statutes, rules and regulations to determine if state limited LTC requirements apply to annuity products with a limited LTC element. If so, then the applicable *Annuity Disclosure Model Regulation* (#245) would apply

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Life Insurance Disclosure Model Regulation (#580)
Life Insurance Illustrations Model Regulation (#582)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity uses applications for limited LTCI policies or certificates containing clear and unambiguous questions designed to ascertain the health condition of the applicant. (In most cases, application forms should have been reviewed by the insurance department's rates and forms division.)

Verify that the entity complies with right to return/"free look" requirements.

Verify that the outline of coverage is delivered to the applicant at time of initial solicitation through means that prominently directs the attention of the recipient to the document and its purpose.

Verify that at the time of policy delivery the insurer has delivered a policy summary for an individual life insurance policy that provides limited LTC benefits within the policy or by rider. In the case of direct response solicitations, verify that the insurer has delivered the policy summary upon the applicant's request, but regardless of the request has made delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, ensure that the summary also includes:

- An explanation of how the limited LTC benefit interacts with other components of the policy;
- Any exclusions, reductions and limitations on benefits of limited LTC; and
- A statement that any limited LTC inflation protection option required by the applicable state's statutes, rules and regulations regarding inflation protection option requirements comparable to Section 13 of the *Limited Long-Term Care Insurance Model Regulation* (#643) is not available under this policy.

In addition to the above, if applicable to the policy type, ensure that the summary includes the following:

- A disclosure of the effects of exercising other rights under the policy; and
- A disclosure of guarantees related to limited LTC costs of insurance charges.

The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with the applicable state's basic illustration requirements comparable to Sections 7 and 8 of the *Life Insurance Illustrations Model Regulation* (#582) or into the life insurance policy summary, which is required to be delivered in accordance with the applicable state's life insurance policy summary requirements comparable to Section 5 of the *Life Insurance Disclosure Model Regulation* (#580).

Verify that the entity complies with records maintenance and reporting requirements:

- Entity must maintain records for each producer of that producer's amount of replacement sales as a percentage of the producer's total annual sales and the amount of lapses of limited LTCI policies sold by the producer as a percentage of the producer's total annual sales;
- Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements;
- Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year; and
- Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year.

STANDARDS
MARKETING AND SALES

Standard 4
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for advertisements approved by the Compact)

_____ All company advertising and sales materials, including radio and audiovisual items, such as TV commercials, telemarketing scripts and pictorial materials

_____ Policy forms, including any required buyer's guides, outline of coverage, limited LTCI personal worksheets and disclosure forms as they coincide with advertising and sales materials

_____ Producer's own advertising and sales materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Evaluate the company's system for controlling advertisements. Every insurer should have and maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the insurer.

Ensure the company maintains, at its home or principal office, a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies. There should be a notation indicating the manner and extent of distribution and the form number of every policy advertised. All advertisements should be maintained in the file for a period of either at least three years from the date the advertisement was first used or later if required by state statutes, rules and regulations.

Review advertising materials in conjunction with the appropriate policy form. Materials should not:

- Misrepresent policy benefits, advantages or conditions by failing to disclose limitations, exclusions or reductions, or use terms or expressions that are misleading or ambiguous;
- Make unfair or incomplete comparisons with other policies;
- Make false, deceptive or misleading statements or representations with respect to any person, company or organization in the conduct of insurance business;
- Offer unlawful rebates;
- Use terminology that would lead prospective buyers to believe that they are purchasing an investment or savings plan. Problematic terminology may include the following terms: investment, investment plan, founder's plan, charter plan, deposit, expansion plan, profit, profits, profit sharing, interest plan, savings or savings plan;
- Omit material information or use words, phrases, statements, references or illustrations, if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences;
- Use terms such as "non-medical" or "no medical examination required," if the issue is not guaranteed, unless the terms are accompanied by a further disclosure of equal prominence and juxtaposition that issuance of the policy may depend on the answers to the health questions set forth in the application;
- State that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company;
- State or imply that the policy or combination of policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless that is a fact. Enrollment periods may not be described in terms such as "special" or "limited" when the insurer uses successive enrollment periods as its usual method of marketing its policies;
- State or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy;
- Offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium should be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised;
- Imply licensing beyond limits, if an advertisement is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed;
- Exaggerate, suggest or imply that competing insurers or insurance producers may not be licensed, if the advertisement states that an insurer or insurance producer is licensed in the state where the advertisement appears;
- Create the impression that the insurer, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, that fact may be stated, if the entity authorizes its recommendation or endorsement to be used in the advertisement;
- State or imply that prospective insureds are or become members of a special class, group or quasi-group and enjoy special rates, dividends or underwriting privileges, unless that is a fact; and
- Misrepresent any policy as being shares of stock.

Materials should:

- Clearly disclose the name and address of the insurer;
- If using a trade name, disclose the name of the insurer, insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy;
- Prominently describe the type of policy being advertised;
- Indicate that the product being marketed is insurance;
- Comply with applicable statutes, rules and regulations;
- Cite the source of statistics used;
- Identify the policy form that is being advertised, where appropriate;
- Clearly define the scope and extent of a recommendation by any commercial rating system;
- Only include testimonials, appraisals or analysis if they are genuine, represent the current opinion of the author, are applicable to the policy advertised and accurately reproduced to avoid misleading or deceiving prospective insureds. Any financial interest by the person making the testimonial in the insurer or related entity must be prominently disclosed; and
- Only state or imply endorsement by a group of individuals, society, association, etc., if it is a fact. Any proprietary relationship or payment for the testimonial must be disclosed.

Determine if the company approves producer sales materials and advertising. Ensure that copies of sales material other than company-approved materials, if permitted, are maintained in a central file. Determine if advertisements or lead-generating calls falsely project the image that they were sent by a government agency.

Determine if the advertising and solicitation materials mislead consumers relative to the producer's capacity as an insurance producer. Improper terms may include "financial planner," "investment advisor," "financial consultant" or "financial counseling," if they imply the producer is primarily engaged in an advisory business in which compensation is unrelated to sales, if such is not the case.

Review the use of the words "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words of similar import. Those words should not be used with respect to any benefit or service being made available with a policy, unless it is a fact. If there is no charge to the insured, then the identity of the payor must be prominently disclosed. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the premium or use other appropriate language.

Ensure the advertisement does not contain a statement or representation that premiums paid for a limited LTCI policy can be withdrawn under the terms of the policy. Reference may be made to amounts paid into an advance premium fund, which are intended to pay premiums at a future time, to the effect that they may be withdrawn under the conditions of the prepayment agreement. Reference may also be made to withdrawal rights under any unconditional premium refund offer.

Determine that company procedures and materials relative to limited LTC products comply with right to return/"free look" requirements.

Review the company and producer's Internet sites with the following questions in mind:

- Does the website disclose who is selling/advertising/servicing for the website?
- Does the website disclose what is being sold or advertised?
- If required by statutes, rules or regulations, does the website reveal the physical location of the company/entity?
- Does the website reveal the jurisdictions where the advertised products are (or are not) approved, or use some other mechanism (including, but not limited to, identifying persons by geographic location) to accomplish an appropriate result?
- For the review of Internet advertisements:

- Run an inquiry with the company's name;
- Review the company's home page;
- Identify all lines of business referenced on the company's home page;
- Research the ability to request more information about a particular product and verify that the information provided is accurate; and
- Review the company's procedures related to producers' advertising on the Internet and ensure that the company requires prior approval of the producers' web pages, if the company name is used.

STANDARDS
MARKETING AND SALES

Standard 5
Company rules pertaining to producer requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Policy/Underwriting file

_____ Loan and surrender files, if applicable

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Review policy/underwriting files to determine if producers have identified replacement transactions on applications.

Review replacement register and policy/underwriting files to determine if required disclosure forms have been submitted on replacement transactions.

Review policy/underwriting files to confirm applicant's receipt of replacement notice.

Review replacement disclosure forms for completeness and signatures as required.

Standard 6
Company rules pertaining to company requirements in connection with replacements are in compliance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Replacement register

_____ Policy/Underwriting file

_____ Agency correspondence file/Agency bulletins

_____ Agency procedural manual

_____ Claim files

_____ Agency sales/Lapse records

_____ Company systems manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Life Insurance and Annuities Replacement Model Regulation (#613), if applicable
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the company has advised its producers of its replacement policy.

Determine if the company has separate commission schedules for replacement business, pursuant to applicable state statutes, rules and regulations. Note: Some states limit the compensation payable on replacement business to no more than that payable on renewal policies.

Determine if the company has provided timely notice to the existing insurers of the replacement.

Examine the company system of identifying undisclosed replacements for effectiveness.

Determine if the company has the capacity to produce the data required by replacement regulation to assess producer replacement activity.

Determine if the company has issued letters in a timely manner to policyholders advising of the effects of preexisting conditions on covered benefits.

Review policy/underwriting files to determine if the company is retaining required records for required time frames.

Examine company procedures for verifying producer compliance with requirements on replacement transactions.

Review claim files to determine if the company provides required credit for preexisting conditions or probationary periods on replacements.

D. Producer Licensing

Use the Producer Licensing Standard 2 that is provided in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
POLICYHOLDER SERVICE

Standard 1
Policy renewals are applied consistently and in accordance with policy provisions.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Review renewal business to determine if the entity's procedures for handling renewals are in accordance with applicable statutes, rules and regulations.

Ensure that individual policies or certificates do not contain renewal provisions other than "guaranteed renewable" or "noncancellable," and that these terms are adequately defined in the policy or certificate.

Review the underwriting/policy file to determine if premium notices were sent in a timely and accurate manner.

Review mailroom records for billings sent by the entity to ensure they were sent in a timely manner.

STANDARDS
POLICYHOLDER SERVICE

Standard 2
Nonforfeiture upon lapse and reinstatement provisions is applied consistently and in accordance with policy provisions.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Administrative files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the required notification of lapse or termination is sent to the proper addressee(s), within the required time frames and that the required information is provided, per applicable statutes, rules and regulations.

Ensure that the entity receives designation of a person(s), other than the insured, to receive notice of lapse or termination of the policy or certificate for nonpayment of premiums or a written waiver by the insured not to designate an additional person(s) to receive notice.

Ensure that the insurer notifies existing insureds of their right to change their written designation at least once every two years, or as specified by state statutes, rules and regulations.

Verify that nonforfeiture and reinstatement provisions were applied consistently and in a non-discriminatory manner. Nonforfeiture provisions upon lapse and reinstatements should be applied per policy provisions and in accordance with applicable statutes, rules and regulations.

Ensure that the policy includes a provision that provides for reinstatement of coverage in the event of lapse, if the entity has provided evidence that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option should be made available to the insured for a period of 5 months after the date of termination.

STANDARDS
POLICYHOLDER SERVICE

Standard 3
Nonforfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Administrative file

_____ Entity procedures manual

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the entity offers applicants the opportunity to purchase a limited LTC policy that includes a nonforfeiture benefit, as required by applicable statutes, rules and regulations.

If the applicant declines the nonforfeiture benefit, ensure that the entity provides a contingent benefit upon lapse of the policy for a specified period following a substantial increase in premium rates, as required and defined by applicable statutes, rules and regulations.

Ensure that a policy offered with nonforfeiture benefits contains the same coverage elements, eligibility, benefit triggers and benefit length as a policy without the nonforfeiture benefit.

Determine if the entity provides notice as required by applicable statutes, rules and regulations prior to the due date of the premium reflecting a substantial premium increase.

Ensure that the entity offers the proper nonforfeiture benefit and nonforfeiture credit, as required by applicable statutes, rules and regulations.

Determine if the policy contains the proper time frames for nonforfeiture benefit and the contingent benefit upon lapse, as required by applicable statutes, rules and regulations.

Determine if the correct nonforfeiture option is provided in case of policy lapse.

Review correspondence with policyholders to determine if options were explained adequately.

If there are questions related to nonforfeiture values, refer to applicable statutes, rules and regulations regarding the calculation of nonforfeiture values.

Review the entity's procedures and policies regarding the handling of each type of nonforfeiture transaction (including whether the request may be made verbally).

Ensure that the entity notifies policyowners of material changes to any nonforfeiture benefits in accordance with applicable statutes, rules and regulations.

STANDARDS
POLICYHOLDER SERVICE

Standard 4
Policyholder service for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Policy file

_____ Underwriting/Administrative procedures manuals

_____ Procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Verify that the entity offers nonforfeiture benefits.

F. Appeal of Benefit Trigger Adverse Determination

Use the standard set forth below.

STANDARDS
APPEAL OF BENEFIT TRIGGER ADVERSE DETERMINATION

Standard 1
Insurers shall be in compliance with applicable state statutes, rules and regulations regarding appeal of adverse benefit trigger determination.

Apply to: All limited long-term care insurers

Priority: Essential

Documents to be Reviewed

_____ Company's written procedures explaining administration of appeals process and template denial letters

_____ Internal company procedures which describe the appeals process

_____ Applicable statutes, rules and regulations

_____ Request copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ask insurer how it describes its appeal procedures to the insured.

Ask for copies of correspondence on actual claimants who have appealed benefit trigger decisions (e.g., request for appeal, acknowledgement of appeal, appeal outcome communicated) after state statutes, rules and regulations became effective.

In the event the insurer has determined that the benefit trigger of a limited LTCI policy has not been met, verify that the insurer has provided a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

- The reason that the insurer determined that the insured's benefit trigger had not been met;
- The insured's right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request within 120 calendar days of receipt of the notice; and
- The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination to contact their state insurance department and their State Health Insurance Program (SHIP) office.

Ensure that the individual or individuals making the internal appeal decision are not the same individual or individuals who made the initial benefit determination.

Verify that the insurer, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made, has completed and sent written notice of the internal appeal decision to the insured and the insured's authorized representative, if applicable.

If the insurer's original determination is upheld upon internal appeal, ensure that the notice of the internal appeal decision describes any additional internal appeal rights offered by the insurer.

If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their state insurance department and their State Health Insurance Program (SHIP) office, pursuant to applicable state statutes, rules and regulations.

Verify that if any new or additional information not previously provided to the insurer is submitted by the insured or the insured's authorized representative, the insurer either (1) considers and affirms or (2) overturns its benefit trigger determination.

If the insurer overturns its benefit trigger determination, verify that the insurer has provided notice to the insured and the insured's authorized representative, if applicable, and the commissioner of its decision.

G. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the entity treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

- Rating practices;
- Underwriting practices;
- Use of correct and properly filed and approved forms and endorsements;
- Termination practices;
- Unfair discrimination;
- Use of proper disclosures, outlines of coverage and delivery receipts;
- Reinsurance; and
- Marketing and sales materials.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including:

- Rating manuals and rate cards;
- Underwriting manuals, guidelines and classification manuals;
- Medical underwriting manuals;
- Individual and group issued and renewed policy files;
- Policy summaries;
- Replacement and conservation materials;
- Documentation of required disclosures and delivery receipts;
- Individual and group canceled policy files and certificates;
- Documentation of premium refund upon election of "free look" period;
- Recessions occurring prior to a claim;
- Policy forms, endorsements and applications, along with appropriate filings;
- Producer licensing information;
- Producer compensation agreements, where applicable;
- Premium statements and billing statements;
- Group trust arrangements, where applicable;
- Declined applications and notices;
- Individual and group lapsed policy files and notices;
- Individual and group nonforfeiture files and notices;
- Reinsurer policies/treaties; and
- Reinsurer guidelines and manuals.

For the purposes of this chapter, "underwriting file" means the file or files containing the new business application, renewal application, certificates or evidences of coverage, including binders, rate calculation sheets, billings, medical information, credit information, inspection or interview reports, all underwriting information obtained or developed, policy summary page, endorsements, cancellation or reinstatement notices, correspondence and any other documentation supporting selection, classification, rating or termination of the policy.

In selecting samples for testing, individual policies should generally not be combined with group policies. Because these two areas are generally not homogeneous, any conclusions or inferences made from the results of sampling may not be valid if combined. The examiner should be familiar with the process for gathering and processing underwriting information and the quality controls for the issuance of policies, endorsements and premium statements. The list of files from which a sample is to be drawn may be generated through a computer run or, in some cases, through a policy register covering the period of time selected in the notice of the examination.

Next, determine the entity's policy population (policy count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review, the examiner must be certain that the examination results are clearly identified as representative of the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for entity judgment.

a. Rating Practices

   It is necessary to determine if the entity is in compliance with rating systems that have been filed with and, in some cases, approved by the insurance department. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates are being applied consistently and in accordance with the entity's own rating methods. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by an entity might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that an entity is engaged in unfair competitive practices. Inconsistent application of rates or classifications can result in unfair discrimination.

   If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems or the use of improperly worded, vague or obsolete rating manuals. When exceptions are noted, it is advisable to determine the scope and extent of the problem.

   Occasionally, the examiner may need to review loss statistics to determine if premiums are fair and reasonable in relation to the associated claims experience. When possible, the examination team should make use of audit software to verify the correct application of specific rating components and the consistent use of rates. This allows for a more thorough review and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

   The rating practices for renewal policies and newly issued policies should be reviewed. The examination team should also review premium notices and billing statements. The examiner should ensure the proper application of rate increases or rate decreases.

   The examiner should also ensure that the underwriting files contain sufficient information to support the rates that have been developed.

b. Underwriting Practices

The examiner should review relevant underwriting information; e.g., the entity's underwriting manuals, underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers. Interoffice memoranda and entity minutes that may furnish evidence of anti-competitive behavior may also be requested. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the entity's compliance with its own manuals and guidelines. The examiner should confirm that the entity's underwriters and producers consistently apply the entity guidelines for all business selected or rejected. The examination team should verify that the entity has correctly classified insured individuals.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the entity's management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of the business. Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each applicable field office.

Any practice suggesting anti-competitive behavior may involve legal considerations that should be referred to the insurance department's counsel. Ultimately, the information obtained may be useful in drafting legislation or regulations.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage and riders requested by the applicant are not issued, proper notification should be provided to the applicant. In some cases, supplemental applications are appropriate.

d. Termination Practices

The examination team should review the entity's policy cancellation and reinstatement practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the entity's own rules, guidelines and policy provisions.

Cancellation and lapsed policy processing should include a formal notice to the insured, including secondary addressees, where elected by the insured. Adherence to policy provisions for renewal language and for applicable grace periods should be reviewed.

The examination team should verify that premium refunds upon election of "free look" provisions are handled correctly, uniformly and in a timely manner.

The examination team should review reinstatement offers and determine what the entity's practice is for offering reinstatement. In addition, the examination team should be mindful of billing practices that may encourage policy lapses.

e. Unfair Discrimination

The examination team should be mindful of entity underwriting practices that may be unfairly discriminatory. The classification of insureds into rating or underwriting groups must be based on sound business or actuarial principles. Failure to follow established rating and underwriting guidelines may result in unintentional, yet unfair discrimination. Unfair trade practice acts and related regulatory rules adopted by the applicable jurisdiction also may prohibit specific underwriting practices.

f. Use of Proper Disclosures, Buyer's Guides and Outlines of Coverage

The examination team should review the entity's use of required disclosure forms, buyer's guides, policy summaries, replacement notices, "free look" periods and outlines of coverage. In addition to the use of such required items, the examiner may wish to verify that the above items contain the correct content and are in the correct format.

g. Reinsurance

Most state statutes include a feature that for many lines of business the entity is not permitted to place more than 10 percent of its surplus to policyholders at risk on any one placement of insurance. While this is primarily a solvency issue, it is one that market conduct examiners are in an ideal position to test in view of the sampling of underwriting files.

Adherence to the requirement is easy to test, but requires familiarity with the structure and content of the reinsurance treaties covering the business written by the entity. This item is particularly important for companies that hold minimal policyholder surplus accounts (i.e., surplus of less than $10 million). It also may reflect on the care that the entity's management places on its selection of business, and represent a danger to the financial health of the entity. Errors in this area should be forwarded to the appropriate state financial examiners. Any tests of this type must be coordinated with the state's financial examiners.

h. Marketing and Sales Materials

It is recommended that a review of all forms and materials be conducted by reviewing the marketing and sales standards simultaneously during the underwriting and rating review.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the entity's underwriting activities. The sequence of the standards listed here does not indicate priority of the various standards.

STANDARDS
UNDERWRITING AND RATING

Standard 1
All mandated definitions and requirements for group limited long-term care insurance are followed in accordance with applicable statutes, rules and regulations.

Apply to: All group limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Underwriting files

_____ Rating/Quote information provided electronically

____ Marketing materials

____ Correspondence to producers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

If a group policy is issued to an employer or labor organization or association, determine if the group meets the required criteria to qualify the association or organization as a bona fide organization established for the benefits of its members.

Determine if all group limited LTC policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group limited LTC policy standard provisions that are applicable in the examining jurisdiction are incorporated into the group policy. These provisions include, but are not limited to, grace periods, periods of incontestability, required copies of applications, deemers of representations and not warranties, medical or other evidence of insurability, provision for a certificate of insurance and conversion to an individual policy in the event of termination or total disability.

Standard 2
Pertinent information on applications that form a part of the policy is complete and accurate, and applications conform to applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ All applications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the requested coverage is issued.

Determine if the entity has a verification process in place to determine the accuracy of application information.

Verify that applicable nonforfeiture options and inflation protection options are indicated on the application.

Verify that changes to the application and supplements to the application are initialed by the applicant.

Verify that supplemental applications are used, where appropriate.

Determine if the application complies with applicable statutes, rules and regulations regarding form and content.

Standard 3
The entity complies with specific requirements for AIDS-related concerns in accordance with applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Applications and related disclosure and consent forms

_____ Health questionnaires for applicants

_____ Medical underwriting guidelines

_____ Entity guidelines regarding the handling of AIDS-related test results, if such tests are allowed

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Ensure the entity does not use medical records indicating AIDS-related concerns to discriminate against applicants without medical evidence of disease. Companies shall establish reasonable procedures related to the administration of an AIDS-related test.

Medical underwriting guidelines may consider factual matters that reveal the existence of a medical condition. For example, no adverse underwriting decision shall be based on medical records that only indicate the applicant demonstrated AIDS-related concerns by seeking counseling from a health care professional.

Disclosure forms signed by the applicant must clearly disclose the requirement, if any, for applicants to take an AIDS-related test, and should be a part of the underwriting file. Applications must contain a consent form for such testing.

Review any application forms and health questionnaires used by the entity or its producers for questions that would require the applicant to provide information regarding sexual orientation.

Questions may ask if the applicant has been diagnosed with AIDS or ARC, if they are designed to establish the existence of the condition, but are not to be used as a proxy to establish sexual orientation of the applicant.

Ensure the entity or insurance support organization does not use the sexual orientation of an applicant in the underwriting process or in the determination of insurability.

Underwriting guidelines must not consider an applicant's sexual orientation a factor in the determination of insurability.

Review a sample of underwriting files for denied applications in order to verify that denials were non-discriminatory.

Review inspection reports to determine if they are being used in a discriminatory manner, or ordered on the basis of the entity guidelines (e.g., based on the amount of insurance).

Neither the marital status, the living arrangements, the occupation, gender, medical history, beneficiary designation, nor the ZIP code or other territorial classification may be used to establish the applicant's sexual orientation.

STANDARDS
UNDERWRITING AND RATING

Standard 4
Policies, riders, amendments, endorsements, applications and certificates of coverage contain required provisions, definitions and disclosures.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Underwriting/Administration file

_____ Policies, riders, amendments, endorsements, applications and certificates of coverage

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the policy contains the required terms and definition of such terms per applicable statutes, rules and regulations, including, but not limited to:

- Guaranteed renewable and noncancellable;
- Activities of daily living, acute condition, adult day care, bathing, cognitive impairment, continence, dressing, eating, hands-on assistance, home health care services, Medicare, mental or nervous disorder, personal care, skilled nursing care, toileting and transferring. In addition, coverage specific to limited LTC benefits may include non-skilled nursing care by providers of service, including, but not limited to, skilled nursing facility, extended care facility, convalescent nursing home, personal care facility, specialized care providers, assisted living facility, and home care agency; and
- Reasonable and customary/usual and customary.

Determine if riders and endorsements added after the original date of issue, at reinstatement or renewal that reduce or eliminate benefits or coverage (except as requested by the insured) require signed acceptance by the insured.

Ensure that the entity has not established a new waiting period in the event existing coverage is converted or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the individual or group policyholder.

Ensure that the entity does not apply preexisting condition provisions more restrictive than "…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person," unless the insurance commissioner has extended limitation periods.

A limited LTCI policy or certificate, other than a policy or certificate issued to a defined group, may not exclude coverage for a loss or confinement that is the result of a preexisting condition, unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

A limited LTCI policy or certificate may not exclude or use riders or waivers to exclude, limit or reduce benefits for specifically named or described preexisting conditions or physical conditions beyond the defined waiting period.

Determine if the policy meets the requirements under applicable statutes, rules and regulations with regard to prior hospitalization/institutionalization. The policy may not:

- Condition eligibility of any benefits on a prior hospitalization requirement, or, in the case of benefits provided in an institutional care setting, on the receipt of a higher level of institutional care;
- Condition eligibility for benefits (other than waiver of premium, post-confinement, post-acute care or recuperative benefits) on a prior institutionalization requirement;
- Condition eligibility of non-institutional benefits based on the prior receipt of institutional care on a prior institutional stay of more than 30 days; and
- Condition the receipt of benefits following institutionalization upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge.

A policy or rider containing post-confinement, post-acute care or recuperative benefit shall contain in a separate paragraph titled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

Determine if the policy contains any limitations regarding preexisting conditions, and, if so, ensure that they are outlined in a separate paragraph titled "Preexisting Condition Limitations."

Ensure that the policy measures the need for limited LTC on the activities of daily living (ADLs) and cognitive impairment, and that they are described—along with any additional benefit triggers, benefits and entity-required certification of functional dependency—in a separate paragraph titled "Eligibility for the Payment of Benefits."

If a limited LTC policy provides benefits for home health care or community care services, ensure that it meets the required minimum standards required by applicable statutes, rules and regulations.

STANDARDS
UNDERWRITING AND RATING

Standard 5
Underwriting and rating for limited long-term care products complies with applicable statutes, rules and regulations.

Apply to: All group limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Insurance department approval of forms

_____ Underwriter's file or notes on a system log

_____ Insured's request (if applicable)

_____ Entity cancellation/nonrenewal guidelines

_____ Certificate of mailing

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)

Review Procedures and Criteria

Determine if the notice of cancellation/nonrenewal was valid according to policy provisions and applicable statutes, rules and regulations.

Review entity procedures for cancellation/nonrenewal to determine if the entity is following its own guidelines.

Review cancellation and billing notices, grace period descriptions, reinstatement offers, lapse notices, etc., to ensure the forms, if necessary, were approved by the insurance department.

In addition to other applicable review procedures, verify the following:

- The entity has not cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder;
- The entity has not established a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same entity, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
- The entity does not provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care; and
- The entity does not apply preexisting condition provisions more restrictive than "…a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within 6 months preceding the effective date of coverage of an insured person," unless limitation periods have been extended by the insurance commissioner.

Verify that standards for incontestability periods are no more restrictive than as follows:

- Within 6 months, misrepresentations must be material;
- Within 2 years and more than 6 months, misrepresentation must be material and pertain to the condition for which benefits are sought; and
- After 2 years, benefits are contestable only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

Verify that the entity's underwriting practices reflect minimum requirements related to guaranteed renewability, noncancellability and continuation or conversion.

Replacement of a group limited LTC policy with another group limited LTC policy shall offer coverage to all persons covered under the previous group policy on its date of termination, with no preexisting condition exclusions that would have been covered on the prior policy and shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of limited LTC services.

Verify that the entity provides notice to the designated person, in addition to the applicant, for termination of a policy or certificate for nonpayment of premium.

Verify that the entity allows for reinstatement of coverage in the event of lapse if provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

Verify that prior to issuance of a limited LTC policy or certificate to an applicant age 80 or older, the insurer obtains one of the following:

- A report of a physical examination;
- An assessment of functional capacity;
- An attending physician's statement; or
- Copies of medical records.

Verify that the entity delivers a copy of the completed application or enrollment form (whichever is applicable) to the insured no later than at the time of delivery of the policy or certificate, unless it was retained by the applicant at the time of application.

Verify that the entity maintains a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated. The entity shall annually furnish this information to the insurance commissioner in the format prescribed by applicable statutes, rules and regulations.

Verify that the premium charged does not increase due to increase of age beyond 65 or the duration the insured has been covered under the policy.

STANDARDS
UNDERWRITING AND RATING

Standard 6
The company's underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risks.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ New business application

_____ All underwriting information obtained

_____ Company underwriting guidelines and bulletins

_____ Declination procedures

_____ Agency agreements and correspondence with producers

_____ Riders or extensions of coverage

_____ Interoffice memoranda and company minutes

_____ Policy specifications page

_____ Underwriter's file or notes on a system log

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Limited Long-Term Care Insurance Model Act (#642)
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment (#887)
Model Regulation on Unfair Discrimination on the Basis of Blindness or Partial Blindness (#888)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Unfair Trade Practices Act (#880)
Credit Reports and Insurance Underwriting White Paper

Review Procedures and Criteria

Ensure the file documentation adequately supports the decisions made:

- The application should be complete and signed;
- Determine when, and under what conditions the company requires motor vehicle reports, inspection reports, credit reports, Medical Information Bureau (MIB) or other medical physician reports or other underwriting information to confirm exposure or premium basis;
- Determine if the file contains the necessary information to support the classification, rating and selection decision made; and
- Verify that when a policy is issued on a basis other than applied for, that notice of an adverse underwriting decision is provided in accordance with applicable statutes, rules and regulations.

Review relevant underwriting information to ensure that no unfair discrimination is occurring, according to the state's definition of unfair discrimination.

Determine if the company is following its underwriting guidelines, and that the guidelines conform to applicable statutes, rules and regulations, including, but not limited to:

- The insurer shall obtain one of the following prior to issuance of a policy or certificate to an applicant aged 80 or older:
    - A report of physical examination;
    - An assessment of functional capacity;
    - An attending physician's statement; or
    - Copies of medical records.
- All applications for limited LTC, except policies issued on a guaranteed-issue basis, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant; and
- If an application for limited LTC coverage contains a question regarding whether the applicant has had medication prescribed by a physician, the company shall also ask the applicant to list the medication.

Determine if the company underwriting guidelines have been filed, where applicable.

Review interoffice memoranda for evidence of anti-competitive behavior, collusive practices or improper replacement tactics.

Underwriting guidelines may vary by geographic areas in the jurisdiction and, therefore, such guidelines should be reviewed for each office being examined.

Inconsistent handling of rating or underwriting practices, even if not intentional, can result in unfair discrimination. Companies may not permit discrimination between individuals of the same class and equal health status.

Ensure that underwriting requirements are not applied in an unfairly discriminatory manner.

Review guaranteed issue criteria to ensure correct handling.

Review policy provisions for skilled nursing care to ensure that no restrictions are placed on the proper level of care; i.e., the company does not provide only skilled nursing care or does not provide more coverage for skilled care in a facility than coverage for lower levels of care.

Verify that the questions on applications are sufficiently clear and applicable to the coverage being requested.

Verify that Medical Information Bureau (MIB) information is not used as the sole basis for an underwriting decision.

Companies may not refuse to insure, continue to insure or limit coverage based on:

- Sex;
- Marital status;
- Race;
- Religion;
- National origin;
- Physical or mental impairment (except where based on sound actuarial principles or actual or reasonably anticipated experience);
- Blindness or partial blindness only* (however, all other conditions, including the underlying cause of the blindness or partial blindness, are subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person); and
- Abuse status.

*Note: Review individual state statutes, rules and regulations that may provide that an insurer may not refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual solely because of blindness or partial blindness.

Many jurisdictions have enacted legislation regarding subjects of abuse. Examiners should be familiar with their statutes, rules and regulations in this area.

Examine new business applications for the required fraud statement.

H. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
CLAIMS

Standard 1
Claim files are handled in accordance with policy provisions and applicable statutes, rules and regulations.

Apply to: All limited long-term care products

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations (Note: Reference applicable Interstate Insurance Product Regulation Commission (Compact) uniform standards for products approved by the Compact)

_____ Company claim procedure manuals

_____ Claim training manuals

_____ Internal company claim audit reports

_____ Insured's requests (if applicable)

_____ Claim bulletins and procedure manuals

_____ Company claim forms manual

_____ Claim files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Limited Long-Term Care Insurance Model Act (#642)
Limited Long-Term Care Insurance Model Regulation (#643)
Unfair Claims Settlement Practices Act (#900)
Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)

Review Procedures and Criteria

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether standards comply with state statutes. Determine if company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner.

Determine if claim handling meets applicable statutes, rules and regulations, including:

- Correct payees and addresses; and
- Correct benefit amounts.

Ascertain whether the company has misrepresented relevant facts or policy provisions relating to coverages at issue.

Determine if claim files are handled according to policy provisions.

If a claim under a limited LTCI contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder, or a representative thereof:

- Provide a written explanation of the reasons for the denial; and
- Make available all information directly related to the denial.

Determine if the insurer is in compliance with proper payment of "clean claims," as defined in applicable state statutes, rules and regulations. Verify that the insurer pays clean claims within 30 business days after receipt of a clean claim. For claims that do not fall within the category of a clean claim, verify that the insurer has sent a written notice acknowledging the date of receipt of the claim and containing one of the following provisions within 30 business days:

- The insurer has declined to pay all or part of the claim and the specific reason(s) for denial; or
- That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

Verify that the insurer has paid clean claims within 30 business days after receipt of all requested additional information, or has sent a written notice that the insurer has declined to pay all or part of the claim within 30 days. The notice should specify the specific reason(s) for denial.

If, upon review of insurer clean claim payment practices, an examiner determines that an insurer has failed to comply with clean claim requirements, verify that the insurer has paid interest at the rate of one percent per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the receipt of the claim or, in the event the insurer has requested additional information, upon receipt of all requested additional information.

Verify that the insurer has included interest payable in any late reimbursement without requiring the individual who filed the original claim to make any additional claim for such interest.

It is an unfair practice to settle, or attempt to settle, a claim on the basis of an application that was materially altered without the consent of the insured.

Confirm that a monthly report is issued to the policyholder whenever limited LTC benefits are issued through acceleration of death benefit provisions of a life insurance product.

Confirm that mandatory nonforfeiture benefits are offered.

Determine that eligibility for the payment of benefits is based on a deficiency in the ability to perform not more than 3 of the activities of daily living (ADLs) or the presence of cognitive impairment.

Ensure that determination of deficiency is not more restrictive than:

- Requiring the hands-on assistance of another person to perform the prescribed ADLs; and
- For a cognitive impairment, supervision or verbal cueing by another person is needed to protect the insured or others.

Ensure that licensed or certified professionals, such as physicians, nurses or social workers, perform assessments of ADLs and cognitive impairment.

Chapter 27—Conducting the Consumer Credit Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a suggested format for conducting examinations of companies that offer one or more consumer credit products. The fundamental purpose of the examination is to determine compliance with applicable statutes, rules and regulations governing companies that write credit insurance.

The examination of credit insurance operations may involve any review of one or a combination of the following business areas:

A. Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

Many states have executed an agreement to share complaint information with one or more federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The company conducts a thorough periodic review of creditors with respect to their credit insurance business to ensure compliance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates and policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

_____ State-specific periodic review requirements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

In some states, a credit insurer is responsible for conducting a thorough periodic review of creditors with respect to their credit insurance business. The review should ensure compliance with applicable statutes, rules and regulations. There may be a requirement that written records of the reviews be maintained by the insurer. If applicable, review company procedures and, if required, written records of reviews.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the company has taken appropriate corrective action.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
MARKETING AND SALES

Standard 1
All mandated disclosures and advertisements are documented and in compliance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Bulletins, newsletters and memos

_____ Underwriting files

_____ Rating/Quote information provided electronically

_____ Marketing materials

_____ Organizational chart of marketing division

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Note: The NAIC model acts related to the marketing and sale of credit insurance are listed above and are the source for the following review procedures and criteria. In some cases, a state may have one or more of these measures, or a combination thereof, in force. The examiner will need to determine which models or sections of the models have been adopted by the state to conduct the examination.

Review written and electronic communication related to mandated disclosures in advertisements between company and producers/debtors/insureds in accordance with applicable statutes, rules and regulations.
Determine if communication conforms to Standard 1 when referencing advertising and sales.

The company may use email to communicate with producers. The examiners should ask for saved, stored or archived email that was broadcast to the sales force.

Ensure the debtor is provided a disclosure in writing with the following information prior to the election to purchase insurance (*Consumer Credit Insurance Model Act* (#360), Section 6). This may be produced by the company or as part of the loan document:

- That the purchase of consumer credit insurance is optional;
- If more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase each kind separately, or the multiple coverages are available for purchase only as a package;
- The conditions of eligibility;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit insurance;
- That, within the first 30 days after receiving the individual policy or group certificate, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time and receive a refund of any of the unearned premium;
- A brief description of the coverage, including a description of the amount, the term, any exceptions, limitations and exclusions, the insured event, any waiting or elimination period, any deductible, any applicable waiver of premium provision, to whom the benefits would be paid and the premium rate for each coverage or for all coverages in a package; and
- That, if the premium or insurance charge is financed, it will be subject to finance charges.

Personal Property—Pre-Purchase Disclosure

The following is to be disclosed to the debtor in writing, and may be combined with other disclosures required by state or federal laws and regulations (*Credit Personal Property Insurance Model Act* (#365), Section 5):

- That the purchase of credit personal property insurance through the creditor is optional, and not a condition of obtaining credit approval;
- If more than one kind of credit insurance is being made available to the debtor, that the debtor can purchase credit personal property insurance separately;
- That, if the consumer has other insurance that covers the risk, he or she may not want or need credit personal property insurance;
- That, within the first 30 days after receiving the individual policy or certificate of insurance, the debtor may cancel the coverage and have all premiums paid by the debtor refunded or credited. Thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund or any of the unearned premium. However, only in those instances where the creditor requires evidence of insurance for the extension of credit, the debtor may be required to offer evidence of alternative insurance acceptable to the creditor at the time of cancellation;
- A brief description of the coverage, including a description of the major perils and exclusions, any deductible, to whom the benefits would be paid and the premium or premium rate for the credit personal property coverage; and
- If the premium or insurance charge is financed, it will be subject to finance charges at the rate applicable to the credit transaction.

Standard 2
The amount of credit insurance sold is in compliance with the requirements of applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Consumer disclosures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

Note: The NAIC model acts related to the marketing and sale of credit insurance are listed above and are the source for the following review procedures and criteria. In some cases, a state may have one or more of these measures, or a combination thereof, in force. The examiners will need to determine which models or sections of the models have been adopted by the state to conduct the examination.

Credit Life Insurance

- Verify the amount of insurance at no time exceeds the greater of the actual net debt, scheduled net debt, level, gross and/or monthly outstanding balance (*Consumer Credit Insurance Model Act* (#360), Section 4A(1));
- If the coverage is written on the actual net debt, verify the amount payable at the time of loss is not less than the actual net debt less any payments more than 2 months overdue (*Consumer Credit Insurance Model Act* (#360), Section 4A(2)); and
- If the coverage is written on the scheduled net debt, verify the amount payable at the time of loss is:
    - If the actual net debt is less than or equal to the scheduled net debt, then the scheduled net debt;
    - If the actual net debt is greater than the scheduled net debt, but less than or equal to the scheduled net debt plus 2 months of payments, then the actual net debt; or
    - If the actual net debt is greater than the scheduled net debt plus two months of payments, then the scheduled net debt plus two months of payments (*Consumer Credit Insurance Model Act* (#360), Section 4A(3)).

Credit Accident and Health insurance and Credit Unemployment Insurance

- Verify the total amount of periodic indemnity does not exceed the aggregate of the periodic scheduled unpaid installments of the gross debt[33] (*Consumer Credit Insurance Model Act* (#360), Section 4B(1));
- Verify the amount of each periodic indemnity payment does not exceed the original gross debt divided by the number of periodic installments (*Consumer Credit Insurance Model Act* (#360), Section 4B(1)); and
- If coverage is written in connection with an open-ended credit agreement, verify the amount of insurance does not exceed the gross debt that would accrue on that amount using the periodic indemnity. Subject to any policy maximums, the periodic indemnity must not be less than the creditor's minimum repayment schedule (*Consumer Credit Insurance Model Act* (#360), Section 4B(2)). Periodic indemnity can be less than the creditor's minimum payment, if the policy has a maximum monthly indemnity.

Credit Personal Property Insurance

- Verify coverage is, at a minimum, included in the coverages in the standard fire policy (*Credit Personal Property Insurance Model A*ct (#365), Section 4D); and covers a substantial risk of loss of or damage to the property related to the credit transaction (*Consumer Credit Insurance Model Act* (#360), Section 4E).
- Verify that an insurer does not require the bundling of other credit insurance coverages with the purchase of credit personal property insurance coverage and that a debtor has the choice to purchase credit personal property insurance separate from other credit insurance coverage (*Consumer Credit Insurance Model Act* (#360), Section 4F);
- Verify that the insurer is not using gross debt as an exposure base in determining credit personal property insurance premiums (*Consumer Credit Insurance Model Act* (#360), Section 4G);
- Verify that when insurance is sold in conjunction with a closed-ended transaction, the insurer:
    - Is not issuing credit personal property insurance coverage unless the amount financed exceeds the dollar amount established in state statute (*Consumer Credit Insurance Model Act* (#360), Section 4A);
    - Is not issuing credit personal property insurance in an amount that exceeds the amount of the underlying credit transaction, unless otherwise required by state law (*Consumer Credit Insurance Model Act* (#360), Section 4B); and
    - Is not selling credit personal property insurance with a term that exceeds in duration the scheduled term of the underlying credit transaction (*Consumer Credit Insurance Model Act* (#360), Section 4C).

[33] Gross debt is defined as the sum of the remaining payments owed to the creditor by the debtor.

D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

1. Purpose

The underwriting portion of the examination is designed to provide a view of how the company treats the public and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. It is concerned with compliance issues. The areas to be considered in this kind of review include:

a. Rating practices;
b. Underwriting or enrollment practices;
c. Use of correct and properly filed and approved forms and endorsements;
d. Termination practices;
e. Declination practices;
f. Unfair discrimination; and
g. Use of proper disclosures.

2. Techniques

During an examination, it is necessary for the examiner to review a number of information sources, including:

- Rating manuals and rate cards;
- Rate classifications;
- Rating systems filed with regulators;
- Payment plans;
- Minimum premiums;
- Company-automated rating systems;
- Rating materials provided to producers;
- Underwriting guidelines;
- Applicable policy or certificate forms and endorsements;
- Producer compensation agreements, where applicable; and
- Underwriting files' content and structure.

For the purposes of this chapter, "underwriting file" means the file or files containing the new business application or enrollment, rate calculation sheets, billings, audits, all underwriting information obtained or developed, schedule page, enrollment forms, medical records, policy or certificate endorsements, cancellation or refinancing transactions, correspondence and any other documentation supporting selection, classification, rating or termination of the risk.

The list of files from which a sample is to be drawn may be generated through a computer run or listing of certificates or policies covering the period of time selected in the notice or call of examination.

Next, determine the company's policy or certificate population (policy or certificate count) by line of business. Review a random selection of business for application of a particular test or apply specific tests to a census population using automated tools. (In the event specific files are chosen for a target review,

the examiner must be certain that the examination results are clearly identified as being from the target selection.) The examiner should maintain a list of the various tests to be applied to each file in the sample. This will aid in consistency by ensuring that each test is considered for each file in the sample.

If exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty automated rating systems, or the development and use of improperly or vaguely worded manuals or guidelines. When exceptions are noted, it is advisable to determine the scope and extent of the problem. The examiner's responses should maximize objectivity; the examiner should avoid replacing examiner judgment for company judgment.

a. Rating Practices

It is necessary to determine if the company is in compliance with rating systems that have been filed with and, in some cases, approved by, the state insurance departments. Where rates are not required to be filed with an applicable regulatory agency, it is prudent to determine if rates or formulas are being applied consistently and in accordance with the company's own rating methods. Many states have established prima facie rates. In general, rates should not be unfairly discriminatory. Wide-scale application of incorrect rates by a company might raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans might also indicate that a company is engaged in unfair competitive practices. Inconsistent application of rates, individual risk premium modifications, modification factors and deviations can result in unfair discrimination.

The examiner should become familiar with the company's policy or certificate form numbers or other identification procedures, inasmuch as references may be made to such numbers or procedures in lieu of having the particular form attached. If certificates or policies are issued by an automated system, the examiner should manually rate a random selection of policies or certificates to verify that the computer has been programmed correctly. If rating exceptions are noted, the examiner must determine if the exception is caused by such practices as the use of faulty rating systems. When exceptions are noted, it is advisable to determine the scope and extent of the problem. Rating errors will generally involve use of incorrect rates, interest rates, loan amounts or loan terms.

When possible, the examination team should make use of audit software to verify the correct application of rates. This allows for a more thorough review, and can save time during the examination process. All new automated audit applications that are developed should be submitted to the NAIC File Repository, in order to assist in building a comprehensive set of audit programs.

b. Underwriting or Enrollment Practices

The examiner should review relevant underwriting information; e.g., the company's underwriting guidelines, underwriting bulletins, declination procedures, agency agreements and correspondence with producers, interoffice memoranda or other relevant information which may furnish evidence of inappropriate behavior may also be requested, if deemed necessary. In addition to reviewing the content of the above information for indications of unfairly discriminatory practices, the examination team also should use the above information to determine the company's compliance with its own manuals and guidelines. The examiner should confirm that the company's underwriters and producers consistently apply the company guidelines for all business selected or rejected.

File documentation should be sufficient to support the underwriting decisions made. Underwriting decisions that are adequately documented generally afford the company's management team with the opportunity to know what business it has selected through its underwriters and producers. The examiner should verify that properly licensed and appointed (where applicable) producers have been used in the production of business.

c. Use of Correct and Properly Filed Forms and Endorsements

The examination team should verify that all policy or certificate forms and endorsements used have been filed with the appropriate regulatory authority, if applicable. In addition, the examination team should verify the consistent and correct use of policy or certificate forms and endorsements. The examiner should be mindful of possible outdated forms or endorsements. If coverage requested by the applicant is not issued, proper notification (if required) should be provided to the applicant. In some cases, supplemental applications are appropriate. The examination team should be aware of state-specific requirements relating to policy or certificate disclosure requirements for preexisting conditions limitations.

d. Termination Practices

The examiner should review the company's declination, cancellation and rescission practices to determine compliance with applicable statutes, rules and regulations, as well as to determine compliance with the company's own rules, guidelines and policy or certificate provisions.

The review of these practices should involve a request for the enrollment or underwriting file for each policy or certificate selected from the random sample of canceled policies or certificates. The examiners should review material submitted to determine that these practices comply with the statutory provisions and policy or certificate provisions. Refund calculations are usually based on filed pro rata, the Rule of 78, the Rule of Anticipation[34] or the actuarial method depending on the state or coverage. The accuracy of return premiums on canceled policies or certificates refunded should be verified.

The examination team should review the company's practices relating to credit insurance issued in conjunction with refinanced loans. Special state provisions may apply.

Review policy or certificate provisions to determine if cancellation notices are applicable. Adherence to policy provisions for renewal language and for applicable grace periods for monthly outstanding balance policies should be reviewed.

e. Declination Practices

The examiner should review the company's declination of policy or certificate practices to determine compliance with applicable statutes, rules and regulations and to determine conformance with the company's own rules and guidelines. "Declination" includes only refusal by an insurer to issue an underwritten policy or certificate upon receipt of a written nonbinding application or written request for coverage or enrollment form from a producer or an applicant.

Insurers should maintain declination files, and the applicant must be provided with a written, specific reason for declination.

The review of declination practices should involve a request for the underwriting or enrollment file for each policy or certificate selected from the random sample.

[34] The Rule of Anticipation establishes unearned premium as the gross single premium for the remaining term and remaining benefits.

3. Tests and Standards

The underwriting and rating review includes, but is not limited to, the following standards addressing various aspects of the company's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
UNDERWRITING AND RATING

Standard 1
The effective dates and termination dates of coverage are in accordance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates and policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Consumer Credit Insurance Model Regulation (#370), Section 3G
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

All Credit Insurance
Review polices and/or certificates chosen for review to determine:

- The coverage commences on the date when the debtor becomes obligated to the creditor, if the coverage was selected before or in conjunction with the credit transaction. Note: Special rules apply if evidence of insurability is required before the company affects coverage;
- The date of coverage is the date the election to obtain coverage is made, or within 30 days of the date the company accepts the risk, according to an objective method such as a date in accordance with a billing or repayment cycle or calendar month, if the coverage is selected after the date of the credit transaction; and
- Under a group policy, coverage does not commence before the effective date of the group policy and no charge for the insurance is retained by the creditor or insurer for any time prior to the effective date of the insurance to which the charge is related.

Credit Life, Credit Accident and Health Insurance, and Credit Involuntary Unemployment Insurance

Review polices and/or certificates chosen for review to determine:

- The coverage does not extend beyond the termination date specified in the policy or certificate;
- The term of coverage does not extend more than 15 days beyond the scheduled maturity date of the debt, unless extended without cost to the insured or unless there is a written agreement in connection with the loan; and
- The coverage is terminated if the debt is discharged in full and before any new coverage is written, if the debt is refinanced.

Note: Terminations may be requested at any time by the debtor. There may be written requirements for the termination request, and it may be subject to terms of the policy or certificate.

STANDARDS
UNDERWRITING AND RATING

Standard 2
Group consumer credit insurance policies and certificates are terminated in accordance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Group master policies

_____ Certificates

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 3C
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

Insurance coverage under a group consumer credit insurance policy or certificate is continued for the entire period for which premium has been paid upon termination of the policy or certificate for any reason.

If a debtor is covered under a policy or certificate providing for the payment of premiums on a monthly basis, the policy or certificate provides for at least 30 days' prior notice of termination, except where replacement with the same or another insurer in the same or greater amount takes place without lapse of coverage. The insurer shall provide or cause to be provided this required information to the debtor.

STANDARDS
UNDERWRITING AND RATING

Standard 3
The creditor submits premium to the insurer in accordance with applicable statutes, rules and regulations.

Apply to: Credit life
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Group master policies

_____ Certificates and individual policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Credit Personal Property Insurance Model Act (#365)

Review Procedures and Criteria

Verify the creditor is remitting and the insurer is collecting the premium within the amount of time required by applicable statutes, rules and regulations.

Note: For credit insurance, the premium is often remitted monthly "in bulk" on a net basis (with commissions and refunds for the reporting period netted out).

STANDARDS
UNDERWRITING AND RATING

Standard 4
The insurer and creditor comply with requirements for the payment of compensation in accordance with applicable statutes, rules and regulations.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates and policies

_____ Company procedures

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370), Section 5A
Credit Personal Property Insurance Model Act (#365)
Producer Licensing Model Act (#218)
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

If the applicable statutes, rules or regulations limit the amount of compensation that may be paid to a producer for credit insurance, ascertain if compensation is in accordance with the allowable percentage.

Determine that producer commissions are aligned with the amounts stated in the agreement between the company and the producer and, if not, ascertain the reason for the variance.

Determine that producer commissions adhere to the company commission schedule(s) and, if not, ascertain the reason for the variance.

In reviewing company advertising, watch for indications of illegal commission-cutting or inducements.

Standard 5
The insurer does not engage in activities that constitute unfair methods of competition.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Essential

Documents to be Reviewed

_____ Certificates, policies and company procedures

_____ Applicable statutes, rules and regulations

_____ Complaint files

_____ Underwriting or enrollment files

_____ Marketing materials

_____ Correspondence to producers from files chosen for review

_____ Producer contracts chosen for review

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Regulation (#370)
Unfair Trade Practices Act (#880), Section 4H

Review Procedures and Criteria

Review documents to determine:

- No offers of any special advantage or service to creditors not set out in the contract, other than the payment of producer's commissions, have been made;
- There are no agreements to deposit with a bank or financial institution money or securities with the design or intent that the same shall affect or take the place of a deposit of money or securities that otherwise would be required of the creditor by the bank or financial institutions as a compensating balance or offsetting deposit for a loan or other advancement; and
- The insurer has not deposited money or securities without interest or at a lesser rate of interest than is currently being paid by the creditor, bank or financial institution to other depositors of like amounts for similar durations. This requirement does not prohibit demand deposits or premium deposit accounts necessary for use in the ordinary course of the insurer's business.

Review company correspondence to producers, as well as advertising and marketing materials, for indications of illegal rebating, commission-cutting or inducements.

G. Claims

1. Purpose

The claims portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules and regulations. It is determined by testing a random sampling of files and applying various tests to open and closed claims. For purposes of this chapter, "claim file" means the documentation that allows the examiner to recreate the claim, which may include some or all of the following documents that may be electronic, paper or in some other format:

- The notice of claim;
- Claim forms;
- Proof of loss;
- Settlement demands;
- Accident reports;
- Police reports;
- Adjusters' logs;
- Claim investigation documentation;
- Inspection reports;
- Supporting bills;
- Correspondence to and from insureds and claimants or their representatives;
- Complaint correspondence;
- Proof of payment;
- All applicable notices and correspondence used for determining and concluding claim payments or denials;
- Salvage documentation; and
- Any other documentation necessary to support claim handling activity.

The review is concerned with the company's claims practices by line of business for compliance with applicable statutes, rules and regulations, as well as policy or certificate provisions. The areas to be considered in this kind of review include:

a. Time studies to measure acknowledgment, investigation and settlement times;
b. General handling study;
c. Closed without payment survey;
d. Unfair claims practices survey;
e. Claims forms review;
f. Company procedures, training manuals and claim bulletin review; and
g. Review of other procedures, as deemed necessary.

2. Techniques

Each area of claims review involves selecting a sample of claims (open, closed without payment, closed with payment, denied). However, it is not necessary to use different samples to review timeliness of payment, conformity to policy/certificate language or adequacy of proof. A general approach to examination would be to:

- Define the scope of the examination in terms of the lines of business and type of claims covered. Lines of business should be defined as specifically as possible;

- Become familiar with the company's claim handling procedures for the line of business identified. Review corresponding policy or certificate forms for coverage, exclusions and nonstandard provisions. Review the methods for processing claims from notification to conclusion. Review with the claim manager, or other appropriate personnel, the maintenance of claim records and draft and settlement authority. Any claim procedure manuals, adjuster training manuals and claim bulletins should be reviewed. Company procedures for total loss settlement and salvage disposition efforts should be determined; and
- Select a representative sample of files to be reviewed. Chapter 17—Sampling should be reviewed. If field sizes are relatively small and company records appear complete, representative samples or a census should be selected. In the case of large field sizes and incomplete or complicated records, the use of audit software should be considered. Care should be taken that no adverse selection occurs.

a. Time Studies to Measure Acknowledgment, Investigation and Settlement Times

Record the date of loss, the date reported to the producer or company, the date sufficient information was available to determine the company's liability and the date the company accepted or rejected the claim. Record identifying data such as the claim/policy number and the claimant's name.

Determine for each claim the number of days the company took to accomplish each task. Compare the days required by the company to the appropriate state standards, and document in the report those claims that exceed standards for inclusion in the report. Delays beyond the control of the company should be excluded; e.g., delay caused by an uncooperative insured. Establish a mean and median time to acknowledge, investigate and accept/deny claims, if necessary, to determine a business practice.

Note: If a file has a violation of a standard with multiple tests, and the standard is the item measured, the file can only fail one time. If the individual test is the item measured, the file can fail each test. If failure of a standard or of a test assures failure of another standard or test under another standard, then no substitution of the file need occur. The relationship, however, should be explained.

b. General Handling Study

Record identifying data such as claim/policy or certificate number, date of loss and claimant name. Files should be reviewed for adequate and accurate documentation. The correct application of deductibles and limits of coverage should be established. Mathematical accuracy should be determined. Reductions should be reviewed for fairness and accuracy.

Proof of payment should be reviewed for correct payees. Files should be reviewed for specific state requirements. Compliance with company standards should be established.

c. Closed without Payment Survey

This includes denied, rejected and incomplete claims, and claims not paid for any reason including deductibles/waiting periods not met. Conduct tests similar to the "General Handling Study" above. Record identifying data such as claim/policy or certificate number, date of loss and claimant name. Review specific state requirements for content and method of denial notification to the claimant. Note general handling by the company to determine validity of its action in the final disposition of these types of claims.

d. Unfair Claims Practices Survey

Record identifying data such as claim/policy or certificate number, date and claimant name. Review selected files for violations of specific state unfair claims practices such as misrepresentation of policy or certificate provisions or concealment of coverage.

Calculate error ratios for the sample and field sizes. This is especially important in this study, because most unfair claims practices statutes make reference to "business practices."

e. Claim Forms Review

Request copies of all claim forms in use for the lines of business being examined. Forms should be reviewed for content and appropriate usage. Inappropriate forms should be documented and included in the report. Claim forms also may be reviewed as they are encountered in the file reviews.

f. Company Procedures, Training Manuals and Claim Bulletin Review

Review company procedures, training manuals and claim bulletins to determine if company standards exist and whether such standards comply with applicable statutes, rules and regulations, including:

- If company procedures provide for the detection and reporting of fraudulent or potentially fraudulent insurance acts to the insurance commissioner;
- Whether all claims are paid by draft drawn upon the insurer, by electronic funds transfer or by check of the insurer to the order of the claimant to whom payment of the claim is due or upon direction of such claimant; and
- That no plan or arrangement is used whereby any person, firm or corporation other than the insurer or its designated claim representative is authorized to settle or adjust claims. The creditor has not been designated as claim representative for the insurer in adjusting claims, provided that a group of policyholders may, by arrangement, draw drafts, checks or electric transfers subject to audit and review by the insurer.

g. Review of Other Procedures

Other review, as deemed necessary, should follow the same format for objectivity and sampling techniques as those already described. These reviews may be instigated by consumer complaints regarding specific claims practices and should be tailored to resolve specific issues.

3. Tests and Standards

The claim review includes, but is not limited to, the following standards addressing various aspects of the company's claim handling. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CLAIMS

Standard 1
Proof of payments reflect appropriate claim handling practices.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Cashed benefit checks and drafts

_____ Company claim procedure manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)
Unfair Claims Settlement Practices Act (#900)

Review Procedures and Criteria

Perform a time study on proof of payment documentation—which may include canceled claim checks, drafts, electronic funds transfer documentation or accounting reports for accounts doing batch reporting on a net basis—to ascertain whether claim proceeds are being promptly mailed or delivered.

Determine if proof of payment includes the correct payee and is for the correct amount.

Ascertain whether the proof of payment indicates the payment is "final," when such is not the case.

Ascertain whether checks or drafts purport to release the insurer from total liability, when such is not the case.

Review endorsements to see if they are consistent with the payee name listed on the check or draft.

If drafts are used, ascertain whether there is prompt clearance by the insurer.

STANDARDS
CLAIMS

Standard 2
Claim files clearly establish pertinent events and the dates of such events.

Apply to: Credit life insurance
Credit accident and health insurance
Credit involuntary unemployment insurance
Credit personal property insurance

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Closed claim files

_____ Company claim procedures manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Consumer Credit Insurance Model Act (#360)
Credit Personal Property Insurance Model Act (#365)
Unfair Claims Settlement Practices Act (#900)

Review Procedures and Criteria

Ensure documents provide chronological order of events in a claim file.

Chapter 28—Conducting the Surplus Lines Broker Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a suggested format for conducting surplus lines broker examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of surplus lines brokers may involve any review of one or a combination of the following business areas:

A. Broker Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Procedural Considerations
I. Placement, Cancellation and Nonrenewal

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the broker is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

Surplus lines carriers, by definition, are nonadmitted carriers that are not subject to many requirements (e.g., rate and form filing). Since U.S.-domiciled surplus lines carriers will be licensed in at least one state, it is recognized that they will be subject to the same examination process in their domicile state that applies to other types of carriers. Alien insurers are not subject to a state's examination process, but may nonetheless be reviewed by the NAIC International Insurers Department (IID), if the insurer is listed on the *Quarterly Listing of Alien Insurers*.

A. Broker Operations/Management

1. Special Considerations for the Surplus Lines Examination

a. Resident or Non-Resident

Appropriate licensing of persons who, by their function, should be licensed is more of a challenge with the non-resident.

b. Wholesale vs. Retail Production

There are distinct differences in wholesale vs. retail production. Standards that require direct contact with an insured/applicant may not apply to a wholesale surplus lines broker. For the purposes of this chapter, the definitions of wholesale vs. retail business are as follows:

- Retail: Retail surplus lines business is insurance that is obtained or placed for the client directly with the nonadmitted insurer by the client's agent/broker (retail agent/broker). The producer/broker must have a surplus lines license to place business with the nonadmitted carrier and the carrier must be eligible, or "white listed," in order for the licensed surplus lines broker to use the company.
- Wholesale: Wholesale surplus lines business is insurance that is obtained or placed for an insured or prospective insured by an intermediary broker, licensed as a surplus lines broker, with a nonadmitted insurer, at the request of an agent or broker working for the insured or prospective insured. The agent or broker requesting the insurance does not need to have a surplus lines license, as long as the placing intermediary broker is properly licensed for surplus lines and complies with applicable statutes, rules and regulations concerning surplus lines. The agent/broker requesting the coverage can be known as the retail, initiating or producing agent/broker.

c. Relationship with Insurer (MGA, Producer, Intermediary, Subsidiary, Controlling Producer, etc.)

Of concern is the oversight utilized by the controlling party and the conflicts of interest or with statute that arise due to the nature of the relationship.

d. Policy Not Produced in Examining State

This can pose a significant taxation concern. Is the examining state getting the appropriate level of tax for risk placed in another state, but which is resident, located or to be performed in that state?

e. Staff Training

Are copies of the laws and regulations available to persons operating under a surplus lines broker license? Does the licensee provide training to staff concerning state developments, including case law, laws, regulations, orders and bulletins?

f. Stamping Office vs. No Stamping Office

In some jurisdictions, a stamping office performs many functions that would otherwise be done by the state. They may be able to provide the examiner with invaluable information and reports.

g. Placement File

For purposes of this chapter, "placement file" means the file or files containing:

- The application;
- Rate calculation sheets;
- Billings;
- Audits, including binders;
- Engineering reports;
- Inspection reports;
- Risk or hazard investigative or evaluation reports;
- Motor vehicle reports (MVRs);
- Credit reports;
- All placement information obtained or developed;

- Policy declaration page;
- Endorsements;
- Premium finance agreements, with accompanying activities;
- Cancellation or reinstatement notices; and
- Correspondence and any other documentation supporting selection, classification, rating or termination of the risk.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 1
All statutorily required bonds are in force.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Statutory bonds

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure all required bonds are procured and in force.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 2
All required reports have been filed with the insurance department or the appropriate authority.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Reports

_____ Individual placement files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Verify reports were filed with the appropriate authority in a timely manner.

Verify the accuracy of the reports.

Track individual placements to ensure they are accurately reflected in the required reports.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 3
The applicable taxes are reported and are credited to the state.

Apply to: All surplus lines brokers

Priority: Essential, if a function of the insurance department

Documents to be Reviewed

_____ Tax worksheets in the files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Allocation of Surplus Lines and Independently Procured Insurance Premium Tax on Multistate Risks Model Regulation (#872)

Review Procedures and Criteria

There are no consistent state-by-state requirements regarding the payment of taxes related to multistate placements. Certain states regard 100 percent of the surplus lines premium taxable in their state if the placement is made in their state, even if some of the coverage and premium derives from another state. Other states regard that tax as payable on a pro rata basis based on the share of the premium derived from their state. These two philosophies can, and do, conflict, such that the same premium might be taxed twice by two different states.

If the placement is a multistate placement and the state recognizes the sharing of premium tax, check the calculation and reasonableness of the methodology to allocate the premium tax. The *Allocation of Surplus Lines and Independently Procured Insurance Premium Tax on Multistate Risks Model Regulation* (#872) provides examples of criteria for tax allocation of multistate risks.

Ensure the premium is properly allocated and the applicable taxes are reported to the examining state.

STANDARDS
BROKER OPERATIONS/MANAGEMENT

Standard 4
If the surplus lines broker is responsible for such calculations, then unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Policy contract

_____ Notice of cancellation/nonrenewal

_____ Refund check or complete documentation of refund, if canceled check information is maintained on the computer system

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Calculate the unearned premium (short rate or pro rata method) in accordance with policy provisions or state law.

Determine if the broker, in accordance with the carrier's requirements, advances its audit date on auditable policies when the cancellation occurs.

Verify that any unearned premium was returned to the appropriate party in a timely manner.

Make note of any delays caused by the broker, producer or premium financier.

B. Complaint Handling

Not applicable.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Procedural Considerations

Although the focus of the surplus lines broker examination differs from that of the insurer examination, much of the material in Chapter 20—General Examination Standards also applies to the surplus lines examination.

I. Placement, Cancellation and Nonrenewal

1. Special Considerations for the Surplus Lines Examination

Surplus lines brokers have the burden of determining that the insurer with whom their business is placed is in sound financial condition and can be expected to pay claims when due. The examiner should ensure that a process is in place to make these determinations. If permitted by specific state statute, the function of ascertaining financial soundness by the broker may be supplemented by financial analysis performed by a stamping office.

The policy forms and rates used by a surplus lines broker are generally not required to be filed. The concern with the marketing, advertising and producer files is that most state laws require that there be a diligent effort to place the business in an admitted market before export to a nonadmitted insurer is allowed. Ensure that the marketing files, advertising files and producer correspondence do not conflict with this requirement. In addition, ensure that the export list is referenced as required. The export list is a list of coverages generally regarded as unavailable in the admitted market in the relevant state and for which the diligent search requirements under the surplus lines laws are generally waived.

2. Tests and Standards

The placement, cancellation and nonrenewal review includes, but is not limited to, the following standards addressing various aspects of the surplus lines broker's underwriting activities. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 1
All required disclosures are made in accordance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

A copy of the insured's permission and acknowledgement of the use of a nonadmitted carrier is in the file.

The name and address of the nonadmitted carrier is listed on the policy and is in the file.

The policy reflects the exact amounts of exposure and the policy limits.

The policy reflects gross premiums charged for the contract.

The policy contains a description of the risk and exposure location.

The surplus lines broker's records indicate the exact amount of premium that was charged to and collected from the insured.

The policy includes the binder or other evidence of coverage, if issued in lieu of the policy.

The broker's firm name and license number are disclosed as required.

Standard 2
When issued by the surplus lines broker, all forms and endorsements forming a part of the contract are listed on the declarations page.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ New business application

_____ Policy declaration page

_____ Broker files

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

When the surplus lines broker is issuing the contract, determine if the broker lists all forms and endorsements that form part of the contract on the declarations page.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 3
The selected carrier was evaluated to ensure it complies with applicable statutes, rules and regulations regarding financial condition.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Some states have a list of eligible insurers; others may refer to the *Quarterly Listing of Alien Insurers* published by the NAIC IID.

The broker will need to validate that the coverage is placed with an eligible company and is "stamped" in those states that require review by a stamping office.

Standard 4
The authorization to bind was provided before the binder was extended to the insured.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Applicable producer contracts between the insurer and surplus lines producer.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 5
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Recommended

Documents to be Reviewed

_____ Producers' advertising and sales materials related to surplus lines activities

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review advertising materials to ensure they are in compliance with applicable statutes, rules and regulations.

Materials should not:

- Make unfair or incomplete comparisons; and
- Make false, deceptive or misleading statements or representations with respect to any person or broker in the conduct of insurance business.

Materials should:

- Disclose the name and address of the surplus lines broker; and
- Comply with applicable statutes, rules and regulations.

STANDARDS
PLACEMENT, CANCELLATION AND NONRENEWAL

Standard 6
Diligent effort was made to place the risk with an admitted carrier in compliance with applicable statutes, rules and regulations.

Apply to: All surplus lines brokers

Priority: Essential

Documents to be Reviewed

_____ Underwriting/Placement files

_____ Export lists

_____ Producer affidavits

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Include due consideration to export list and industrial insured exemptions.

In those states with a stamping office, the examiner may want to review the affidavits on file with the stamping office.

If the surplus lines broker is the producing broker, ensure that there is documentation to show a diligent effort to place the risk with an admitted insurer. If the surplus lines broker is not the producing broker, the presence of a producer affidavit in the file is sufficient to pass this test. If the surplus lines broker is the producing broker, a review of the information on the producer affidavit is appropriate.

To the extent permitted by applicable statutes, rules and regulations, the broker may rely on financial analysis and approval of an insurer by the state insurance department or the stamping office.

Chapter 29—Conducting the Advisory Organization Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a suggested format for conducting advisory organization examinations and reviews. In addition to this chapter, the examiner should be familiar with the *Statistical Handbook of Data Available to Insurance Regulators* (*Statistical Handbook)* if reviewing an advisory organization that conducts statistical agent functions.

Background and Definitions
"Advisory organizations" are currently authorized by statute and are defined in the *Property and Casualty Model Rating Law (Prior Approval Version)* (#1780), which was amended in 2009 to a guideline, as:

> "Advisory organization" means any entity, including it affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and which assists insurers in ratemaking-related activities such as enumerated in Sections 10 and 11. Two or more insurers having a common ownership or operating in this State under common management or control constitute a single insurer for purposes of this definition.

State statutes based on an older version of this NAIC model may use the term "rating organization" or "rate service organization" to mean the same thing.

The *Property and Casualty Model Rating Law (Prior Approval Version)* specifically permits advisory organizations to:

a. Develop statistical plans including territorial and class definitions;
b. Collect statistical data from members, subscribers or any other source;
c. Prepare, file and distribute prospective loss costs which may include provisions for special assessments;
d. Prepare and distribute factors, calculations or formulas pertaining to classification, territory, increased limits and other variables;
e. Prepare and distribute manuals of rating rules and rating schedules that do not include final rates, expense provisions, profit provisions or minimum premiums;
f. Distribute information that is required or directed to be filed with the commissioner;
g. Conduct research and on-site inspections in order to prepare classifications of public fire defenses;
h. Consult with public officials regarding public fire protection as it would affect members, subscribers and others;
i. Conduct research in order to discover, identify and classify information relating to causes or prevention of losses;
j. Conduct research relating to the impact of statutory changes upon prospective loss costs and special assessments;
k. Prepare policy forms and endorsements and consult with members, subscribers and others relative to their use and application;
l. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;
m. Conduct on-site inspections to determine rating classifications for individual insureds;
n. For workers' compensation insurance, establish a committee which may include insurance company representatives to review the determination of the rating classification for individual insureds and suggest modifications to the classification system;

o. Collect, compile and distribute past and current prices of individual insurers and publish such information;
p. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;
q. File final rates, at the direction of the commissioner, for residual market mechanisms; and
r. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

The term "statistical agent" is commonly used to describe an advisory organization when it is performing functions a. and b. above. Some advisory organizations limit the activities of the advisory organization to just the statistical agent functions. In general, statistical agents collect data in accordance with the requirements established in the *Statistical Handbook of Data Available to Insurance Regulators* (*Statistical Handbook*) or as otherwise specified by the regulator. Statistical agents typically compile that data into aggregate reports to regulators as specified in the *Statistical Handbook* or as otherwise specified by the regulator. Statistical agents' services are used for the purpose of fulfilling the statistical reporting obligations of insurers under the various state rating laws.

It is unlikely that any single advisory organization will be engaged in all of the permitted activities. Additionally, some entities may provide services that are listed above or that were not contemplated by the various state rate and form acts. Whether or not advisory organization services are regulated and permitted will depend on the various states' laws. Likewise, certain services may not be deemed a priority for examination purposes. Those services that have the greatest potential impact on insurance consumers should be given priority for review.

For purposes of this chapter, the term "advisory organization" will be used to encompass rating organizations, rate service organizations and statistical agents, as appropriate. It should be noted that advisory organizations that develop and file insurance programs and loss costs frequently collect data beyond the minimum standards required of all insurers under the *Statistical Handbook*. This additional detail or additional data is used to support insurance programs and for research.

For purposes of this chapter, the terms "subscriber" and "member company" are used interchangeably to refer to insurers that rely on the advisory organization's services and products. Some advisory organizations provide multiple levels of member company services. For example, with the appropriate advisory organization agreement in place, insurers may designate an advisory organization to file on its behalf. Or, an insurer may file with the department to adopt filed advisory organization materials. Alternatively, an insurer may purchase the right to use advisory organization materials, with or without modifications.

In addition to providing guidance for performing an advisory organization examination, this chapter emphasizes the desirability to coordinate advisory organization examinations between states to prevent duplication. Acceptance of other states' reports of examinations for advisory organizations is permissible in most or all states. It is generally considered acceptable for one state to utilize the report of another state for purposes of fulfilling the state's statutory obligations related to examination of advisory organizations. Generally speaking, processes and procedures established and used by advisory organizations are not unique to single states.

Nature, Scope and Type of the Examination

The advisory organization examination is a review of the organization's systems, operations and management for the collection and reporting of statistical data, preparation of loss cost filings, and rule and form filings. Other regulated permitted activities may also be examined. Its purpose should include a check of the validity of the systems in place. It is neither a traditional market conduct nor financial examination. It is rather a hybrid of a market conduct examination and a data/systems audit. The advisory organization examination is not an examination of the accuracy of the underlying company data reported to the organization. The main purpose of the examination is to determine that the advisory organization is performing its permitted regulated functions in a manner consistent with state rating laws and in a manner that results in accurate and compliant products or services for its subscribing or member companies. When reviewing statistical agent functions, it is important to review how the advisory organization processes, edits and manages the data it collects, compiles and reports so that state regulators know that the statistical filings made with them are accurate and reliable.

The *Property and Casualty Model Rating Law (Prior Approval Version)* has several sections regarding advisory organizations that form the bulk of the statutory requirements that apply specifically to advisory organizations in most states and, therefore, form the basis of an examination:

- Licensing advisory organizations;
- Insurers and advisory organizations: Prohibited activity;
- Advisory organizations: Prohibited activity;
- Advisory organizations: Permitted activity;
- Advisory organizations: Filing requirements;
- Examinations; and
- Statistical and rate administration.

The regulated functions of an advisory organization that are subject to examination may include one or more of the following:

- Filings of insurance programs, including coverage forms, rating rules, policy writing rules and rating manuals;
- Filings of insurance program pricing (i.e., loss costs and related relativity factors);
- Submission of required annual statistical compilations to the states (statistical agent);
- Inspections; and
- Classification administration.

Examinations of advisory organizations can be either comprehensive or targeted. Targeted examinations may be conducted on one of the listed functions, and, for advisory organizations that service more than one line of business, on one function and one line. This has occurred rarely, but most frequently for the statistical agent function, where examinations have focused on that one function across all statistical agents for the line in question.

An advisory organization examination can be conducted by one jurisdiction or as a multistate cooperative examination. To the extent that the advisory organization's systems and procedures are similar, if not identical, for every state or line of business, the examination and resulting report should be acceptable in all states, regardless of which jurisdiction conducts the examination.

Unlike insurance company examinations, there generally is little, if any, "market analysis" for advisory organization examinations. Similarly, advisory organizations are not regulated for solvency. Rather, advisory organization examinations review the processes and procedures used to collect, compile and ensure quality of the data, calculate loss costs and develop insurance programs on behalf of insurers and perform other regulated activities.

Preparation Phase—Pre-Examination for Use in Evaluating, Scheduling, Coordination and Planning Scope

The procedures discussed in this section are to assist the regulator in determining if an examination or other type of regulatory action needs to be scheduled. It will also assist in developing a plan for conducting examinations, investigations, desk audits, interrogatories, letters or interviews when deemed necessary.

1. Determine the jurisdiction's requirements for licensing and examining advisory organizations and statistical agents to ascertain whether examinations are required, optional or permitted. Determine if the jurisdiction is permitted to accept the examination report of another state;
2. Survey appropriate divisions within the insurance department to identify potential areas of concern or interest relating to statistical agents and/or advisory/rating organizations. Identify all advisory organizations and statistical agents operating in the jurisdiction;

3. For those advisory organizations that have provided a current examination report and no unaddressed regulatory concerns exist, no additional analysis should be necessary. If analysis indicates that a market regulation action—such as a desk audit, letter, interrogatory, interview, investigation or examination—is appropriate, consider the possibility of coordinating with other jurisdictions with similar requirements or market regulation issues. Consider use of NAIC tools such as the Market Action Tracking System (MATS) for recording continuum types of regulatory responses and the Advisory Organization (D) Working Group for multistate coordination of regulatory responses;
4. Survey the NAIC Research Division for relevant information to identify potential areas of concern in the evaluation process; and
5. Determine what specialists may be necessary to assist with the examination, such as an actuary (ideally one with experience with the functions of an advisory organization and the lines of business) and an information systems examiner.

For very narrow or specific regulatory issues, or for situations in which an examination is not required by statute, consider use of regulatory options other than an examination. For example, certain issues can be handled by a telephone call, letter or email; a data request; policy and procedure review; interrogatories; or desk audits. The remainder of this chapter is primarily written to facilitate examinations; however, certain information may be adaptable for the above-mentioned "continuum" type responses. Additional discussion of continuum of market actions is located in Chapter 2 of this handbook.

The examination of advisory organizations may require an examination of one or more of the following areas:

A. Procedural Considerations;
B. Advisory Organization Operations/Management/Governance;
C. Statistical Plans;
D. Data Collection and Handling;
E. Correspondence with Insurers and States;
F. Reports, Report Systems and Other Data Requests;
G. Ratemaking Functions;
H. Classification and Appeal Handling;
I. Form Development;
J. Inspection Services;
K. Residual Market Functions—Plan Administration;
L. Residual Market Functions—Reinsurance Administration;
M. Acceptance of Examination Report by Participating States; and
N. Future Examinations of Regulated Entity.

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the advisory organization is meeting standards. Some standards may not be applicable to all jurisdictions or entities. The standards may suggest other areas of review that may be appropriate in a particular examination. If additional standards will be reviewed, it is best to define those standards prior to the start of the examination. The insurance department Examiner-In-Charge (EIC) should approve additional review standards found to be necessary during the course of the examination. Revision of the examination plan should also be made and communicated to the advisory organization if additional standards are added.

A. Procedural Considerations

Although not an insurance company examination, the basic procedures for a market conduct examination in Chapter 20 of this handbook should be followed in an advisory organization examination:

- Scheduling an examination;
- Determining the scope of the examination;
- Estimating time requirements;
- Calling the examination;

- Notification of the examination;
- Pre-examination procedures;
- On-site coordination;
- Communication with advisory organization management;
- Post-examination procedures; and
- The examination report.

Where possible, each state's defined examination protocols applicable to the examination of insurers—such as time frames and report submissions—should be applied to advisory organization examinations, as well.

Pre-Examination Conference
A pre-examination conference call or a pre-examination visit should be conducted at the offices of the advisory organization with state examiners or contract examination companies so they can obtain specific detail from the advisory organization about its processes and procedures.

Scope of the Examination
The scope of the examination should clearly identify which regulated activities are being examined. Activities to be examined are limited to those identified under the Background and Definitions section of this chapter. If there are ad hoc review standards for a particular examination, they should be discussed by the lead states and the examined entity before they are administered by the state examiner or an examination contractor. The scope of the examination should be transparent to the examined entity.

Qualifications of Examiners
In addition to the examiner qualifications addressed in previous chapters of this handbook, specific qualifications and experience are recommended for advisory organization examinations. These operations differ substantially from insurers in terms of operations and regulatory requirements. The unique nature of advisory organization functions requires a sound knowledge of insurance rating, underwriting and classification systems. For purposes of examining statistical organization functions, knowledge is desirable of statistical and ratemaking data and databases, actuarial calculations and procedures, processing controls, and other elements of large mainframe database processing. When necessary, the examiners, together with qualified persons or actuaries, should be able to assess the effectiveness of advisory organization data processing controls, implementation policies and procedures. If these skills are not available within an insurance department, consideration should be given to engaging other qualified entities to coordinate and oversee, and perhaps to conduct, the technical portions of the advisory organization examination. This would include actuarial expertise in ratemaking and technical expertise in information systems.

The plan developed for conducting the examination or other regulatory action should assist in evaluating the appropriate experience and qualifications needed.

Understanding the nature, services and regulation of advisory organizations is necessary. Confidentiality and nondisclosure agreements are appropriate when engaging contract examiners. Detailed billing must be reviewed by both the state and the examined entity. To avoid conflict of interest, determination of the scope of the examination should be performed by the state, rather than the contracted entities.

Types of Examinations

When planning the examination, it is helpful to first identify which services and products are regulated and the impact on regulated entities. An advisory organization examination can take the form of a comprehensive examination, a targeted examination, a risk-focused examination, a re-examination, a multistate cooperative examination or a desk examination. Most of the elements found in Chapter 13—Types of Examinations will apply to the advisory organization examination. Because most operations for these entities remain consistent in all states, it is recommended to coordinate examinations or communicate with the NAIC Advisory Organization (D) Working Group, especially when conducting comprehensive reviews. The following special considerations apply:

a. A comprehensive examination of a single statistical agent will encompass a review of all or most of the following areas: operations/management; statistical plans; licensing or authorization (where needed); data receipt and controls; processing; editing and compilation procedures; error handling and correspondence with reporting insurers; and report submissions to regulators;

b. A comprehensive examination of a single advisory organization will encompass all of the above, plus processes for loss costs, rules, forms and other regulated activities;

c. Limited or targeted examinations of a single advisory organization may be used to address specific concerns. To address specific concerns, additional types of responses should also be considered, such as investigations, letters, desk audits, interrogatories or interviews;

d. A line of business examination for statistical data. This type of examination gathers information from all advisory organizations that provide statistical agent functions for a particular line of business, rather than reviewing a single advisory organization. At times, the regulator will be interested in examining all the data or services for a particular line of insurance. Care must be taken in apportioning expenses among all the examined entities in a manner acknowledging that the time spent at any one entity is likely to be somewhat related to the sequence in which the entities are reviewed. Consideration should be given to apportioning total examination expenses in a reasonable manner. One example is to apportion expenses by the relative premium volume of each statistical agent's reporting insurers for the line examined. When multiple entities are included in the line of business examination, seeking input or advice about apportioning expenses from the entities being examined is recommended;

e. Regardless of whether the activity being undertaken is comprehensive in nature or limited in scope, states are encouraged to coordinate with other states to prevent duplication and to obtain a better overall picture of the entities' operations. Such coordination may simply take the form of communication with other interested states. In some cases, a multistate examination may be desirable. In multistate examinations, the examination of operations/management, statistical plans, data processing and reporting systems will likely have countrywide application. However, data and data elements reviewed by an examiner will be either multistate or that of the participating jurisdictions. The lead state or lead states should seek the assistance of the state's Collaborative Action Designee (CAD) and applicable NAIC committees and working groups for the coordination and communication involved with a multistate endeavor. Confidentiality agreements, if not already in place, may be necessary in order to access or share information or data among jurisdictions; and

f. It is recommended that all billings from outside firms engaged be reviewed by the insurance department for reasonableness prior to submitting to examinees for payment. To the extent that the examination is a multi-statistical agent examination, the allocation of such examination costs should be discussed and agreed upon up front with the participating regulators and the examined entities.

Scheduling, Coordinating and Communications

Most of the chapter elements—including documenting the basis for the examination, review of previous examinations, estimating time requirements, content and timing of notification to the advisory organization, pre-examination procedures, on-site coordination, communicating with company management, and post-examination procedures—will apply to the examination. However, the following special considerations also apply:

a. Obtaining copies of other states' examination reports, either directly from the other states or from the advisory organization, will help to determine the scope of the examination. Many state laws may specifically permit consideration of another state's examination report to meet statutory examination requirements;

b. In determining priorities, the examiner should be aware that many of the listed elements have no application to advisory organizations, including:
   - Complaint ratios and analysis;
   - Producer licensing;
   - NAIC information systems, including the Regulatory Information Retrieval System (RIRS), Complaints Database System (CDS), and Financial Analysis and Solvency Tracking System (FAST);
   - Financial analysis workpapers;
   - Pre-admission; and
   - Annual statements;

c. Some functions—such as the promulgation of rates/loss costs and rules and policy forms and endorsements—may primarily be regulated through existing regulatory processes, such as filing and/or approval mechanisms. When planning an examination, such processes should be considered to prevent duplication of work and potentially conflicting insurance department conclusions;

d. The scope of the examination will be somewhat limited, in that complaint handling, marketing and sales, policyholder services, underwriting and claims do not apply. The scope should be clearly defined and communicated to the examinee prior to the start of the examination;

e. Regulator-only communication with members of the Advisory Organization (D) Working Group is also encouraged for purposes of avoiding duplicative examinations. Communication can also be sent to each state's Collaborative Action Designee, so that information can be directed to the correct person within each insurance department, such as the state's chief property/casualty actuary and property/casualty division administrator. The contact list of Collaborative Action Designees is located on the NAIC website at *https://content.naic.org/cmte_d_mawg.htm*.

f. Consider analysis of existing internal and external audit or consulting reports that may be available from the licensee; and

g. The relevant materials to be required of advisory organizations will not include advertising materials, producer records, renewal material, methods used to solicit business or the consumer complaint register, as these activities do not apply to these entities.

When developing the examination plan, the examination supervisor should be mindful that the examination should not be used as a tool for testing insurers' proper reporting of data. Testing the accuracy of individual insurers' data submissions is best handled during examinations of each specific insurer. That being said, it is appropriate for advisory organizations to communicate unresolved insurer reporting problems to regulators. It may also be appropriate to consider a targeted examination of non-compliant insurers if persistent data reporting problems are known to exist.

Conducting the Examination—Review General Organizational and Entity-Specific Information

Obtain the applicable information, listed below, from the entity being examined:

- Applicable organization contact name, address, telephone number and email address for this review;
- List of licenses, appointments and/or registrations in each jurisdiction that is participating in the examination;
- The previous examination of the organization conducted by the state, along with the organization's response to the report and a description of the organization's implementation of the recommendations from the previous report;
- A brief description and history of the company and its subsidiaries; highlight any major changes since the last examination;
- The certificate of incorporation and bylaws, including amendments made during the examination period.
- The table of organization and overview of management structure;
- Copy of the organization's policies and business practices relative to prohibited activities and adherence to such policies/practices;
- Organizational chart of all departments and divisions, including field offices performing advisory organization activities and officers and management staff of those areas;
- Description of regulated functions and services for each unit listed above. Obtain a list of services and products, along with states where offered and number of insurers using each service or product;
- A brief explanation of how each service or product is used by insurers, and how the product or service impacts ratemaking, actuarial, development or issuance of policy forms and endorsements, loss control purposes or information purposes, as applicable. It is important to keep in mind that some advisory organizations provide additional services and products that are not regulated by the insurance department. There should not be a need to include unregulated activities in the examination work plan or review;
- An explanation of the source of information gathered to produce each product or service;
- Copies of policies or business practices relating to the availability of services to authorized insurers;
- Committee appointments, agendas and minutes of meetings relating to any licensed activity. Examiners should be mindful of the proprietary nature of such documents. No copy of these documents should be retained. Confidentiality agreements, if not already in place, may be necessary in order to view such information;
- A list or statement of the states and lines of business in which the organization is permitted to operate;
- A list of participating insurers or member companies, by line of business;
- A description of the method and basis for the assessment of fees and charges;
- A review of the advisory organization's policy or business practice relating to the availability of regulated services to authorized insurers;
- A description of the organization's methodology of offering its products in the marketplace;
- A list and general description of internal audits performed during the examination period related to any regulated advisory organization activity; and
- A list of complaints received by the department and advisory organization relating to any regulated advisory organization activity during the examination period should be obtained from the insurance department and advisory organization.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the advisory organization has taken appropriate action. No copy of the report should be retained. States should review confidentiality and trade secret laws when deciding what notes to keep.

Writing the Examination Report

The report preparation elements are generally applicable to advisory organization examinations. However, the following special considerations also apply:

- In addition to safeguarding the confidentiality of individual policyholder information, care should be taken to not disclose trade secret information of the examinees or insurers that are customers of the examinees (e.g., individual insurer information in class or territory detail, or the processes and procedures

of the examinee). Advisory organizations should be given the opportunity to mark exhibits and/or portions of the report as "confidential and proprietary," if such is allowed under state law and these are not subject to otherwise applicable public release laws outside the regulatory community; and

- The advisory organization should be given the opportunity to review the examination findings prior to issuing a final report, if such practice is consistent with the state's insurers' examination act or other applicable statute.

Insurance Service and Support Programs

In most regulatory environments, the actual content of the advisory organization's loss cost, manual rules, forms and rating plan filings and the related actuarial formulas are front-end regulated and are not reviewed again during an examination. During an examination, the implementation of those filings in manuals or other distributions to insurers may be reviewed to the extent that these distributions have not been previously reviewed. Typically, examiners also review systems and data quality activities that are used in the loss cost production (i.e., "ratemaking"). These are typically additions to and extensions of systems and data quality activities that the organization performs as a statistical agent. As such, it is recommended that the "statistical agent" functions be reviewed prior to the review of ratemaking systems and additional ratemaking data quality reviews.

Some or all of the following list of items are functions of insurance service and support programs that should be considered for review:

- A description of the significant insurance program revisions (i.e., coverage revisions) made during the examination period;
- A description of significant changes in ratemaking methodology made during the examination period;
- A description of the data handling, systems, control and quality reviews conducted for the ratemaking reviews. Note that this may begin in the "statistical agent" part of the examination, but that additional data quality reviews may be incorporated into the ratemaking/loss cost making function. If the complete statistical agent function is not being examined at this time, this part of the review will be more extensive;
- A list of filings (loss costs, rules and forms) made in the state for the time period under examination;
- A description of the organization's procedures for notifying participating insurers about filings that have been submitted to the insurance department;
- From the list of filings obtained above, review the filing and related documentation for a set of sample filings, including the organization's communications and distribution to its participating insurers on the selected filings; and
- The organization's manuals and all revisions made thereto for the examination period. A list of current forms in effect in the state.

Note: For efficiency, when conducting an examination of a large organization that is licensed for many lines of business, examinations are usually conducted in detail for four or five of the larger significant lines, and by analogy or exception for the other lines.

If the examining state does <u>not</u> review the advisory organization's loss cost filings at the time of filing, a ratemaking review may be conducted. The review should include an overall description of the ratemaking procedures for each line of business, discussing:

- Significant ratemaking changes implemented since the previous examination;
- The data used and its sources, its limitations and adjustments;
- Quality procedures applied to the data;
- Data compilation basis and historical experience period selected;
- Classification methodology;
- Trend methodology;
- Loss development methodology;
- Credibility methodology;
- Catastrophe treatment methodology;

- Increased limits analyses;
- Other ratemaking methods used; and
- Rating plans.

Inspection Services
If applicable to the entity being reviewed and to the planned scope of review, obtain a description of the procedures for initial inspections and re-inspections of risks and/or communities, including a description of the training of such inspectors, and the inspector's oversight, in order to ensure compliance with established procedures. A random review of specific inspection reports will provide insight into the organization's adherence to its relevant internal procedures. The examiner may find it useful to check the examined entity's website to see what services the entity says it provides and verify this with the examined entity's examination contact person.

Classification Administration
The use of classifications should be done in a manner that results in consistent and fair application of the resulting rating plans. Classifications that are ambiguous or unclear for the ultimate users should be clarified. Classifications that may overlap with other classification codes should also be redefined or eliminated to prevent inconsistent or inappropriate use. Classification definitions are generally filed and approved in an organization's loss costs or rules filings. It is not contemplated that definitions be re-examined for compliance in an examination, unless known concerns or complaint patterns indicate the need for review.

The review of classification administration is primarily appropriate for advisory organizations, such as workers' compensation advisory organizations, that develop and maintain the classification system. The examiner should keep in mind that classifications are filed with and approved by the regulator. It is best to limit the review to how the advisory organization addresses known problems or questions that have been communicated by insurance department staff or insurance companies.

Advisory organizations that do not have control over the administration of classification codes may wish to bring known problems (if any) to the attention of the insurance department.

Some advisory organizations, particularly those that handle workers' compensation, may be responsible for processing classification appeals. Handling of such appeals should be done in a timely, fair and consistent manner. Reviewing classification appeals and related complaints may be useful when evaluating the effectiveness of classification administration.

Evaluation of Data Functions
Use of a generalized Information Systems Questionnaire (ISQ) developed for evaluation of insurers should not be used for advisory organizations; but a specialized questionnaire relating to data functions may be appropriate for advisory organizations that are engaged in data-dependent services. For example, it would not be necessary to use the specialized questionnaire during an examination of an advisory organization that only develops and files policy forms and endorsements.

Please reference Appendix F (a specialized questionnaire) and Appendix G (an interactive PDF), which are used to evaluate advisory organization data functions. Regulators with an active myNAIC login ID and password may access Appendices F and G electronically:

- Choose StateNet from the myNAIC login categories;
- Click on Market Regulation Handbook, Handbook Updates and Reference Documents (located in the Market Regulation section of the StateNet home page); and
- Click on Market Regulation Handbook Reference Documents. Appendices F and G are found at the top of the Market Regulation Handbook Reference Documents web page.

Non-regulators may access Appendices F and G on the NAIC Account Manager web page at *https://www.naic.org/account_manager.htm*.

Comprehensive Annual Analysis (CAA) Form for Advisory Organizations and Statistical Reporting Agents
At the 2015 Fall National Meeting, the Property and Casualty (C) Committee and the Market Regulation and Consumer Affairs (D) Committee adopted the Comprehensive Annual Analysis (CAA) form,* which is a form designed to be completed each year by an advisory organization or statistical agent. The form includes questions taken directly from existing examination standards in this chapter. The only difference is the form takes a snapshot of the last 12 months of activity at the advisory or statistical organization, instead of the last five years that an examiner would ask for when performing an examination.

The NAIC working group that adopted the form, the Advisory Organization Examination Oversight (D) Working Group, believed that by identifying operational or staffing level changes in an advisory or statistical organization earlier, the Working Group and its successor Working Groups will be able to speed up the examination process and ultimately reduce examination costs for the state insurance departments or for a contractor hired by a state insurance department.

*An updated Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents (which replaced the CAA form adopted in 2015) was adopted in 2017 by the NAIC Executive (EX) Committee and Plenary. Regulators may access the 2017 updated Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents via myNAIC at the Market Regulation Handbook, Handbook Updates and Reference Documents link on the StateNet home page. The updated CAA form is located in the Market Regulation Handbook Reference Documents section of the web page together with Appendices F and G referenced above. Non-regulators may access the 2017 updated Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents on the NAIC Account Manager web page at *https://www.naic.org/account_manager.htm*.

Use of Examination Standards
Each of the following examination standards may be applicable to specific functions performed by advisory organizations. The examination plan should indicate which standards for review will be used for each specific examination. Section B of this chapter lists standards specific to advisory organization functions. Section C of this chapter lists standards specific to statistical agent functions. These standards, along with the preceding text of the chapter, used in accordance with the *Statistical Handbook of Data Available to Regulators* (applicable to statistical agent functions) should form the basis of the examination. Each standard includes an "Applicable to" notation. Those notations may assist in developing an examination plan.

B. Advisory Organizations Operations/Management/Governance

1. Purpose

The advisory organization examination is designed to verify that the advisory organization maintains procedures for providing regulated services that are in accordance with applicable statutes, rules and regulations.

2. Techniques

The examiner should review the services provided by the advisory organization to the extent required by applicable statutes, rules and regulations.

Section C of this chapter deals with standards that are specific to statistical agent duties.

3. Tests and Standards

The advisory organization operations/management/governance review includes, but is not limited to, the following standards related to the use of advisory organization services. The sequence of the standards listed here does not indicate priority of the standard.

4. Voluntary Self-Reporting

The advisory organization may elect to submit a detailed report on how it complies with the examination standards before the detailed examination work plan is developed. The lead state may take information contained in this self-report into consideration when developing the scope of the examination work plan. However, a self-report should not be considered a substitute for a scheduled examination.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 1
The advisory organization has implemented written policies and procedures to prevent anti-competitive practices in the insurance marketplace, as related to the advisory organization's services and communications to insurers.

Apply to: All advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Service agreements with insurance companies

_____ Board of director and other committee minutes, along with applicable policies and procedures that are applicable to anti-competitive practices

_____ Regulatory actions and lawsuit register (if any)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review policies and procedures to determine if the advisory organization provides guidance to its staff and adopts practices to prevent anti-competitive activity. Although adoption of written policies and procedures are likely not required by law, it is permissible to comment on the lack of, or weaknesses in, such policies or procedures.

Examples of anti-competitive practices in the insurance market include:

- Attempting to monopolize, combine or conspire with any other person to monopolize an insurance market;
- Engaging in boycott on a concerted basis of an insurance market;
- Agreeing with an insurer to mandate adherence to or mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics. The fact that two or more insurers use consistently or intermittently the same rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material is not sufficient in itself to support a finding that an agreement exists;
- Entering into arrangements which have the purpose or effect of unreasonably restraining trade or unreasonably lessening competition in the business of insurance; and

- Except as otherwise permitted by statute, compiling or distributing recommendations relating to rates that include expenses (other than loss adjustment expenses) or profits. Examples of permitted exceptions include information required or directed by the insurance commissioner, research related to impact of statutory changes, compilations of current insurer prices which are also made available to the public, and filing of final rates for residual market mechanisms.

Examples of sound practices include, but may not be limited to:

- Implementation of policies that require reading anti-trust statements and monitoring of meetings or forums with multiple insurers to prevent anti-competitive practices;
- Use of written guidelines that promote the advisory organization's making its products and services available to entitled affiliates, subscribers or purchasers in an appropriate and consistent manner. Written policies should protect the advisory organization, yet not promote anti-competitive results; and
- Implementation of training materials or employee codes of conduct that address prohibition of anti-competitive activities.

Standard 2
The advisory organization uses sound actuarial principles for the development of prospective loss costs.

Apply to: Advisory organizations that develop prospective loss costs

Priority: Essential

Note: If the examining state does not review the advisory organization's loss costs filings at the time of filing, a ratemaking review may be conducted. The review should include an overall description of the ratemaking procedures for each line of business.

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Actuarial guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review processes and procedures for development of loss costs, along with a random sample of specific prospective loss costs.

- Prospective loss costs developed by the advisory organization do not contribute to premiums that are inadequate, excessive or unfairly discriminatory;
- Data used to develop prospective loss costs is applicable, complete (as appropriate) and actuarially sound;
- The advisory organization has procedures in place to test the soundness of data prior to use for development of prospective loss costs; and
- Assumptions, trending factors and other factors used during the development of prospective loss costs are actuarially sound and reasonable.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 3
The advisory organization prepares, submits filings as necessary, adheres to applicable state filing and/or approval requirements and written procedures prior to distribution of prospective loss costs, policy forms, endorsements, factors, classifications or rating rule manuals.

Apply to: Advisory organizations that develop and file prospective loss costs, policy forms, endorsements, factors, classifications or rating rule manuals

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Procedural information from the advisory organization

_____ Filings made to applicable states

_____ Communications and manuals provided by the advisory organization to its members and subscribers

_____ Distributed prospective loss costs, policy forms, endorsements, factors, classifications or manuals

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review a sample of actual filings and materials distributed to member or subscribing companies.

- The advisory organization makes filings on the System for Electronic Rate and Form Filing (SERFF) or other state-approved filing systems;
- The advisory organization follows mandated time requirements (if applicable) following filing or approval before permitting use of materials;
- The advisory organization is responsive to state filing analyst questions regarding filings;
- Distributed materials are the same as those filed with applicable state insurance departments;
- Prospective loss costs, policy forms, endorsements, factors, classifications or rating rules are filed and approved (as applicable) in accordance with state filing laws;
- Instructions are included in the advisory organization's manuals for all prospective loss costs, policy forms, endorsements, factors, classifications or rating rules; and
- The advisory organization provides accurate information to its members and subscribers relating to the states' approval status and approved usage date of prospective loss costs, policy forms, endorsements, factors, classifications or rating rules in a timely manner.

Standard 4
Experience rating factors are developed in a correct and timely manner.

Apply to: Advisory organizations that provide individual risk experience rating modification factors

Priority: Essential

Note: If the examining state does not review the advisory organization's experience rating plan at the time of filing, a review of the plan may be conducted.

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures for the development of experience rating modification factors

_____ Random samples of developed individual experience rating modification factors

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization adheres to consistent and actuarially sound processes and formulas for developing individual experience rating modification factors.

The advisory organization has data integrity checks in place to evaluate data used during calculation of individual experience rating modification factors.

Experience rating modification factors are developed and made available to applicable insurers in a timely manner.

The advisory organization maintains adequate documentation to support individual experience rating modification factors that it developed.

The advisory organization is responsive to questions and grievances relating to individual experience rating modification factors that it developed.

Standard 5
The advisory organization performs thorough and meaningful inspections and research when required for individual insured rating classification.

Apply to: Advisory organizations that provide individual insured rating classifications

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Inspection reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review a sample of inspection reports used for individual rating classifications.

- Inspection and research reports are well documented, including dates of inspection and notes of relevant inspection results;
- Resulting individual rating classifications are provided to applicable entities in a timely manner; and
- Individual rating classifications are consistent with the filed classification system. Examiners should be mindful that such individual classification information may be proprietary.

Standard 6
The advisory organization develops sound, understandable and appropriate risk classifications.

Apply to: Advisory organizations that administer risk classification manuals

Priority: Essential

Note: If the examining state does not review the advisory organization's classification rules at the time of filing, a review of these rules may be conducted.

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization classification manuals

_____ Appeals and grievances related to classifications

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Classifications and accompanying manuals provide clear guidance.

Wherever possible, classifications are developed in a manner that leads to consistent handling of risk classification.

Risk classifications include only risks with similar expected loss exposure, within each rating class.

Standard 7
Loss control services are effective and based on valid risk management, engineering and scientific evidence.

Apply to: Advisory organizations that provide loss control services

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures for loss control services

_____ Random samples of loss control and inspection reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization uses appropriate expertise in analysis and development of loss control reports.

The advisory organization uses up to date technical and scientific evidence in its development of loss control reports.

The advisory organization employs sound and meaningful inspection practices, where required, for loss control purposes.

Standard 8
The advisory organization conducts ongoing research and review of state insurance laws and insurance-related case law in order to be responsive to necessary changes in prospective loss costs, policy forms, endorsements, factors, classifications or manuals, as applicable.

Apply to: Advisory organizations that develop and file prospective loss costs, policy forms, endorsements, factors, classifications or manuals

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Filings made to applicable states

_____ Advisory organization processes and procedures for researching insurance laws and case law

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

From the applicable state or states, obtain specimen copies of recent insurance law changes or case law that directly and significantly impact the content of materials filed by the advisory organization. Review the advisory organization's procedures for responding to those changes or, in the absence of implementing changes, notifying member or subscribing companies when deemed appropriate.

- The advisory organization conducts research into law changes during regular and reasonable intervals;
- The advisory organization identifies applicable materials impacted by law or case law changes; and
- The advisory organization makes appropriate modifications, additions, deletions or withdrawals as necessitated by law changes or case law and performs applicable filings and notifications to member or subscriber companies.

Standard 9
The advisory organization uses objective and established procedures when administering assigned risks.

Apply to: Advisory organizations that administer residual market assigned risk mechanisms

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures

_____ Contracts or agreements with applicable states for which the assigned risk mechanisms are administered

_____ Random sample of assignments

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization adheres to an objective and established selection process for assigning risks.

The advisory organization handles assignments in a timely manner.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 10
When performing analysis and impact studies of proposed legislation, the advisory organization presents thorough and objective information.

Apply to: Advisory organizations that provide legislative impact studies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Reports submitted to insurance departments and legislatures in response to requests from those entities for legislative impact studies

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

- Impact studies present information in an objective manner; and
- Best estimates of impact are presented, using reasonable assumptions, research and data.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 11
The advisory organization has an up-to-date, valid internal or external audit program.

Apply to: Advisory organizations

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Audit plan and advisory organization's procedural manuals

_____ Audit reports and results

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review audit reports to determine if the function is providing meaningful information to management. If external, obtain an explanation.

Determine how management is using the reports.

Determine if the advisory organization responds to internal audit recommendations to correct, modify and implement procedures.

Determine if the accuracy of internal statistical data and information systems is periodically tested by the advisory organization's audit program.

Note: The examiner should be mindful of the proprietary nature of internal audit reports. Administrative action should not be recommended by the examiner based on results of internal audit findings for which the advisory organization has taken appropriate corrective action. No copy of the report should be retained. States should review confidentiality and trade secret laws when deciding what notes to keep.

Standard 12
The advisory organization has appropriate controls, safeguards and procedures for protecting the integrity of computer information.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Electronic records control, and advisory organization's procedural manuals

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Information and Privacy Protection Model Act (#670)
Health Information Privacy Model Act (#55)

Note: When evaluating use of standards relating to privacy, keep in mind that most advisory organizations do not gather protected personal information.

Review Procedures and Criteria

Review physical security procedures related to the computer processing facilities and the network:

- Confirm that the computer/communication facilities (computer room, network operations center, wiring closets, etc.) are secure and protected from hazards;
- Confirm that access to the computer/communication facilities is restricted to only authorized personnel at all times;
- Confirm that the advisory organization uses firewall technology to protect its internal network from unauthorized external access;
- Confirm that the advisory organization scans inbound messages and files for malicious content; and
- Confirm that the advisory organization encrypts sensitive data files when transmitting data outside the physical premises.

Review logical security and computer system control procedures:

- Confirm that access to the advisory organization's network and computer systems is protected minimally with user IDs and passwords, based upon the sensitivity of the information and the requirements of the individuals; and
- Confirm that computer programs/databases/files impacted by user change requests are properly monitored, modified, tested and migrated to the secure production libraries.

Review the segregation of duties between the application development, operations and user departments to confirm that information systems projects are authorized, controlled and documented.

- Confirm that changes to the application portfolio are authorized, controlled and documented;
- Confirm that the user departments review, approve and sign-off on the implemented changes and the test results prior to the migration to the production environment; and
- Confirm that there are sufficient controls in the migration of the new application components to the production environment which guarantee accuracy and completeness.

Standard 13
The advisory organization has a valid disaster recovery plan.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Description of the advisory organization's disaster recovery plan, procedural manuals and controls

_____ Negotiated contracts

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that critical business applications, databases and files are regularly backed up and stored off-site.

Review the disaster recovery plan and procedures:

- Confirm that the recovery procedures are current, detailed and repeatable;
- Confirm that the inventory of critical business applications, databases and files is current and is defined and prioritized in the recovery process; and
- Confirm that critical business areas developed manual recovery testing (off-site retrieval through restoration of a fully operational computing environment) on a regular basis.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 14
The advisory organization is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the advisory organization.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Contracts

_____ Audit reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review audit reports to determine whether the advisory organization is adequately monitoring the activities of the contracted entity.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 15
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Market Conduct Record Retention and Production Model Regulation (#910)
Model Law on Examinations (#390), Section 4

Review Procedures and Criteria

Evaluate the orderly organization, legibility and structure of files.

Review state record retention requirements to determine advisory organization compliance.

Standard 16
The advisory organization is appropriately licensed.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Certificate of authority or other similar documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review authority to act as an advisory organization.

STANDARDS
ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

Standard 17
The advisory organization cooperates on a timely basis with examiners performing the examinations.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations, especially insurance examination law

_____ All records, files and documents

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Law on Examinations (#390)

Review Procedures and Criteria

Monitor the advisory organization's cooperation during the course of the examination; this may be noted in the examination report.

Automation Tip:
Requests for information or "crits" can be monitored using either a database or spreadsheet. The information that should be captured includes: area of review, type of request, contact person, date given, date due and date received. Databases and spreadsheets contain functions that will calculate the number of days between two dates. The information can be easily sorted and reviewed to see what is still outstanding and if the advisory organization is responding in a timely fashion.

Standard 18
The advisory organization has developed and implemented written policies, standards and procedures for the management of insurance information.

Note: This standard applies only to those organizations that maintain data files containing personally identifiable information such as birth dates, social security numbers or other personal information. If the organization does not collect and report information on an individual level, examination of policies and procedures for this standard should not be included in the examination.

Apply to: Advisory organizations

Priority: Essential

Documents to be Reviewed (where applicable)

_____ Applicable statutes, rules and regulations

_____ Advisory organization procedure manual

_____ Advisory organization training manual

_____ Internal advisory organization claim audit procedures

_____ Advisory organization bulletins regarding insurance information

_____ Contractual arrangements between the carrier and a person other than the covered person

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Health Information Privacy Model Act (#55), Section 5
Insurance Information and Privacy Protection Model Act (#670), Sections 4–9

Review Procedures and Criteria (where applicable)

Review advisory organization procedures, training manuals and claim bulletins to determine if advisory organization standards exist and whether standards comply with state law.

Review contractual arrangements between the advisory organization and other persons to determine if the contracts address privacy procedures and standards for the person with whom the advisory organization is contracting.

Review the advisory organization's methods for handling, disclosing, storing and disposing of insurance information. The examiners should determine whether there are procedures in place to ensure proper authorization is obtained prior to disclosure of insurance information.

Review the advisory organization's training manual to determine whether the advisory organization's employees are properly trained on the handling of insurance information.

Verify that the advisory organization provides a "Notice of Information Practices" to all applicants or policyholders or has procedures in place for the producer to deliver the notice. The examiner should determine whether the notice contains all provisions required by applicable state law.

Verify that the advisory organization specifies those questions designed to obtain information solely for marketing or research purposes.

Verify that the advisory organization has implemented reasonable procedures to address investigative consumer reports and personal interviews.

Verify that the advisory organization has established procedures to address access to, correction, amendment or deletion of recorded personal information.

C. Statistical Plans

1. Purpose

The statistical plans portion of the examination is designed to verify that the statistical agent maintains adequate statistical plans in accordance with applicable statutes, rules and regulations, and that the data are reported in accordance with the statistical plans. This test is also intended to measure a statistical agent's compliance regarding the filing and approval of statistical plans, if any.

2. Techniques

The examiner should review the statistical plans in use by the statistical agent and verify that the statistical plans have been filed with the state insurance departments, to the extent required by applicable statutes, rules and regulations. The examiner should also verify that the appropriate statistical plans are being used by the companies that are reporting data to the statistical agent. The examiner should review the statistical plans for consistency with the output specified in the *Statistical Handbook of Data Available to Insurance Regulators*, in addition to other state specifications.

3. Tests and Standards

The statistical plan review includes, but is not limited to, the following standards related to the use of statistical plans by the statistical agent. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
STATISTICAL PLANS

Standard 1
The statistical agent has filed its statistical plans in accordance with applicable statutes, rules and regulations.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Letters or other documentation verifying that statistical plans have been filed, where necessary

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review letters or other documents to determine if the statistical agent is in compliance with applicable statutes, rules and regulations.

STANDARDS
STATISTICAL PLANS

Standard 2
The statistical plans are reviewed and updated in accordance with applicable statutes, rules and regulations.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Statistical plans

_____ Statistical plan updates

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation to determine if statistical plans are periodically updated and in compliance with applicable statutes, rules and regulations.

STANDARDS
STATISTICAL PLANS

Standard 3
The statistical agent verifies that companies submit data in accordance with the appropriate statistical plan.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Edit documentation

_____ Annual calls for statistical submissions

_____ Technical requirements for reporting

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review statistical agent's procedures to ascertain that its member companies are submitting complete and accurate data in compliance with applicable statutes, rules and regulations.

Review edits that the statistical agent applies to data it receives from insurers.

Review incentives applied by statistical agents to encourage member companies to report timely and error-free data.

Review annual calls for statistical submissions and periodic special calls to determine how effective the statistical agent's procedures are in collecting complete and accurate statistical information.

D. Data Collection and Handling

1. Purpose

The data collection and handling portion of the examination is extremely important and is designed to verify that the statistical agent adequately tests reported data for validity, completeness and reasonableness. The areas to be considered in this kind of review include:

- Statistical agent standards regarding data quality; and
- Data checking procedures and edit programs.

2. Techniques

During an examination, it is necessary for examiners to review a number of information sources, including the statistical agent's written policies and procedures regarding data quality (i.e., validity, reasonableness and completeness); the edit programs run by the statistical agent on the data when it is first received; the system of edits that the statistical agent applies to the data; and the steps used by the statistical agent in processing the data.

a. Statistical Agent Standards Regarding Data Quality

The examiner should verify that the statistical agent has formal written policies regarding the quality of the data to be submitted and what level of quality is required of the companies. The statistical agent should also have policies regarding what level of error tolerance is considered to be acceptable.

b. Data Checking Procedures and Edit Programs

The examiner should review the programs and procedures used to verify the validity, reasonableness and completeness of the data. The examiner should verify that the edit systems function as intended and check a sample of data both before and after it has run through the checking programs, to verify that all detectable errors have been caught.

c. Sequence of Examination

Data related to protocols need to be examined in their proper sequence as they exist at the advisory organization. The examiner should review the systems and procedures as they exist and identify gaps that could result in compliance issues for data that is used in loss cost filings, other pricing filings and statistical agent reports.

3. Tests and Standards

The data collection and handling review includes, but is not limited to, the following standards related to the statistical agent's handling of data. The sequence of the standards listed here does not indicate priority of the standard. The *Statistical Handbook of Data Available to Insurance Regulators* includes a comprehensive set of data quality tests to be performed by statistical agents. The *Statistical Handbook* should be used as an additional reference and guide for evaluating data collection and handling functions.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 1
The statistical agent's series of edits are sufficient to catch material errors in data submitted by a company.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Edit definitions

_____ Distributional edit procedures

_____ Statistical agent edit reports

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review edit definitions and distributional edit procedures to determine that all required data elements are tested.

Review a sample of edit/distributional edit reports to verify that material errors are adequately identified.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 2
All data that is collected pursuant to the statistical plan is run through the editing process.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Submission control and balance procedures

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Submission control file

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review procedures and submission control file, and a sample of edit and distribution reports to verify that all submissions are subject to the editing process.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 3
Determine that all databases are updated as needed with all accepted company data.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Database update balancing reports

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Database control logs

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review logs and a sample of reports to confirm that appropriate data is moved to databases.

A predetermined sample size should be established and included in the examination scope document.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 4
Determine that financial data is reconciled to the State Page—Exhibit of Premiums and Losses, Statutory Page 14, of the NAIC annual statement on an annual basis.

Apply to: All statistical agents[35]

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Financial reconciliation procedures

_____ Financial reconciliation reports

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine compliance with applicable statutes, rules and regulations and any standards prescribed in the *Statistical Handbook of Data Available to Insurance Regulators*.

Review procedures and a sample of reconciliation reports to confirm that reconciliations are performed.

Review financial reconciliation criteria (e.g., rules for reconciliation, acceptance tolerance levels).

[35] Statistical agents handling workers' compensation data are expected to undertake substantial data quality checking activities, but the necessary standards and activities relevant to workers' compensation are different than those required for other lines of insurance.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 5
Determine that all calculations associated with the database have been accurately applied.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Statistical agent documentation of database specifications

_____ *Statistical Handbook of Data Available to Insurance Regulators*

_____ Statistical agent database control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of control reports to confirm that specifications have been accurately applied.

Note: The examiner should be mindful of the proprietary nature of database specifications and control reports. Administrative action should not be recommended by the examiner based on results of control reports for which the advisory organization has taken appropriate action. No copy of the specifications or reports should be retained. States should review confidentiality and trade secret laws when deciding what notes to keep. Confidentiality agreements, if not already in place, may be necessary in order to view such information.

STANDARDS
DATA COLLECTION AND HANDLING

Standard 6
Where applicable, determine that the statistical agent employs use of data completeness tests as outlined in the *Statistical Handbook of Data Available to Insurance Regulators.*

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Statistical agent documentation of database specifications

_____ *Statistical Handbook of Data Available to Insurance Regulators* (Section 2.3.1)

_____ Statistical agent database control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of control reports to confirm that data completeness tests have been performed.

E. Correspondence with Insurers and States

1. Purpose

Statistical agents frequently need to contact or correspond with companies regarding the quality and timeliness of the company's data. The purpose of this section of the examination is to verify that the statistical agent promptly notifies the company (and regulators, as requested or required) when a problem with or question about the data is found, and then follows up, if the company does not respond within the appropriate time frame.

2. Techniques

The examiner should review the statistical agent's records of or contact with companies (and regulators, as requested or required) to note the timeliness of the statistical agent's notification to the companies (and regulators, as requested or required) of data errors or questions, as well as any necessary follow-up communications.

3. Tests and Standards

The review of communications includes, but is not limited to, the following standards addressing various aspects of the statistical agent's contact and/or correspondence with companies and regulators. The sequence of the standards listed here does not indicate priority of the standard. The *Statistical Handbook of Data Available to Insurance Regulators* describes reports to be made by statistical agents. The *Statistical Handbook* should be used as an additional reference and guide for evaluating reporting functions and other data requests.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 1
The statistical agent keeps track of companies that fail to meet deadlines.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Submission control files

_____ Financial incentive program or penalty structure, if one exists

_____ Late company monitoring and reporting procedures

_____ Communications to insurers that fail to meet deadlines

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review statistical agent controls and procedures for determining insurer reporting status.

Review a sample of the statistical agent's communications with each delinquent insurer and other documentation to determine if insurers that fail to meet deadlines are identified and notified.

Review the statistical agent's financial incentive program or penalty structure, if one exists.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 2
The statistical agent has established procedures for notifying companies (and regulators, as requested or required) of material errors and for correcting those errors.

Apply to: All statistical agents

Priority: Essential

Documents to be Reviewed

_____ Data validation reports

_____ Submission control files

_____ Communications to insurers (and regulators, as requested or required)

_____ Financial incentive or penalty structure, if one exists

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation to confirm that appropriate procedures exist for notifying companies (and regulators, as requested or required) of material errors and for correcting those errors.

Review a sample of communications to confirm that material errors are brought to the attention of insurers (and regulators, as requested or required).

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 3
The statistical agent maintains a follow-up procedure with companies that have reporting errors or questions.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Outline of communications procedures

_____ Financial incentive programs or penalty structure, if one exists

_____ Correspondence and/or other contact between statistical agent and companies (and regulators, as requested or required)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review statistical agent procedures and controls to determine that appropriate procedures exist.

Review a sample of correspondence/contact documentation to demonstrate follow-up performance.

Review the statistical agent's financial incentive programs or penalty structure, if one exists.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 4
Review any additional data quality programs maintained by the statistical agent pertaining to data collected pursuant to the statistical plan.

Apply to: All statistical agents

Priority: Optional

Documents to be Reviewed

_____ Educational programs or materials

_____ Support procedures

_____ Financial incentive programs or penalty structure, if one exists

_____ Executive evaluations

_____ Individual company assistance the statistical agent uses to promote data quality

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine the extent that other data quality programs are in use by the statistical agent.

STANDARDS
CORRESPONDENCE WITH INSURERS AND STATES

Standard 5
With each standard premium and loss report to the states, the statistical agent provides a listing of companies whose data is included in the compilations and a historical report listing insurers whose data for the state was excluded, as set forth in Section 2.4 of the *Statistical Handbook of Data Available to Insurance Regulators.*

Apply to: All statistical agents

Priority: Optional

Documents to be Reviewed

_____ Standard premium and loss reports to states

_____ Support procedures

_____ *Statistical Handbook of Data Available to Insurance Regulators* (Section 2.4)

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine the applicable lists are included with state reports.

F. Reports, Report Systems and Other Data Requests

1. Purpose

The purpose of this portion of the examination is to review the statistical agent's reports and other statistical compilations prepared for the states, as well as the statistical agent's internal procedures for preparing reports and responding to data requests, including the timeliness and quality of the response.

2. Techniques

The examiner should review recent reports and other statistical compilations prepared for the insurance departments. The examiner should note whether the data submission required that the statistical agent collect additional information from insurers and the procedure the statistical agent used in fulfilling the data request. The examiner should also determine that the statistical agent met the deadline set by the insurance department and that any data collected for the purpose of submitting the aforementioned reports to the insurance department, in addition to that collected under the statistical plan, was adequately reviewed for quality and correctly compiled.

3. Tests and Standards

The report, report systems and other data requests review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 1
All calculations used to develop the database have been performed accurately.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Statistical agent documentation of report specifications

_____ Statistical agent database control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of control reports to confirm that specifications have been accurately applied.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 2
The statistical agent has accurately extracted the appropriate information from the statistical database.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Data extraction control reports

_____ Report system specification documentation

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of reports to determine if the appropriate data has been included.

Note: The examiner should be mindful of the proprietary nature of database specifications. No copy of the specifications should be retained by the examiner. States should review confidentiality and trade secret laws when deciding what notes to keep. Confidentiality agreements, if not already in place, may be necessary in order to view such information.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 3
Any data extracted from the statistical database has been accurately reviewed with any additional data obtained directly from a company in preparing a response to a data request.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Report system specifications and documentation

_____ Data extraction control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review documentation and a sample of reports to determine if the appropriate data has been included.

STANDARDS
REPORTS, REPORT SYSTEMS AND OTHER DATA REQUESTS

Standard 4
Data collected, in addition to the data collected under the statistical plan, was adequately reviewed for quality and compiled according to applicable statutes, rules and regulations.

Apply to: All statistical agents

Priority: Recommended

Documents to be Reviewed

_____ Data quality procedures

_____ Data validation reports

_____ Report system control reports

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review data quality procedures and a sample of data validation and control reports to determine if the data was adequately reviewed for quality and correctly compiled.

G. Ratemaking Functions

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's ratemaking, reports and reporting systems, if any, as well as the advisory organization's internal procedures for preparing related reports and responding to data requests, including the timeliness and quality of the response. There should be no need for review of the advisory organization's pricing formulae as they have already been subjected to front-end regulation when rates are approved by the state insurance department.

2. Techniques

The examiner should review recent ratemaking results and related reports, if any, and other statistical compilations prepared for the insurance departments.

3. Tests and Standards

The ratemaking functions review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
RATEMAKING FUNCTIONS

Standard 1
The advisory organization submits filings and/or submissions to the state within the established time frame.

Apply to: All advisory organizations

Priority: Essential

Documents to be Reviewed

_____ Filings or submissions to individual state insurance departments providing rate/loss cost information

_____ Filings or submissions to individual state insurance departments seeking approval of loss costs and accompanying rules

_____ Other correspondence with individual state insurance departments related to rates or loss costs

_____ Communications and manuals provided by the advisory organization to its subscribers

_____ Applicable statutes, rules and regulations

_____ *Statistical Handbook of Data Available to Insurance Regulators*

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Identify which filings and submissions are required by the state (if any), along with any required time frames. For filings that are optional, but require prior approval by the state, identify the required waiting periods, if any, between approval and usage.

Determine compliance with state statutes, rules and regulations.

The examiner should review regulators' requests for additional information and check for timeliness of the response to such requests.

Determine that the organization prepares and disseminates information impacting the rating of individual policies, such as experience rating modification factors, on a timely basis.

Determine that the organization provides accurate information to its subscribers relating to the states' approval status and approved usage date of regulated materials and services, such as loss costs.

H. Classification and Appeal Handling

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's classification and appeal processes, where applicable. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review recent classification appeals or requests for clarification, if any.

3. Tests and Standards

The classification and appeal handling review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CLASSIFICATION AND APPEAL HANDLING

Standard 1
The advisory organization takes adequate steps to finalize and dispose of the classification appeal in accordance with applicable statutes, rules and regulations, and written manuals and procedures.

Apply to: Advisory organizations that process classification appeals

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization's listing of appeals

_____ Supporting documentation (e.g., manuals, etc.)

_____ Advisory organization correspondence

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review appeal documentation to determine if the advisory organization response fully addresses the issues raised. If the advisory organization did not properly address/resolve the appeal, the examiner should ask the advisory organization what corrective action it intends to take.

Review manuals to verify appeal procedures exist.

Procedures in place should be sufficient to require satisfactory handling of appeals received, as well as internal procedures for analysis of classification codes that commonly cause appeals.

Criteria for reviewing appeal responses:

- The response is timely;
- The response is complete and responsive to all issue raised;
- The response includes adequate documentation to support the respondent's position;
- The respondent's actions are appropriate from a business practice standpoint;
- The respondent's actions comply with all applicable statutes, rules and policy or contract provisions, and
- The appropriate remedies for the consumer are identified.

I. Form Development

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's processes for development, maintenance and filing of forms for insurance programs. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review communications with insurers and states relating to forms developed and determine that the communications to insurers are consistent with existing filings. Quality assurance programs should be in place to ensure that the forms remain up-to-date and that filings to states are checked for the appropriate level of quality.

3. Tests and Standards

The insurance program development and maintenance review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
FORM DEVELOPMENT

Standard 1
The advisory organization has processes in place to identify and provide subscribers with necessary changes (by virtue of changes in state laws or case law) to advisory forms.

Apply to: All advisory organizations

Priority: Recommended

Documents to be Reviewed

_____ Communication with companies regarding changes to applicable forms

_____ Procedural information from the advisory organization

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

If the examiner knows law changes or case law necessitating changes to applicable forms, verify that the advisory organization responded accordingly.

Alternatively, provide the advisory organization with a brief questionnaire, asking about procedures for handling such changes.

STANDARDS
FORM DEVELOPMENT

Standard 2
The advisory organization has quality assurance processes in place to review submissions of forms prior to filing or submitting to the applicable state.

Apply to: All advisory organizations

Priority: Optional—best practice only

Documents to be Reviewed

_____ Procedural information from the advisory organization

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine whether the advisory organization uses applicable readability tools, such as Flesch tests, if required by law.

Provide the advisory organization with a brief questionnaire, asking about procedures for quality control and readability.

J. Inspection Services

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's processes for ensuring proper classification of risks that are subject to inspection, and to report the results of this review to carriers and insureds.

2. Techniques

The examiner should review the procedural information from the advisory organization, as well as completed reports. Communications and manuals provided by the advisory organization to its members and subscribers—as well as applicable statutes, rules and regulations—should be reviewed to determine that the communications to insurers and insureds are consistent with existing classifications of risk.

3. Tests and Standards

The inspection services review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
INSPECTION SERVICES

Standard 1
The advisory organization conducts inspection services in accordance with applicable statutes, rules and regulations, and written procedures.

Apply to: All advisory organizations maintaining a workers' compensation classification system

Priority: Essential

Documents to be Reviewed

_____ Procedural information from the advisory organization

_____ Reports to individual state insurance departments providing inspection services information

_____ Communications and manuals provided by the advisory organization to its subscribers

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization has an inspection program in place to ensure proper classifications of risks.

The advisory organization communicates inspection results to carriers and insureds.

K. Residual Market Functions—Plan Administration

1. Purpose

The purpose of this portion of the examination is to review all advisory organizations acting as a residual plan administrator in regard to the implementation of rules, procedures, manuals, policy forms, endorsements, pricing programs, application processing procedures, carrier selection, compensation and oversight. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review contracts, designations or agreements with applicable states for which the assigned risk mechanisms are administered as available and/or required. The examiner should also check to be sure that applicable statutes, rules and regulations are addressed in national and/or state rules and/or procedures where appropriate. A sample of actual filings and materials should be submitted for review.

3. Tests and Standards

The residual market functions—plan administration review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
RESIDUAL MARKET FUNCTIONS—PLAN ADMINISTRATION

Standard 1
The advisory organization uses objective and established procedures when administering assigned risk plans.

Apply to: All advisory organizations, acting as a residual market plan administrator, that develop file and implement prospective rules, procedures, manuals, policy forms and endorsements, pricing programs, application processing procedures, carrier selection, compensation and oversight

Priority: Essential—market of last resort

Documents to be Reviewed

_____ Administration of the rules and procedures

_____ Standards of performance for assigned carriers

_____ Servicing carrier selection, compensation and oversight

_____ Application processing procedures

_____ Dispute resolution process

_____ Contractual agreements with state, if applicable

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Contracts, designations or agreements with applicable states for which the assigned risk mechanisms are administered as available and/or required.

Applicable statutes, rules and regulations are addressed in national and/or state-approved filing systems and inquiries are responded to in a timely manner.

Review a sample of actual filings and materials submitted for approvals.

The plan administrator makes filings on the System for Electronic Rate and Form Filing (SERFF) or other state-approved filing systems and responds to inquiries.

The plan administrator is responsive to inquiries relating to individual assigned risk policy issues.

The plan administrator develops standards of performance for assigned carriers.

The plan administrator adheres to an established selection process for choosing and compensating service carriers.

The plan administrator handles applications for assigned risk coverage in a timely manner.

The plan administrator adheres to an established process for making assignments to assigned carriers.

The plan administrator adheres to established audit practices and procedures for auditing an assigned carrier.

The plan administrator develops and/or implements a dispute resolution process for resolution of assigned risk policyholder disputes.

STANDARDS
RESIDUAL MARKET FUNCTIONS—PLAN ADMINISTRATION

Standard 2
The advisory organization uses objective and established procedures when administering residual market or pool assessments.

Apply to: Advisory organizations that administer residual market mechanisms or pools with assessment provisions

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advisory organization policies and procedures

_____ Contracts or agreements with applicable states for which the residual market mechanisms are administered

_____ Random sample of assessments

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

The advisory organization uses data integrity checks to test the quality of the data upon which calculation of assessments is based.

The advisory organization provides accurate and timely information to applicable state insurance departments relating to assessments made, and reporting or payment problems.

L. Residual Market Functions—Reinsurance Administration

1. Purpose

The purpose of this portion of the examination is to review the advisory organization's processes for preparing and publishing manuals, procedures and/or information for such reinsurance administration. The examiner should note that this section will not be applicable to all advisory organizations.

2. Techniques

The examiner should review communications with insurers and states relating to contracts, designations or agreements with applicable states for which the assigned risk reinsurance pooling mechanisms are administered as available and/or required. Actuarial practices and procedures for developing reserves should also be reviewed, and the examiner should verify that accurate information is being reported to member participants relating to the state's assigned risk deficit or surplus on a timely basis.

3. Tests and Standards

The residual market functions—reinsurance administration review includes, but is not limited to, the following standards. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
RESIDUAL MARKET FUNCTIONS—REINSURANCE ADMINISTRATION

Standard 1
The advisory organization uses established procedures when administering residual market pool assessments or reinsurance pooling mechanisms.

Apply to: All advisory organizations, acting as a residual market reinsurance administrator, that manage a reinsurance pooling mechanism required by statute on behalf of member participants

Priority: Essential—market of last resort

Documents and Procedures to be Reviewed

_____ Manuals, procedures and information prepared or published by the advisory organization that relate to residual market pool assessments or reinsurance

_____ Reporting of financial information

_____ Financial and accounting responsibilities

_____ Reserving practices

_____ Deficit/surplus administration

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Contracts, designations or agreements with applicable states for which the assigned risk reinsurance pooling mechanisms are administered as available and/or required.

The reinsurance administrator adheres to established actuarial practices and procedures for developing reserves.

The reinsurance administrator provides accurate information to its member participants relating to the state's assigned risk deficit or surplus on a timely basis.

The reinsurance administrator provides accurate and timely information to applicable state insurance departments relating to state deficit or surplus results on a timely basis.

M. Acceptance of Examination Report by Participating States

1. Purpose

Once the examination is complete and the examination report has been reviewed by the advisory organization and the lead states, the lead states will certify the examination. Copies of the certified examination will be distributed to the participating states; the participating states will be asked to review the report and sign off on the examination.

2. Techniques

The staff support person of the Advisory Organization (D) Working Group will distribute copies of the certified examination report to the Collaborative Action Designees (CADs) for review and approval by each CAD's state insurance commissioner. An examination certification form developed by the NAIC Legal Division will accompany a copy of the examination report. States may elect to use the supplied form, or if state statutes require modification of the form, states may modify the form to satisfy state requirements. If a state has issues with any of the findings in a report that has been certified, a state should bring these to the attention of the NAIC staff support person and the chairperson of the Advisory Organization (D) Working Group.

3. Standards for State Responses

- States should return the certification form to the NAIC staff support person responsible for the Advisory Organization (D) Working Group no later than **30 days** from the date that the state receives the examination report;
- If a state disagrees with the finding in a multistate examination, the state should advise NAIC staff and the chairperson of the Advisory Organization (D) Working Group no later than **30 days** after the examination report is published; and
- All discussions of Advisory Organization (D) Working Group findings should be kept confidential until all states have accepted the examination report.

N. Future Examinations of Examined Entity

1. Purpose

Future examinations will occur no later than five years from the start date of the most recent completed exam. If states identify particular issues at any point before the normal examination date, the Advisory Organization (D) Working Group may elect to schedule an immediate examination.

2. Techniques

The examination calendar will be reviewed by the Advisory Organization (D) Working Group during each conference call and at each NAIC national meeting. States may suggest that additional examinations be added to the examination schedule. As new advisory organizations are formed and licensed, those advisory organizations' names should be added to the examination calendar.

Chapter 30—Conducting the Third-Party Administrator Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a format for conducting third-party administrator examinations. The standards found within this chapter may not be applicable for other licensed entities—such as property and casualty and life and health companies—whose examination standards may be found elsewhere within this handbook.

The examination of a third-party administrator's operations may involve any review of one or a combination of the following business areas:

A. TPA Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Special Considerations for the Third-Party Administrator Examination
I. Contracts and Written Agreements

When conducting an exam that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the TPA is meeting standards. Some standards may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. TPA Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
TPA OPERATIONS/MANAGEMENT

Standard 1
The TPA is in compliance with applicable statutes, rules and regulations regarding financial security.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Evidence of bonding (fidelity or surety)

_____ Evidence of errors and omissions coverage

_____ Letters of credit

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Review evidence of financial security to ensure compliance with applicable statutes, rules and regulations.

B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Special Considerations for the Third-Party Administrator Examination

1. Definition of Third-Party Administrator

While the NAIC definition of TPA specifically identifies life, health and annuity products, there has been a recent increase in the number of property and casualty TPAs. In addition, some of the physician and hospital organizations, health insurance purchasing cooperatives (HIPCS), associations for member employers, administrative services only (ASO) and consulting firms providing continuing benefit administrative services, etc., are also performing administrative functions that would meet the definition of a TPA.

A TPA is someone who contracts with an entity on a third-party basis to provide employee benefit administrative services, distribute benefits for a benefit plan and/or adjudicate claims. Parties are defined as follows: (first-party) employer; (second-party) plan; and/or (third-party) entity providing administrative services. Examiners should refer to individual state statutes to determine what is and is not considered a TPA in their respective state.

The NAIC *Third-Party Administrator Statute* (#90) defines a third-party administrator (TPA) as follows:

A. "Administrator" or "third-party administrator" or "TPA" means a person who directly or indirectly underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity or health coverage offered or provided by an insurer, except any of the following:
   (1) An employer, or a wholly-owned direct or indirect subsidiary of an employer, on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of such employer;
   (2) A union on behalf of its members;

(3) An insurer that is authorized to transact insurance in this state pursuant to [insert appropriate state statutory citation];
(4) An insurance producer licensed to sell life, annuities or health coverage in this state, whose activities are limited exclusively to the sale of insurance;
(5) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;
(6) A trust and its trustees, agents and employees acting pursuant to such trust established in conformity with 29 USC Section 186;
(7) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;
(8) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent they collect and remit premiums to licensed insurance producers or to limited lines producers or authorized insurers in connection with loan payments;
(9) A credit card issuing company that advances for and collects insurance premiums or charges from its credit card holders who have authorized collection;
(10) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life, annuity or health;
(11) [Optional] An adjuster licensed by this state whose activities are limited to adjustment of claims;
(12) A person licensed as a managing general agent in this state, whose activities are limited exclusively to the scope of activities conveyed under such license; or

Drafting Note: This exception to the definition of "administrator" should be included if the state has enacted the NAIC Managing General Agents Model Act.

(13) An administrator who is affiliated with an insurer and who only performs the contractual duties (between the administrator and the insurer) of an administrator for the direct and assumed insurance business of the affiliated insurer. The insurer is responsible for the acts of the administrator and is responsible for providing all of the administrator's books and records to the insurance commissioner, upon a request from the insurance commissioner. For purposes of this paragraph, "insurer" means a licensed insurance company, prepaid hospital or medical care plan or a health maintenance organization.

Note: Many trade associations and professional organizations at the national, regional and state level offer members group benefits. Traditionally, these programs are direct member-only benefits. Typically, the sponsoring trade or professional group is the owner of the program. These programs typically are not items states should examine, due to their relationship and legal obligations to their paying members.

2. Duties of the Third-Party Administrator

There are a significant number of variations in the duties that a TPA performs. Some TPAs only collect and bill for premiums, while others may issue policies, handle claims and provide client service duties. The written agreement between a TPA and the client, applicable insurer or other related entity should provide details of the relationship between the two organizations. Some contracts may grant authority to the TPA to accept risks, assess eligibility for benefits and make management decisions on behalf of a client, applicable insurer or other related entity. If the examination team finds a violation of standards, they should determine if the TPA or the client, applicable insurer or other related entity had contractual control of the practice in question.

I. Contracts and Written Agreements

1. Purpose

The written contract between the TPA and the client, applicable insurer or other related entity is an essential document that ensures proper treatment of covered persons. Accordingly, there are standards required to ensure the agreement is adequately defining the relationship between the TPA and client, applicable insurer or other related entity.

2. Techniques

The examiner should review all written agreements between the TPA and the client, applicable insurer or other related entity to ensure they meet the standards outlined in this chapter. Most jurisdictions have statutes defining specific provisions and requirements for these written agreements.

3. Tests and Standards

The review of contracts and agreements includes, but is not limited to, the following standards addressing various aspects of a TPA's contracts. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 1
Verify written agreement(s) are executed between the TPA and client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreement(s)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Verify the contract includes the following:

- The insurer or TPA may, with written notice, terminate the written agreement for cause as provided in the agreement;
- The insurer may suspend the underwriting authority of the TPA pending any dispute regarding the cause for termination of the written agreement;
- The insurer shall fulfill any lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the insurer and the TPA; and
- Ensure an agreement is executed for each client, applicable insurer or other related entity in accordance with applicable statutes, rules and regulations.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 2
The written agreement includes a statement of duties the TPA is expected to perform on behalf of the insurer or regulated, risk-bearing entity subject to the jurisdiction of the insurance department and the lines, classes or types of insurance for which the TPA is authorized to administer.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

The agreement shall make provision with respect to underwriting or other standards pertaining to the business underwritten by the insurer.

To the extent the agreement requires a TPA to perform duties on behalf of an insurer or a regulated, risk-bearing entity subject to the jurisdiction of the insurance department, the examiner should ensure those functions are in compliance with applicable statutes, rules and regulations (e.g., underwriting, producer licensing, claims).

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 3
The written agreement between the TPA and the insurer provides for the TPA to periodically render an accounting to the client, applicable insurer or other related entity detailing all transactions performed by the TPA pertaining to the business underwritten by the client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreements

_____ Detailed accounting of transactions

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure the TPA provides an accounting of transactions to the client, applicable insurer or other related entity as required by the written agreement, in addition to applicable statutes, rules and regulations.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 4
The written agreement defines specifics of the TPA's authority to make withdrawals from financial institution accounts.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

The written agreement should include details for handling the following:

- Remittance to an insurer entitled to remittance;
- Deposit in an account maintained in the name of the insurer;
- Transfer to and deposit in a claims-paying account, with claims to be paid as provided for in applicable statutes, rules and regulations;
- Payment to a group policyholder for remittance to the insurer entitled to such remittance;
- Payment to the TPA of its commissions, fees or charges; and
- Remittance of return premium to the person or persons entitled to such return premium.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 5
If prohibited by applicable statutes, rules or regulations, the TPA does not enter into an agreement or understanding with the client, applicable insurer or other related entity to make the TPA's commissions, fees or charges contingent upon savings effective in the adjustment, settlement or payment of losses on behalf of the client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Agreement(s)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Compensation for performance for providing hospital or other auditing services is allowed.

Compensation may be based on premiums or charges collected or the number of claims paid or processed.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 6
The TPA holds all insurance charges or premiums collected on behalf of the client, applicable insurer or other related entity in a fiduciary capacity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Accounting records

_____ Financial institution account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

The following applies, per Section 7 of the NAIC *Third-Party Administrator Statute*:

Section 7. Premium Collection and Payment of Claims

A. All insurance charges or premiums collected by an administrator on behalf of or for an insurer, and the return of premiums received from that insurer, shall be held by the administrator in a fiduciary capacity. The funds shall be immediately remitted to the person entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the administrator in a federally or state insured financial institution. The written agreement between the administrator and the insurer shall provide for the administrator to periodically render an accounting to the insurer detailing all transactions performed by the administrator pertaining to the business underwritten by the insurer.

B. If charges or premiums deposited in a fiduciary account have been collected on behalf of or for one or more insurers, the administrator shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each insurer. The administrator shall keep copies of all the records and, upon request of an insurer, shall furnish the insurer with copies of the records pertaining to the deposits and withdrawals.

C. The administrator shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Withdrawals from the account shall be made as provided in the written agreement between the administrator and the insurer. The written agreement shall address, but not be limited to, the following:
   (1) Remittance to an insurer entitled to remittance;
   (2) Deposit in an account maintained in the name of the insurer;
   (3) Transfer to and deposit in a claims-paying account, with claims to be paid as provided for in Subsection D;
   (4) Payment to a group policyholder for remittance to the insurer entitled to such remittance;
   (5) Payment to the administrator of its commissions, fees or charges; and
   (6) Remittance of return premium to the person or persons entitled to such return premium.

D. All claims paid by the administrator from funds collected on behalf of or for an insurer shall be paid only on drafts or checks of and as authorized by the insurer.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 7
The TPA provides required written notices (approved by the client, applicable insurer or other related entity) to covered individuals in accordance with applicable statutes, rules and regulations.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written notices

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Notice may be required to covered individuals advising them of the identity of, and the relationship between the TPA, the policyholder and the client, applicable insurer or other related entity.

Notice may also be required for fees collected by the TPA. The reason for collection must be identified and the fee must be shown separately from any premium.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 8
The TPA delivers materials and written communications in a timely manner.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

_____ Policy files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

All policies, certificates, booklets, termination notices or other written communications delivered by the client, applicable insurer or other related entity to the TPA shall be delivered promptly after receipt of instructions from the client, applicable insurer or other related entity to deliver them.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 9
Transactions are processed accurately and completely.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure proper documentation is maintained.

Ensure that requests from the client, applicable insurer or other related entity, agent and policyholder are processed accurately, completely and as soon as reasonably possible.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 10
The TPA maintains and makes available to the client, applicable insurer or other related entity complete books and records of all transactions performed on behalf of the client, applicable insurer or other related entity.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ TPA correspondence files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure proper documentation is maintained.

Books and records should be maintained in accordance with prudent standards of insurance recordkeeping and should be maintained in accordance with applicable statutes, rules and regulations regarding record retention (or a period of not less than 5 years from the date of their creation).

In the event the TPA and the client, applicable insurer or other related entity cancel their agreement, the TPA may, by written agreement with the client, applicable insurer or other related entity, transfer all records to a new TPA rather than retain them for 5 years. In such cases, the new TPA shall acknowledge, in writing, that it is responsible for retaining the records of the prior TPA.

STANDARDS
CONTRACTS AND WRITTEN AGREEMENTS

Standard 11
The TPA uses only advertising pertaining to the business underwritten by the client, applicable insurer or other related entity that has been approved by the client, applicable insurer or other related entity in advance of its use.

Apply to: All TPAs

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written agreements

_____ Advertising

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Registration and Regulation of Third-Party Administrators, An NAIC Guideline (#1090)
Third-Party Administrator Statute (#90)

Review Procedures and Criteria

Ensure applicable advertisements are approved in accordance with the written agreements.

Chapter 31—Conducting the Examination of a Viatical Settlement Provider

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a suggested format for conducting examinations of viatical settlement providers, for state insurance departments that regulate them. The fundamental purpose of the examination is the determination of compliance with state statutes, rules and regulations governing viatical settlement providers and contracts.

Viatical settlements are state-regulated insurance activities that involve the following:

1. A life insurance contract owner enters into a contractual sale, exchange, assignment or other transfer of a life insurance policy or named beneficiary for compensation or value, thereby becoming a "viator";
2. The compensation or value is less than the expected death benefit of the insurance policy or certificate; and
3. A viator shall not be limited to mean the owner of a life insurance contract under which the insured has been diagnosed with a catastrophic or life-threatening illness or condition.

The typical transaction occurs after a life insurance policy has been in force beyond the contestable period. The policyowner and insured may be different persons. The viatical settlement may involve the transfer of all, or a portion, of the ownership of the life insurance policy, as long as ownership may be transferred. This is true for almost any type of policy, be it term, whole or universal life, or even an employer group policy.

The scope of a viatical settlement provider examination differs from that of an insurer. Viatical settlement providers arrange for the transfer of a life insurance policy in exchange for consideration. The scope of examination, therefore, should be modified to reflect this difference. There are various market conduct areas that may be covered in an examination. These include, but are not limited to:

- Provider operations/management, including licensure;
- Viatical settlement contracts and disclosure forms;
- Advertising;
- Complaint handling;
- Customer service;
- Reporting requirements; and
- Reasonableness of payments.

For the purposes of categorizing these market conduct areas in relation to the viatical settlements examination, the following viatical business areas should be reviewed:

A. Provider Operations/Management
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Viatical Settlement Contracts and Disclosures (also refer to the supplemental checklist in Section K.)
I. Viatical Settlement Transactions (also refer to the supplemental checklist in Section L.)

J. Viatical Settlement Provider Marketing and Sales (also refer to the supplemental checklist in Section M.)
K. Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2
L. Supplemental Checklist for Viatical Settlement Transactions, Standard #5
M. Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the provider is meeting standards established by applicable statutes, rules and regulations. Some standards listed in this chapter may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

The content of the notice of examination is discussed in Chapter 16—Scheduling, Coordinating and Communicating. In most instances, an examination notification and some form of pre-examination information request (coordinator's handbook, pre-examination packet or memorandum) will have been sent to the provider prior to the start of the examination. The request is a listing of those items and information essential for the conduct and completion of the examination. The request should note that any exceptions to the items requested will be specified by the Examiner-in-Charge during the examination.

The pre-examination information request listing may include the following:

1. Computer access to or listing of all viaticated policies from a state or, if a multistate examination, from all of the participating states during the time frame of the examination;
2. Computer access to or listing of all applications from a state or, if a multistate examination, from all of the participating states that were received by the provider, but were not viaticated during the time frame of the examination;
3. Insurance department complaint records and provider complaint files, as required by applicable statutes, rules or regulations;
4. Business operation forms used by the provider during the time frame of the examination. These will include disclosure forms, financing agreements, purchase agreements, notices to insurers and any other forms or form letters used to communicate with insurers, viators or any other parties to the settlement contract;
5. Advertising materials present in the state or, if a multistate examination, of all of the participating states and as required by applicable statutes, rules or regulations;
6. Any viator payment calculation formulae or forms, as required by applicable statutes, rules or regulations;
7. Annual statements or reports, as required by applicable statutes, rules or regulations;
8. Listing of agreements or contracts with other entities relating to the assignment, servicing, sale or purchase of viatical settlement contracts; and
9. Copies of filings and antifraud plans, as required by applicable statutes, rules or regulations.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

A. Provider Operations/Management

1. Antifraud Initiatives

The viatical settlement provider should have antifraud initiatives reasonably calculated to detect, prevent and report fraudulent insurance acts. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management.

Examples of possible fraudulent activity related to viaticals may include:

- "Cleansheeting" scams, whereby the viator, life insurance producer or broker obtains or sells a life insurance policy that was obtained by means of a false, deceptive or misleading application;
- "Fence posting," whereby the underlying insurance policy is issued on the life of a fictitious person or on an actual person without their knowledge;
- "Wet ink" or "wet paper" scams, whereby there is a transfer of the policy interest to a viator immediately after a policy is issued; and
- "Dirtysheeting," whereby the policy is procured by a healthy person that is transferred to a viatical provider with the insured claiming to be critically ill. The insured may submit a forged medical report from another person to the viatical settlement provider.

If the examiner notes or suspects any suspicious activity, it should be reported to the appropriate individual or agency.

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
PROVIDER OPERATIONS/MANAGEMENT

Standard 1
The viatical settlement provider has procedures for the collection and reporting of information regarding the provider's viatical settlement transactions, as required by applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Written procedures of viatical settlement provider for the collection and reporting of information

_____ Viatical settlement provider files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Information and Privacy Protection Model Act (#670)
Unfair Discrimination Against Subjects of Abuse in Life Insurance Model Act (#896)
Viatical Settlements Model Act (#697), Section 6
Viatical Settlements Model Regulation (#698), Section 6

Review Procedures and Criteria

Determine if the viatical settlement provider, broker or investment agent has established and implemented procedures for the collection and reporting of information regarding the provider's viatical settlement transactions where the viator is a resident of the state and for all states in the aggregate. The examiner may have to seek this information from other sources.

Determine if the viatical settlement provider, broker or investment agent has established procedures to safeguard the privacy of the insured's financial and medical information.

B. Complaint Handling

Not applicable.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Viatical Settlement Contracts and Disclosures

1. Purpose

The review of viatical settlement contracts and disclosure forms is designed to verify that contracts entered into with a viator have been filed with and approved by the insurance department and that the forms are reasonable and not contrary to the interests of the public.

2. Tests and Standards

The contract and disclosure review includes, but is not limited to, the following standards addressing various aspects of a viatical settlement provider's use of the viatical settlement contracts. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
VIATICAL SETTLEMENT CONTRACTS AND DISCLOSURES

Standard 1
The viatical settlement provider uses viatical settlement contracts that have been filed with and approved by the insurance department.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical contracts and related account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Sections 5 and 9

Review Procedures and Criteria

Verify that the provider maintains contracts as required by applicable statutes, rules and regulations.

Verify that the provider maintains completed copies of each contract.

Verify that contract forms have been filed with and approved by the insurance department and comply with the requirements of applicable statutes, rules and regulations.

Verify that all rescissions comply with applicable statutes, rules and regulations.

Standard 2
The viatical settlement provider complies with applicable disclosure and notice requirements.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical disclosure forms and related account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 8
Viatical Settlements Model Regulation (#698), Sections 7H and 8

Review Procedures and Criteria

Ensure that all notice and disclosure forms and documents are complete, timely presented to the proper individuals or entities and that the signatures are obtained as required by applicable statutes, rules and regulations.

Refer to the supplemental checklist in Section K of this chapter for a list of disclosure requirements.

I. Viatical Settlement Transactions

1. Purpose

The review of viatical settlement practices is designed to verify that viatical settlement providers conduct transactions in a manner that complies with applicable laws, rules and regulations.

2. Tests and Standards

The transaction review includes, but is not limited to, the following standards addressing various aspects of a provider's viatical settlement practices. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 1
The viatical settlement provider obtains and/or provides required documents relating to each viatical settlement transaction.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697)

Review Procedures and Criteria

Verify that the following items have been obtained:

- If the viator is the insured, a written statement from an attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract;
- A witnessed document, in which the viator 1) consents to the contract; 2) represents that he or she has a full and complete understanding of the contract; 3) signifies that he or she has full and complete understanding of the benefits of the life insurance policy; and 4) acknowledges that he or she is entering into the contract freely and voluntarily;
- For persons with a terminal or chronic illness or condition, acknowledgement that the insured has a terminal or chronic illness that was diagnosed after the life insurance policy was issued;
- A document in which the insured consents to the release of his or her medical records to the viatical settlement provider, viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured; and
- Notice to the insurer after a viator executes the documents necessary for the transfer, along with a copy of the viator's application for the viatical settlement contract and a request for verification of coverage. The notice should be provided in the time frame required by applicable statutes, rules and regulations.

Standard 2
The viatical settlement provider complies with applicable statutes, rules and regulations relating to the confidentiality of medical records.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

_____ Signed contracts relative to the release of confidential medical information

_____ Transactions involving the release of medical information

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Information and Privacy Protection Model Act (#670)
Viatical Settlements Model Act (#697), Section 9B
Viatical Settlements Model Regulation (#698), Sections 8B, 8C, 9A and 9B

Review Procedures and Criteria

Verify that the release of medical information is made in accordance with applicable statutes, rules and regulations.

Except as otherwise allowed or required by law, a viatical settlement provider, broker, insurance company, insurance producer, information bureau, rating agency or company or any other person with actual knowledge of an insured's identity, shall not disclose that identity to any other person unless the disclosure:

- Is necessary to effect a viatical settlement contract between the viator and viatical settlement provider, and the insured has provided prior written consent to the disclosure;
- Is necessary to effect a viatical settlement purchase agreement between the viatical settlement purchaser and a viatical settlement provider, and the insured has provided prior written consent to the disclosure;
- Is necessary to permit a financing entity to finance the purchase of policies by a viatical provider or a viatical settlement purchaser, and the insured has provided prior written consent to the disclosure;
- Is provided in response to an examination or investigation by the insurance department or any other governmental officer or agency; and
- Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider, and the insured has provided prior written consent to disclosure.

Verify the following with respect to the release of patient identifying information:

- That the patient identifying information is released in accordance with applicable statutes, rules and regulations;
- That the insured and viator have provided written consent to the release of the information at or before the time of the viatical settlement transaction;
- That the person obtaining the patient identifying information has provided a signed affirmation that the person will not further divulge the information without procuring the express written consent of the insured for the disclosure; and
- That the viatical settlement provider has established procedures to adequately inform the viator and the insured in writing, if the patient identifying information has been subpoenaed.

Standard 3
The viatical settlement provider tenders consideration in the form required by law and within 3 business days of receipt of documents necessary to effect the transaction (unless otherwise indicated in state statutes, rules or regulations).

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 9
Viatical Settlements Model Regulation (#698), Sections 7B and 7C

Review Procedures and Criteria

The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to the independent escrow agent. Within 3 business days after the date the escrow agent receives the document, the provider shall pay or transfer the proceeds into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the viatical settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgement, the escrow agent shall pay the settlement proceeds to the viator.

Failure to tender consideration to the viator for the contract within the time disclosed renders the contract voidable by the viator for lack of consideration until the time consideration is tendered and accepted by the viator.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 4
Post-settlement contacts with the insured made by the viatical settlement provider are in compliance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 9G

Review Procedures and Criteria

Verify that contacts with the insured for the purpose of determining health status are:

- Limited to no more than once every 3 months for insureds with a life expectancy of more than one 1 year; and
- Limited to no more than once per month for insureds with a life expectancy of 1 year or less.

Verify that the provider or broker has explained the procedure for making these contacts at the time the viatical settlement contract is entered into.

Verify that such contacts are logged for the purpose of documenting compliance with this provision.

Note: This information may not be available for some types of settlements.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 5
The viatical settlement provider does not engage in prohibited practices relating to the viatication of policies within the first 2-year period after issuance.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 4A

Review Procedures and Criteria

Verify that viatical settlement contracts were entered into within the guidelines of applicable statutes, rules and regulations.

Verify that proper documentation, submission of documentation that may be required and proper notification to individuals or entities has been provided as required by applicable statutes, rules and regulations for the effectuation of a viatical settlement transaction.

Verify that any assigning, transferring or pledging of any viaticated policies complies with applicable statutes, rules and regulations.

Refer to the supplemental checklist in Section L of this chapter for a list of transaction requirements.

Note: The examiner should review applicable statutes, rules and regulations to determine their state's prohibited practices.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 6
The viatical settlement provider demonstrates a pattern of reasonable payments to viators.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

_____ Other materials relative to viatical settlement reimbursement guidelines

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697), Section 4
Viatical Settlements Model Regulation (#698), Sections 5 and 9

Review Procedures and Criteria

Review payments made to viators to determine whether payments are reasonable and fair.

Review documents to ensure that life expectancies are consistent with the requirements of applicable statutes, rules and regulations.

Standard 7
Verify rescission period refund procedures and timeliness of refunds issued.

Apply to: All viatical settlement providers and viatical settlement brokers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ All requests for rescission by viators

_____ Rescission procedures and all completed rescission transactions

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697)
Viatical Settlements Model Regulation (#698)

Review Procedures and Criteria

Verify that rescission requests are handled in accordance with applicable statutes, rules and regulations.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 8
The viatical settlement provider obtains required documents prior to entering into a viatical settlement purchase agreement.

Apply to: All viatical settlement providers that do not hold 100% of the ownership and beneficiary interest in the policies it has viaticated or otherwise purchased

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files (and viatical settlement purchase agreements related to the sample)

_____ Representative sample of viatical settlement purchase agreements (and viatical settlement contracts related to the sample)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Act (#697)
Viatical Settlements Model Regulation (#698)

Review Procedures and Criteria

Verify the following items:

- Investment agent licensure, if applicable, as required by respective state statutes;
- A policy exists for the viatical settlement purchaser transaction;
- Beneficiaries and their status are included on policies in the sample;
- Proper and timely verification of coverage was received and documented; and
- Viatical settlement purchase agreements were properly documented and executed, including what ownership or beneficiary rights, if any, the viatical settlement purchaser has in the policies in the sample.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 9
The viatical settlement provider, or its representative, has procedures in place to document and resolve complaints from viators and viatical settlement purchasers.

Apply to: All viatical settlement providers and/or their representatives

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Insurance department complaint records

_____ Provider complaint files

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act (#884)
Consumer Complaints White Paper

Review Procedures and Criteria

Ensure that the provider has procedures in place to document and resolve complaints from viators and viatical settlement purchasers.

STANDARDS
VIATICAL SETTLEMENT TRANSACTIONS

Standard 10
The viatical settlement provider has antifraud initiatives in place that are reasonably calculated to detect, prevent and report fraudulent insurance acts.

Apply to: All viatical settlement providers and/or their representatives

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Procedures and antifraud plans, where required, to be submitted to the insurance department for detection and reporting of suspected fraudulent activities

_____ Representative sample of viatical settlement contract files (and viatical settlement purchase agreements related to the sample)

_____ Representative sample of viatical settlement purchase agreements (and viatical settlement contracts related to the sample)

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Insurance Fraud Prevention Model Act (#680)
Viatical Settlements Model Act (#697), Section 12

Review Procedures and Criteria

Review the provider's procedures to ensure that the licensee avoids transactions where the insurance policy was obtained by means of a false, deceptive or misleading application.

Review the provider's procedures to ensure compliance with fraud reporting, education and training requirements in the state where the viatical settlement occurred or where business is conducted. Antifraud initiatives shall include fraud investigators, who may be viatical settlement provider or broker employees or independent contractors.

Determine that antifraud plans are submitted to the insurance department, where required by applicable statutes, rules and regulations. Such plans shall include procedures for reporting possible fraudulent viatical settlement acts to the insurance department, a description of the plan for antifraud education and training, and a description or chart outlining organization arrangement of antifraud personnel responsible for investigation and reporting fraud. Antifraud plans shall be privileged and confidential.

A person in the business of viatical settlement shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

Viatical settlement contracts and purchase agreement forms shall include the following or substantially similar fraud warning statement:

> "Any person who knowingly presents false information in an application for insurance or viatical settlement contract or viatical settlement purchase agreement is guilty of a crime and may be subject to fines and confinement in prison."

Any person engaged in the business of viatical settlements having knowledge or reasonable belief that a fraudulent viatical settlement act is or will be committed must notify the insurance department.

J. Viatical Settlement Provider Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the company about its product(s). Examiners should review representations to ensure that viatical settlement providers and viatical settlement brokers provide prospective viators and purchasers with clear and unambiguous statements in advertisements. Guidelines for advertising viatical settlement contracts or purchase agreements include Internet and media advertising viewed by persons located in the examining department's state. The advertising review is not typically based on sampling techniques, but it can be. The areas to be considered in this kind of review include all written, visual and verbal advertising and sales materials.

2. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 1
The viatical settlement provider does not discriminate in the making or solicitation of viatical settlements.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of viatical settlement contract files

_____ Representative sample of viatical settlement contracts declined

_____ Marketing and sales material

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Viatical Settlements Model Regulation (#698), Section 7D

Review Procedures and Criteria

Determine whether the viatical settlement provider exhibits a pattern of discrimination in the making or solicitation of viatical settlement contracts on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation.

Determine whether the viatical settlement provider exhibits a pattern of discrimination in the making or solicitation of viatical settlement contracts between viators with and without dependents.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 2
The viatical settlement provider pays finder's fees, commission or other compensation in accordance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Commission or compensation records or reports

_____ Representative sample of viatical settlement contract files

_____ Other materials relative to the payment of commissions or other compensation paid to entities related to the viatical settlement transaction

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Regulation (#698), Section 7E

Review Procedures and Criteria

Determine if the viatical settlement provider pays any finder's fees, commission or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator with respect to the viatical settlement.

Note: This language as written, "any other person acting as an agent of the viator," includes the viatical settlement broker, because they are technically an agent of the viator and receive compensation.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 3
The viatical settlement provider solicits viatical settlement purchasers in accordance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Marketing and solicitation materials

_____ Representative sample of viatical settlement contract files

_____ Other materials relative to the solicitation of viatical settlement purchasers

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Regulation (#698), Section F

Review Procedures and Criteria

Determine if the viatical settlement provider knowingly solicits viatical settlement purchasers who have treated, or have been asked to treat, the illness of the insured whose coverage would be the subject of the viatical settlement purchase.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 4
The viatical settlement provider has an established system of control over the content, form and dissemination of all advertisements of its contracts, products and services.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advertising and solicitation materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Viatical Settlements Model Regulation (#698), Section 11B

Review Procedures and Criteria

Review advertisements to ensure that proper notification requirements and procedures for approval are provided to any person disseminating any advertisements on behalf of the licensee.

STANDARDS
VIATICAL SETTLEMENT PROVIDER MARKETING AND SALES

Standard 5
The viatical settlement provider advertises in accordance with applicable statutes, rules and regulations.

Apply to: All viatical settlement providers

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Advertising and solicitation materials

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Unfair Trade Practices Act (#880)
Viatical Settlements Model Regulation (#698)

Review Procedures and Criteria

Determine if all advertising materials have been filed with the insurance department, if required by applicable statutes, rules and regulations.

Review all advertising and solicitation materials to determine if the material is truthful and not misleading by fact or implication.

Refer to the supplemental checklist in Section M for a list of marketing and sales requirements.

K. Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2

Yes	No	Requirement
No later than at the time of application, the viatical settlement provider or the provider's representative shall disclose the following to the viator:		
		If the provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate the change of ownership or beneficiary to the insured within 20 days after the change.
		The viatical settlement purchase agreement is voidable by the purchaser at any time within 3 days after the disclosures mandated are received by the purchaser.
		Possible alternatives to viatical settlement contracts for individuals with catastrophic, life threatening or chronic illnesses, including any accelerated death benefits or policy loans offered under the viator's life insurance policy.
		Some or all of the proceeds may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.
		Proceeds of the viatical settlement could be subject to the claims of creditors.
		Receipt of the proceeds may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.
		The viator has the right to rescind a viatical settlement contract within 15 calendar days after receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans and loan interest to the viatical settlement provider or purchaser.
		Funds will be transferred to the viator within 3 business days after the viatical settlement provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
		Entering into a contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial advisor.
		Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The NAIC's form for the brochure shall be used, unless one has been developed by the insurance department.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2 (cont'd)

Yes	No	Requirement
		The disclosure document shall contain the following language: "All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."
		The insured may be contacted by the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every 3 months if the insured has a life expectancy of more than 1 year, and no more than once per month if the insured has a life expectancy of 1 year or less.
Prior to the date the contract is signed by all parties, the viatical settlement provider or the provider's representative shall disclose the following to the viator:		
		State the affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated.
		The document shall include the name, address and telephone number of the viatical settlement provider.
		A viatical settlement broker shall disclose to a prospective viator the amount and method of calculating the broker's compensation. The term "compensation" includes anything of value paid or given to the viatical settlement broker for the placement of a policy.
		If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement.
		The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the viatical settlement provider's interest in those benefits.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2 (cont'd)

Yes	No	Requirement
		State the name, business address and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.
A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following information prior to the date the agreement is signed by all parties:		
		The purchaser will receive no returns (i.e., dividends and interest) until the insured dies.
		The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual "guaranteed" rate of return is not determinable.
		The viaticated life insurance contract should not be considered a liquid purchase, because it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.
		The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.
		The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party shall also be disclosed.
		The purchaser is responsible for payment of the insurance premiums or other costs related to the policy if the insured returns to health. Disclose the amount of such premiums, if applicable.
		State the name and address of any person providing escrow services and the relationship to the broker.
		Disclose the amount of any trust fees or other expenses to be charged to the viatical settlement purchaser.
		State whether the purchaser is entitled to a refund of all or part of his or her investment under the settlement contract, if the policy is later determined to be null and void.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2 (cont'd)

Yes	No	Requirement
		Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.
		Disclose the risks associated with policy contestability, including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.
		Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid.
		Describe the experience and qualifications of the person who determines the life expectancy of the insured (i.e., in-house staff, independent physicians and specialty firms that weigh medical and actuarial data), the information this projection is based on and the relationship of the projection-maker to the viatical settlement provider, if any.
		Distribute to investors a brochure describing the process of investment in viatical settlements. The NAIC's form for the brochure shall be used, unless one has been developed by the insurance department.
A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following no later than at the time of the assignment, transfer or sale:		
		Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.
		State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.
		State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums, if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

Supplemental Checklist for Viatical Settlement Contracts and Disclosures Standard #2 (cont'd)

Yes	No	Requirement
		Disclose the type of policy offered or sold (i.e., whole life, term life, universal life or a group policy certificate), any additional benefits contained in the policy and the current status of the policy.
		If the policy is term insurance, disclose the special risks associated with term insurance, including, but not limited to, the purchaser's responsibility for additional premiums, if the viator continues the term policy at the end of the current term.
		State whether the policy is contestable.
		State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are and under what conditions these rights are activated.
		State the name and address of the person responsible for monitoring the insured's condition. Describe how often the insured's condition is monitored, how the date of death is determined and how and when this information will be transmitted to the purchaser.

L. Supplemental Checklist for Viatical Settlement Transactions, Standard #5

Yes	No	Requirement
The viatical settlement provider or viatical settlement broker shall not enter into a viatical settlement contract within a 2 year period after issuance of a life insurance policy or certificate, unless the viator certifies that one or more of the following conditions have been met:		
		The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.
		The viator is a charitable organization exempt from taxation under 26 USC §501(c)(3).
		The viator is not a natural person (e.g., the owner is a corporation, limited liability company, partnership, etc.).
		(1) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the 2 year period:
		• The viator or insured is terminally or chronically ill;
		• The viator's spouse dies;
		• The viator divorces his or her spouse;
		• The viator retires from full-time employment;
		• The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;
		• The viator was the insured's employer at the time the policy or certificate was issued and the employment relationship terminated;
		• A final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a receiver, trustee or liquidator to all or a substantial part of the viator's assets;
		• The viator experiences a significant decrease in income that is unexpected and that impairs the viator's reasonable ability to pay the policy premium; or
		• The viator or insured disposes of his or her ownership interests in a closely held corporation.

Supplemental Checklist for Viatical Settlement Transactions, Standard #5 (cont'd)

Yes	No	Requirement
		(2) Copies of the independent evidence described in (1) above and documents required by Section 9A of the model act shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.
		The viatical settlement provider shall submit to the insurer a copy of the owner or insured's certification described in (1) and (2) above when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfied the requirements of this section, and the insurer shall timely respond to the request.

M. Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5

Yes	No	Requirement
Advertisements shall not make the following representations:		
		That viatical settlement contracts are "guaranteed," "fully secured," "100 percent secured," "fully insured," "secure," "safe," "backed by rated insurance companies," "backed by federal law," "backed by state law," "backed by state guaranty funds" or similar representations.
		That viatical settlement contracts are "no risk," "minimal risk," "no speculation," "no fluctuation" or similar representations.
		That viatical settlement contracts are "qualified or approved for individual retirement accounts" or otherwise qualified for other tax-deferred retirement-type accounts.
		That viatical settlement contract returns, principal, earnings, profit or investments are "guaranteed."
		That there are no sales charges or fees, or similar representations.
		That viatical settlement contracts provide "high yield," "superior return," "excellent return," "high return," "quick profit" or similar representations.
		Purport favorable representations or testimonials about the benefits of viatical settlement contracts or viatical settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and TV programs, and all other forms of print and electronic media.

Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5 (cont'd)

Yes	No	Requirement
Verify that all advertising and solicitation material contains the disclosures required by applicable statutes, rules and regulations in a manner that is not minimized, obscure, ambiguous or misleading. An advertisement shall not:		
		Omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving viators, purchasers or prospective purchasers as to the nature or extent of any benefit, loss covered, premium payable or state or federal tax consequence. "Free look" periods shall not remedy misleading statements.
		Use the name or title of a life insurance company or policy, unless the advertisement has been approved by the insurer.
		Represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a viatical settlement contract or viatical settlement purchase agreement in order to maintain that policy, unless that is a fact.
		State or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable or in any manner an incorrect or improper practice.
		Falsely use the words "free," "no cost," "without cost," "no additional cost," "at no extra cost" or words of similar import regarding any benefit or service. An advertisement may specify the charge for a benefit or service or may state that a charge is included in the payment or use other appropriate language.
		Contain statistical information, unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.
		Disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services or methods of marketing.
		Fail to identify the name of the viatical settlement licensee, the contract form number and application and, if the application is part of the advertisement, identify the viatical settlement provider.
		Use a trade name, group designation name or the parent company name of a viatical settlement licensee, service mark, slogan, symbol or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract or purchase agreement.
		Use any combination of words, symbols or physical materials that would mislead prospective viators or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5 (cont'd)

Yes	No	Requirement
		Imply that competing viatical settlement licensees may not be licensed. An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears or may ask the audience to consult its website or contact the state insurance department to check on licensing status.
		Create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims or the merits, desirability or advisability of its contracts or purchase agreement forms are recommended or endorsed by any government entity.
		Directly or indirectly create the impression that any division or agency of the state or U.S. government endorses, approves or favors 1) any viatical settlement licensee or its practices or methods of operation; 2) the merits, desirability or advisability of any contract or purchase agreement; 3) any viatical settlement contract or purchase agreement; or 4) any life insurance policy or life insurance company.
		Emphasize the speed that the viatication will occur, unless the average time from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator are disclosed.
		Emphasize the dollar amounts available to viators, unless the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past 6 months is disclosed.

Chapter 32—Conducting the Premium Finance Company Examination

IMPORTANT NOTE:
The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guide to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in the Foreword section of the handbook.

This chapter provides a suggested format for conducting examinations of premium finance companies for state insurance departments that regulate such companies. The fundamental purpose of the examination of an insurance premium finance company is the determination of compliance with state statutes, rules and regulations governing premium financing transactions.

The scope of a premium finance company examination differs from that of an insurer. Premium finance companies finance insurance premiums, they do not provide insurance. The scope of examination, therefore, should be modified to reflect this difference. There are various market conduct areas that may be covered in an examination. These include, but are not limited to:

A. Operations/Management, including licensure
B. Complaint Handling
C. Marketing and Sales
D. Producer Licensing
E. Policyholder Service
F. Underwriting and Rating
G. Claims
H. Premium Finance Agreements
I. Borrower Complaints
J. Customer Service

When conducting an examination that reviews these areas, there are essential tests that should be completed. The tests are applied to determine if the company is meeting standards established by applicable statutes, rules and regulations. Some standards listed in this chapter may not be applicable to all jurisdictions. The standards may suggest other areas of review that may be appropriate on an individual state basis.

When an examination involves a depository institution or their affiliates, the bank may also be regulated by federal agencies such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). Many states have executed an agreement to share complaint information with one or more of these federal agencies. If the examination results find adverse trends or a pattern of activities that may be of concern to a federal agency and there is an agreement to share information, it may be appropriate to notify the agency of the examination findings.

The content of the notice of examination is discussed in Chapter 16—Scheduling, Coordinating and Communication. In most instances, an examination notification and some form of pre-examination information request (coordinator's handbook, pre-examination packet or memorandum) will have been sent to the company prior to the start of the examination. The request is a listing of those items and information essential for the conduct and completion of the examination. The request should note that any exceptions to the items requested will be specified by the Examiner-in-Charge during the examination. The memorandum listing may include the following:

1. Computer access or listing of all active and paid out agreements during the time frame of the examination;
2. Computer access or listing of all agreements canceled during the time frame of the examination;
3. Insurance department complaint records;
4. Business operation forms used by the company during the time frame of the examination. These include:
    - Premium finance agreement with power-of-attorney;
    - Notice of premium finance agreement;
    - Notice of intent to cancel;
    - Notice of cancellation;
    - Reinstatement request; and
    - Any other forms or form letters used to communicate with insurers, borrowers or producers, as required by applicable statutes, rules and regulations.
5. Rate and adjustment schedules, as required by applicable statutes, rules and regulations;
6. Annual operations report, as required by applicable statutes, rules and regulations; and
7. Listing of agreements or contracts with other entities relating to the assignment, servicing, sale or purchase of premium finance agreements.

A. Operations/Management

Use the standards for this business area that are listed in Chapter 20—General Examination Standards, in addition to the standards set forth below.

STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
Company does not pay any compensation to producers if such payment is prohibited by applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Company financial statement

_____ Producer files

_____ Disbursements to producer for non-premium items

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Review insurance department complaint files.

B. Complaint Handling

Not applicable.

C. Marketing and Sales

Not applicable.

D. Producer Licensing

Not applicable.

E. Policyholder Service

Not applicable.

F. Underwriting and Rating

Not applicable.

G. Claims

Not applicable.

H. Premium Finance Agreements

1. Purpose

The premium finance agreements portion of the examination is designed to review the documentation of the principal product of the premium finance company. It is based on sampling techniques. It is concerned with individual application of the rules applying to its product rather than overall structure.

The review of premium finance agreements and account information enables determination of the company's compliance in several areas, including the following:

a. Acceptance of completed agreements;
b. Notification and funding;
c. Correct calculation of finance charges;
d. Financing of insurance products;
e. Proper cancellation procedures;
f. Correct calculation of unearned finance charges; and
g. Collection practices in regard to unearned premiums and commissions.

2. Techniques

Special attention should be directed toward the company's cancellation procedures. The use of correct forms, correct calculation of unearned interest, collection practices and prompt returns of any moneys due borrowers is essential for compliance.

3. Tests and Standards

The premium finance agreements review includes, but is not limited to, the following standards addressing various aspects of a company's use of the agreements. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 1
Company maintains individual account records in compliance with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements and related account records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that the company maintains agreements as required by applicable statutes, rules and regulations.

Ensure that the company maintains completed agreements, which must contain power-of-attorney language and be signed by or on behalf of the borrower, or by the borrower, if required by applicable statutes, rules and regulations.

Ensure that the company maintains a copy of the power-of-attorney.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 2
Notification and funding procedures are in compliance with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements

_____ Notifications required by applicable statutes, rules and regulations

_____ Disbursement records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if wording used in notifications provides adequate notification.

Ensure the disbursement is in accordance with applicable statutes, rules and regulations.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 3
Products that the company is financing comply with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine whether the agreement distinguishes between primary coverage and add-on products.

Ensure that add-on products meet state-specific limitations and disclosures. Add-on products may include motor/travel clubs, auto medical supplementary plans, etc.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 4
Agency fees are not financed, if prohibited; or, if permitted to be financed, agency fees are properly disclosed, if required by applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if premium finance agreements distinguish between premium for insurance coverage and producer fees or charges.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 5
The company uses the appropriate forms for premium finance agreements.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

If forms are subject to approval, ensure that the approved forms are used.

Ensure that the forms contain a clearly worded power-of-attorney.

Verify that the required disclosures are made on appropriate forms.

Verify that the forms include the premium finance company's address and telephone number, if required, and the producer's name.

If the forms are not subject to approval, ensure that the premium finance agreement complies with applicable statutes, rules and regulations.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 6
The company makes a diligent effort to obtain completed agreements.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that the premium finance agreements contain no material blank spaces.

Verify that there is evidence the premium finance company sought correct information for any incomplete agreement.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 7
The company charges the correct finance charge. The interest rate charged complies with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of all premium finance agreements

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the rate of interest charged is in compliance with applicable statutes, rules and regulations.

Confirm the finance charge calculation is correct.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 8
Notice of intent to cancel procedures is handled correctly, including the use of the proper forms.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements canceled during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if borrowers are provided the required period of notice of company intent to cancel for nonpayment of the loan.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 9
Notice of cancellation procedures are handled correctly, including the use of the proper forms.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements canceled during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Notice of cancellation procedures can only be used if a premium finance company has been assigned the right to cancel by the borrower. Ensure that the premium finance company received such authorization in the premium finance agreement or otherwise.

Verify that the approved forms are used. If approval is not required, verify that appropriate forms are used.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 10
Insurer and producer returns of unearned premiums and commissions comply with applicable statutes, rules and regulations.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Sample of premium finance agreements canceled during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if insurer and producer returns are made in a timely manner to the premium finance company following cancellation for nonpayment of the loan.

Note: If it is determined that insurer and producer returns are not made in a timely manner to the premium finance company, it is not a violation by the premium finance company. The noncomplying insurers and producers should be reported to the Examiner-in-Charge for further investigation and examination into their refund practices.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 11
Unearned interest is calculated correctly.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements prepaid during the time frame of the examination

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the premium finance company's unearned interest calculations are in accordance with applicable statutes, rules and regulations.

STANDARDS
PREMIUM FINANCE AGREEMENTS

Standard 12
Refunds due borrowers are calculated accurately and paid in a timely manner.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Representative sample of premium finance agreements prepaid during the time frame of the examination

_____ Disbursement logs or register or other evidence of payment of refund

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine the average time for disbursement of refunds.

Ensure that the reasons for delay are documented, and determine if the company has a standard for timeliness on refunds.

I. Borrower Complaints

1. Purpose

The borrower complaints portion of the examination is designed to evaluate company responsiveness to borrower complaints arising from its product. It is typically based on sampling techniques. The NAIC definition of "complaint" is "any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose."

2. Techniques

The examiner should review the company's procedures for processing borrower or other related complaints. Specific problem areas may necessitate an overall review of a particular segment of the company's operation.

A review of complaint handling may incorporate both borrower direct complaints to the company and complaints filed with the insurance department. A random sample of complaints should be selected for review from the company's complaint register. If such a register is not maintained, alternative methods of isolating complaints may be implemented.

The examiner should review the frequency of similar complaints and be aware of any pattern of specific type of complaints. The examiner should take into consideration the increase of complaints that typically follows a catastrophe. Should the type of complaints generated be cause for unusual concern, specific measures should be instituted to investigate other areas of the company's operations. This may include modifying the scope of examination to examine specific company behavior.

The examiner should review the NAIC Complaints Database System (CDS) to determine the company's complaint index, along with any adverse trends in complaint volume. The examiner may wish to review complaint trends and the complaint index for the preceding 3 years.

The examiner should review the final disposition of the complaints and determine if the company has taken adequate steps to finalize the complaint. The examiner should determine if the actions taken are in compliance with applicable statutes, rules and regulations.

In states that have established a statutory or regulatory standard of promptness, a study should be conducted to determine how promptly the company responds to complaints, the adequacy of the responses and what, if any, actions were taken to resolve the problems.

If the examination involves a depository institution or their affiliates, it may also be regulated by a federal agency such as the Office of the Comptroller of the Currency (OCC), the Federal Reserve Board, the Office of Thrift Supervision (OTS) or the Federal Deposit Insurance Corporation (FDIC). If the state has signed an agreement to share complaint information with these agencies, any adverse trends or pattern of concern to the examiners may be identified and relayed to the agency.

3. Tests and Standards

The complaints review includes, but is not limited to, the following standards addressing various aspects of a company's handling of complaints. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
BORROWER COMPLAINTS

Standard 1
The company responds to inquiries from the insurance department appropriately and in a timely manner.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Borrower complaint registers, files and logs or other complaint records

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the company responds to the insurance department within the time frame required by applicable statutes, rules and regulations.

Determine if any directives from the insurance department have been followed and completed as required.

Reconcile the company complaint register with a list of complaints from the insurance department.

STANDARDS
BORROWER COMPLAINTS

Standard 2
The company complaint files demonstrate fair treatment of borrowers.

Apply to: All premium finance companies

Priority: Essential

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Borrower complaint files and complaint logs

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Ensure that the company is maintaining adequate documentation. Review borrower complaint files and complaint logs to make sure the company is:

- Recording all complaints (both borrower-direct and insurance department); and
- Recording required information in the company complaint register.

Review manuals to verify complaint procedures exist. Ensure that the procedures in place are sufficient to require satisfactory handling of complaints received, as well as internal procedures for analysis by the areas of the company that handle complaints.

Determine if there is a method for the distribution of and the obtaining and recording of responses to complaints. This method should be sufficient to allow a response within the time frame required by applicable statues, rules and regulations.

Determine if the company responds in the time frame required by applicable statutes, rules and regulations.

Ensure that the company provides a telephone number and address for borrower inquiries.

Review complaint documentation to determine if the company's response fully addresses the issues raised. If the company did not properly address/resolve the complaint, the examiner should ask the company what corrective action it intends to take.

J. Customer Service

1. Purpose

The customer service portion of the examination is designed to test a company's compliance with applicable statutes, rules and regulations regarding notice/billing, delays/no response, cancellation and refunds.

2. Techniques

Customer service departments vary from company to company. It is important to check with the examination coordinator to determine where the borrower service function lies and then apply the following tests to determine the effectiveness of the unit.

3. Tests and Standards

The customer service review includes, but is not limited to, the following standards related to the adequacy and level of customer service provided by the company. The sequence of the standards listed here does not indicate priority of the standard.

STANDARDS
CUSTOMER SERVICE

Standard 1
Reinstatement request is applied consistently and in accordance with premium finance agreement provisions.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Premium finance agreement files

_____ Notice of reinstatement

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Verify that the notice was sent out in a timely manner, if required by applicable statutes, rules and regulations.

Reinstatement should be applied per the premium finance agreement provisions, if any.

STANDARDS
CUSTOMER SERVICE

Standard 2
Procedures for handling unclaimed property are proper.

Apply to: All premium finance companies

Priority: Recommended

Documents to be Reviewed

_____ Applicable statutes, rules and regulations

_____ Premium finance agreement files

_____ Unpaid payees of returned refund checks

Others Reviewed

_____ _____

_____ _____

NAIC Model References

Review Procedures and Criteria

Determine if the company has a proper procedure that handles unclaimed property.

The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

For more information, visit **naic.org**.