

# Market Regulation Handbook

VOLUME II

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2017

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NAIC Executive Office  
440 North Capitol Street, NW  
Washington, DC 20001  
202.471.3990

NAIC Central Office  
1100 Walnut Street  
Suite 1500  
Kansas City, MO 64106  
816.842.3600

NAIC Capital Markets  
& Investment Analysis Office  
One New York Plaza, Suite 4210  
New York, NY 10004  
212.398.9000

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### Examination Standards Summary

Designed to serve as a compilation of the market conduct examination standards found in chapters 16–28 of the *Market Regulation Handbook*. Arranged and organized by chapter and area of examination, regulated entities might find this summary useful in creating an outline for internal review templates. Please note: This summary does not represent examination standards, methodologies and areas of review that could be utilized by an insurance department.



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## Market Regulation Handbook

2017 Edition

Volume II

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

The holder of this manual may enter a password-protected NAIC website at [www.naic.org](http://www.naic.org) to access this information:

- Select Committees.
- Go to the Committees, Task Forces & Working Groups section of the web page and click on the “+” sign next to the Market Regulation and Consumer Affairs (D) Committee section to expand it. Then click on the Market Conduct Examination Standards (D) Working Group link.
- On the Market Conduct Examination Standards (D) Working Group web page, click on the link Market Regulation Handbook Updates and Reference Documents and enter the user ID and password referenced below.

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## Chapter 20—Conducting the Health Examination

### Introduction

The examination standards in Chapter 20—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 20A—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 20A. 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 20 and Chapter 20A. In the event of duplication or conflict of examination standards between the chapters, the examination standards and review criteria located in Chapter 20A—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 20A—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 20A 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 16—General Examination Standards for general examination standards that apply to all insurers.

### 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 guideline to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination. Further important information on this and how to use this handbook is included in Chapter 1—Introduction.**

This chapter provides a format for conducting 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. Check for 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 procedure.

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 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 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 (IIPRC) on behalf of a compacting state, it is important to keep in mind that the uniform standards—and not state-specific statutes, rules and regulations—are applicable to the content and approval of the product. The IIPRC website is [www.insurancecompact.org](http://www.insurancecompact.org) and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a completed reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards).

**A. Operations/Management**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

**B. Complaint Handling**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

**C. Marketing and Sales**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**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.

**STANDARDS  
MARKETING AND SALES**

**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*

**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 provision 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 long-term care 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.

Not for Distribution

**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**

**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 long-term care 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 16—General Examination Standards.

**E. Policyholder Service**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**STANDARDS  
POLICYHOLDER SERVICE**

**Standard 1**  
**Reinstatement is applied consistently and in accordance with policy provisions.**

**Apply to:** All 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.

Not for Distribution

**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)

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\_\_\_\_\_

**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 benefit 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:

- Explanation 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 “spouse” 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 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**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.

Not for Distribution

**STANDARDS  
UNDERWRITING AND RATING**

**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.

Not for Distribution

**STANDARDS  
UNDERWRITING AND RATING**

**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 cannot 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.

Not for Distribution

**STANDARDS  
UNDERWRITING AND RATING**

**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.

**STANDARDS  
UNDERWRITING AND RATING**

**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.

Not for Distribution

**STANDARDS  
UNDERWRITING AND RATING**

**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 (#25)*

**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 following 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.

**STANDARDS  
UNDERWRITING AND RATING**

**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.

Not for Distribution

**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 covers 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 the 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 on 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.)

**STANDARDS  
UNDERWRITING AND RATING**

**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 (#109)*

**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.

Not for Distribution

**G. Claims**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**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 Acts, Unfair Claims Settlement Practices Act and Unfair 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 (#300)*
- Consumer Credit Insurance Model Regulation (#370)*
- Coordination of Benefits Model Regulation (#120)*
- 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)*
- Health Maintenance Organization Model Act (#430)*

**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 ERISA. 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 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.

Not for Distribution

**STANDARDS  
CLAIMS**

**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 (#900)*

*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.

**STANDARDS  
CLAIMS**

**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 increase 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.

**STANDARDS  
CLAIMS**

**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.

Not for Distribution

## 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.

Not for Distribution

**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 and 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.

Not for Distribution

**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., notices, 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.

Not for Distribution

**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**

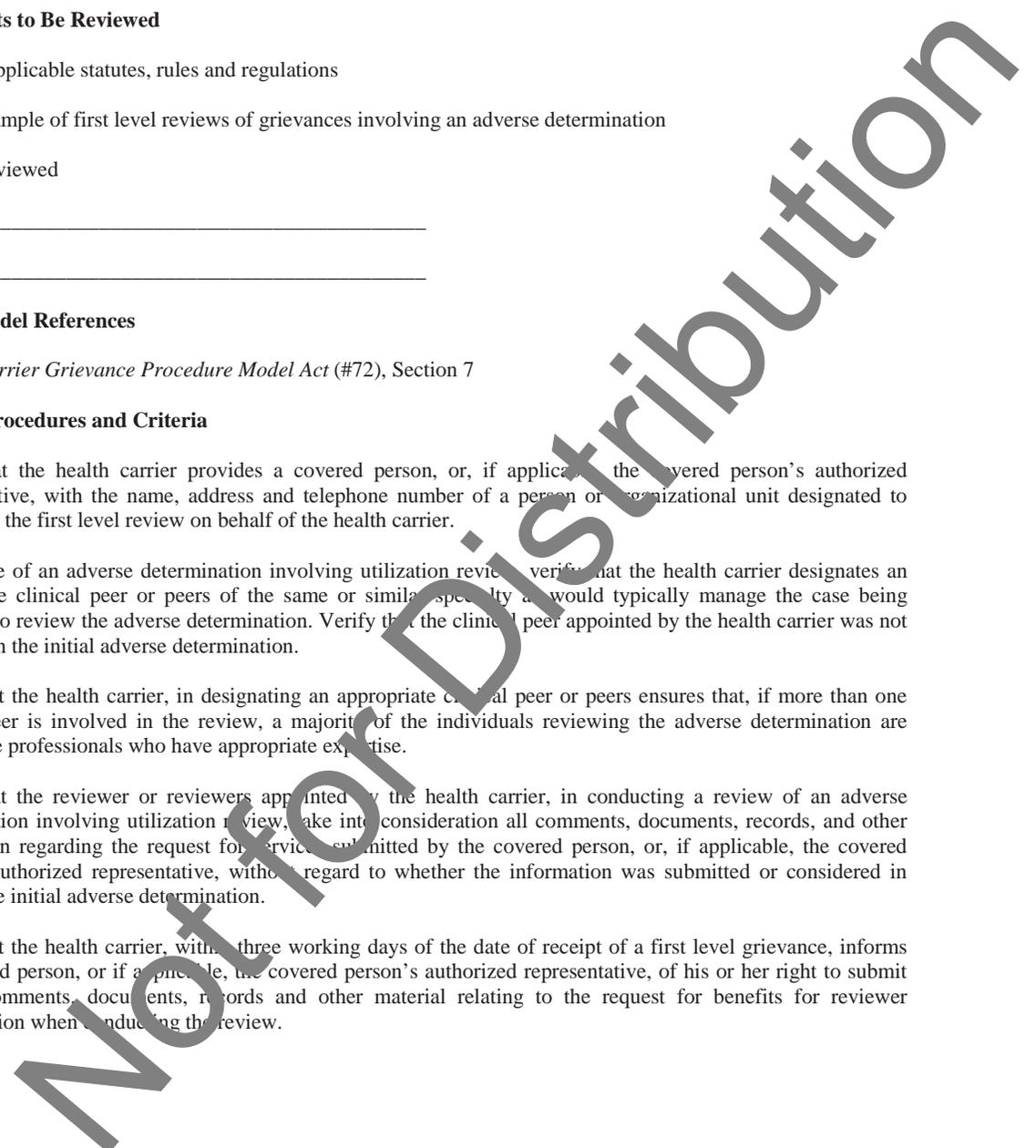
Verify that the health carrier provides a covered person, or, if applicable, the covered person's authorized representative, with the name, address and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier.

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, and 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 4*

**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 to 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.

Not for Distribution

**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, 2011.

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.

Not for Distribution

**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 9*

**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.

Not for Distribution

## 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.

Not for Distribution

**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 literacy; 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.

Not for Distribution

**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.

Not for Distribution

**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)*

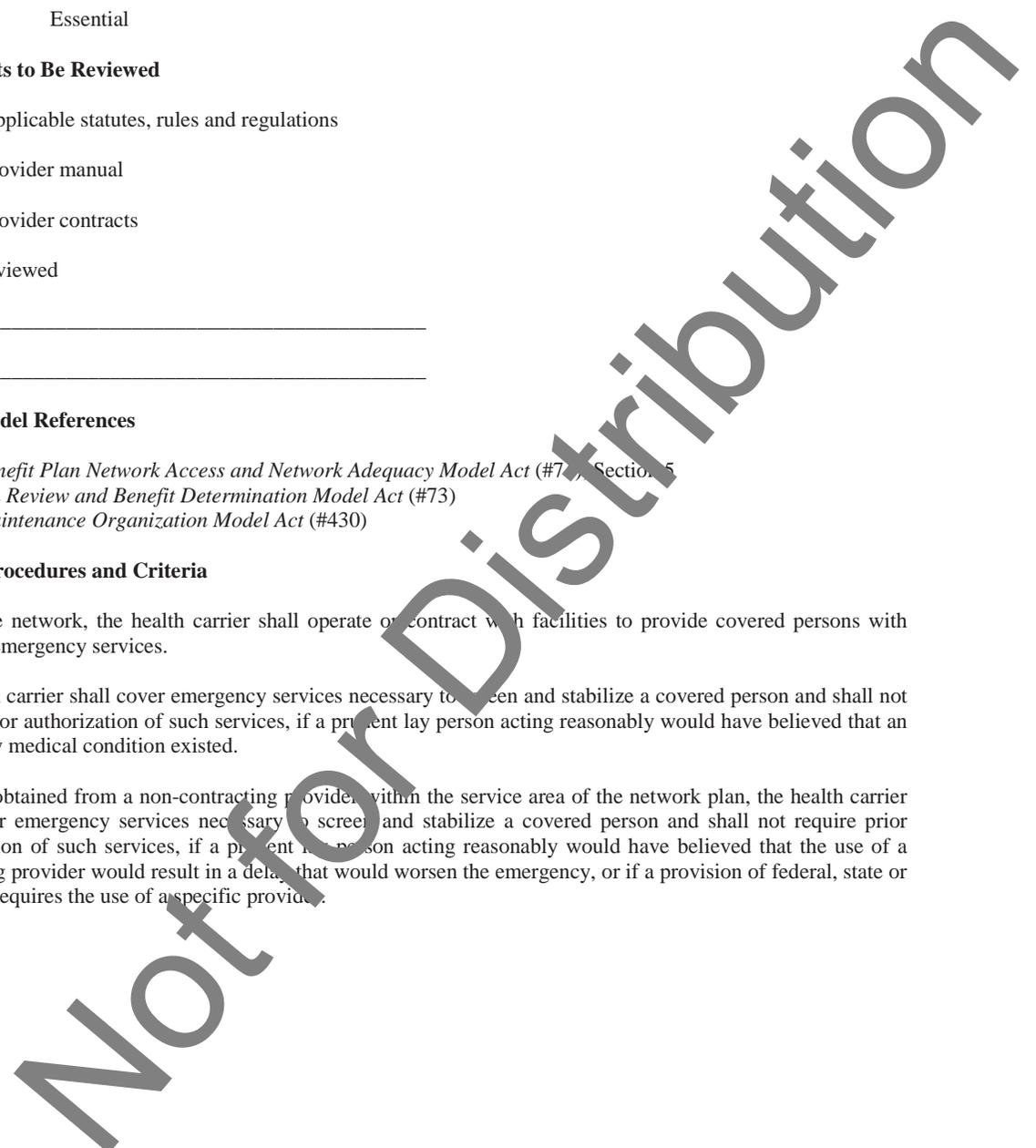
*Health Maintenance Organization Model Act (#430)*

**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).

Not for Distribution

**STANDARDS  
NETWORK ADEQUACY**

**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 and 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.

- 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.

Not for Distribution

**STANDARDS  
NETWORK ADEQUACY**

**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 provider 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.

**STANDARDS  
NETWORK ADEQUACY**

**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.

Not for Distribution

## 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 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.

Not for Distribution

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.

Not for Distribution

**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.

Not for Distribution

**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 B*  
*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.

Not for Distribution

**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).

Not for Distribution

**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.

Not for Distribution

**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 a guarantee 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 carriers
- \_\_\_\_\_ Minutes of the health carrier’s credentialing committee
- \_\_\_\_\_ Minutes of the health carrier’s board of directors

Others Reviewed

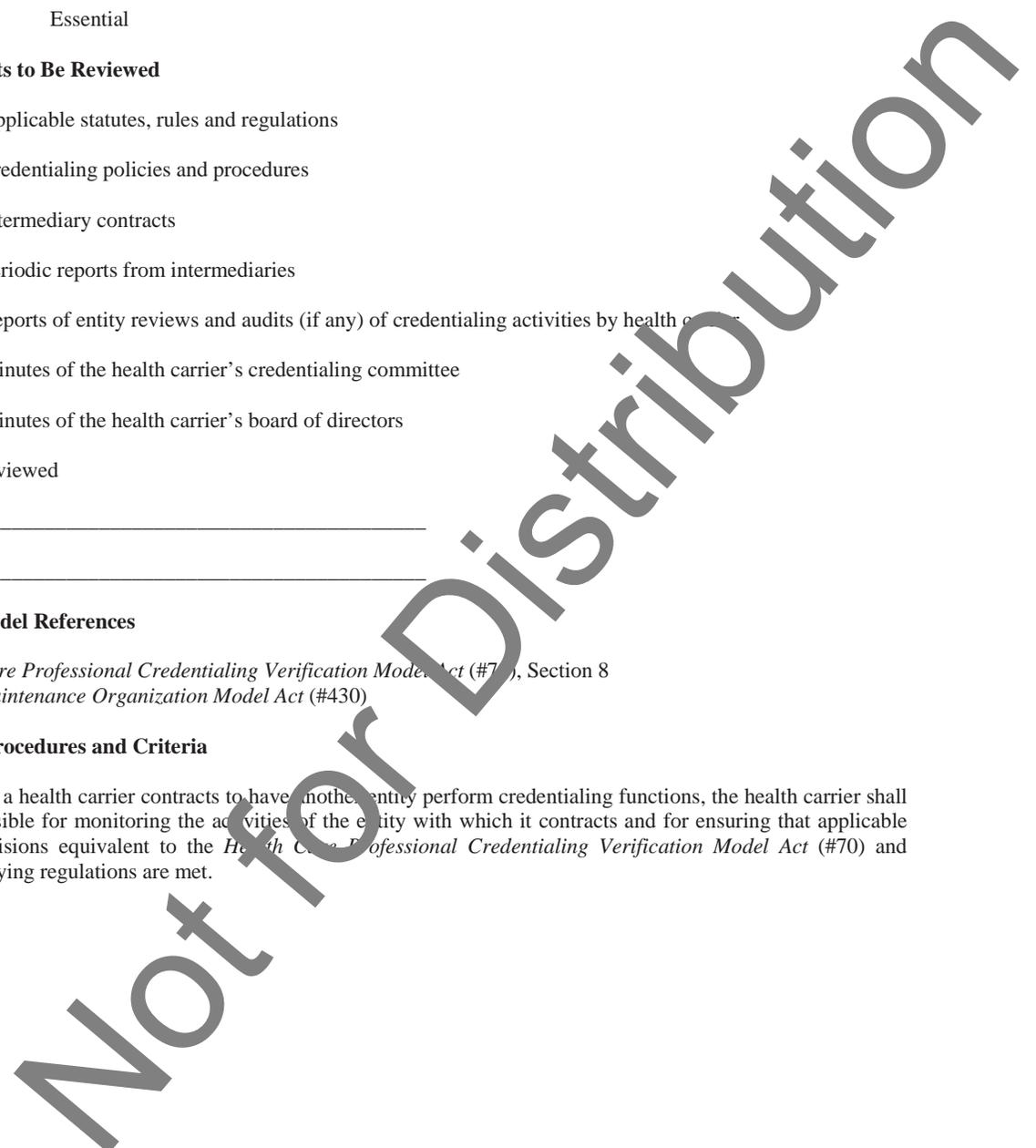
- \_\_\_\_\_
- \_\_\_\_\_

**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 a 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.

Not for Distribution

**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.

Not for Distribution

**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

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.

Not for Distribution

**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.

Not for Distribution

**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 the 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.

Not for Distribution

**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**

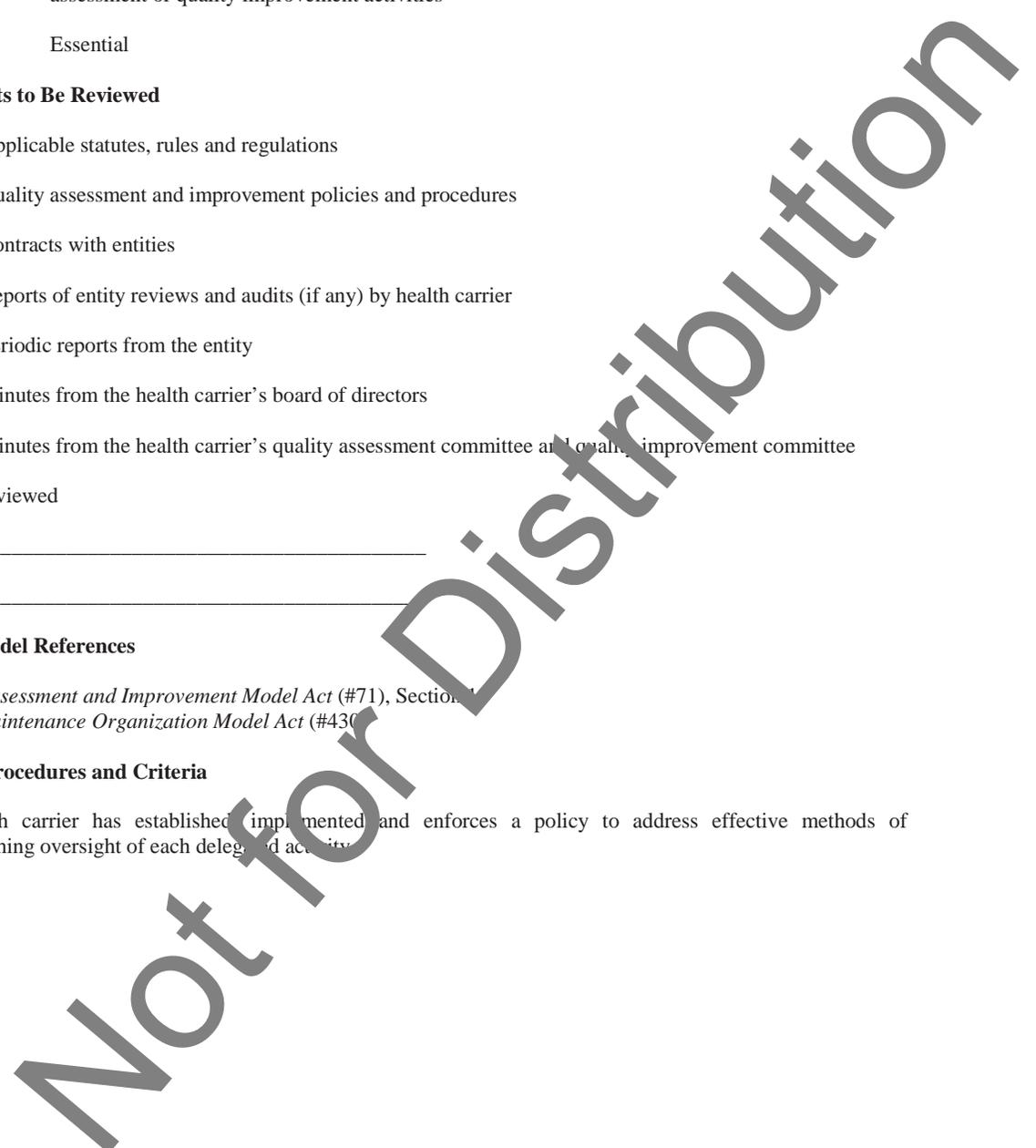
- \_\_\_\_\_
- \_\_\_\_\_

**NAIC Model References**

*Quality Assessment and Improvement Model Act (#71), Section 1*  
*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.

Not for Distribution

**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 subject to utilization review, implements a written utilization review program that describes all review activities, both delegated and nondelegated for:

- The timing 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.

Not for Distribution

**STANDARDS  
UTILIZATION REVIEW**

**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 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.

Not for Distribution

**STANDARDS  
UTILIZATION REVIEW**

**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 (#10), 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.

Not for Distribution

**STANDARDS  
UTILIZATION REVIEW**

**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 (2005), Section 2*

**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, and 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.

**STANDARDS  
UTILIZATION REVIEW**

**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 (#72), 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.

Not for Distribution

**STANDARDS  
UTILIZATION REVIEW**

**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 (#10), 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 in 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.

**STANDARDS  
UTILIZATION REVIEW**

**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 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.

Not for Distribution

**M. External Review**

Use the standards set forth below.

Not for Distribution

**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 Act (#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 14  
*Health Maintenance Organization Model Act (#400)*  
*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 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.

Not for Distribution

**STANDARDS  
EXTERNAL REVIEW**

**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

\_\_\_\_  
\_\_\_\_

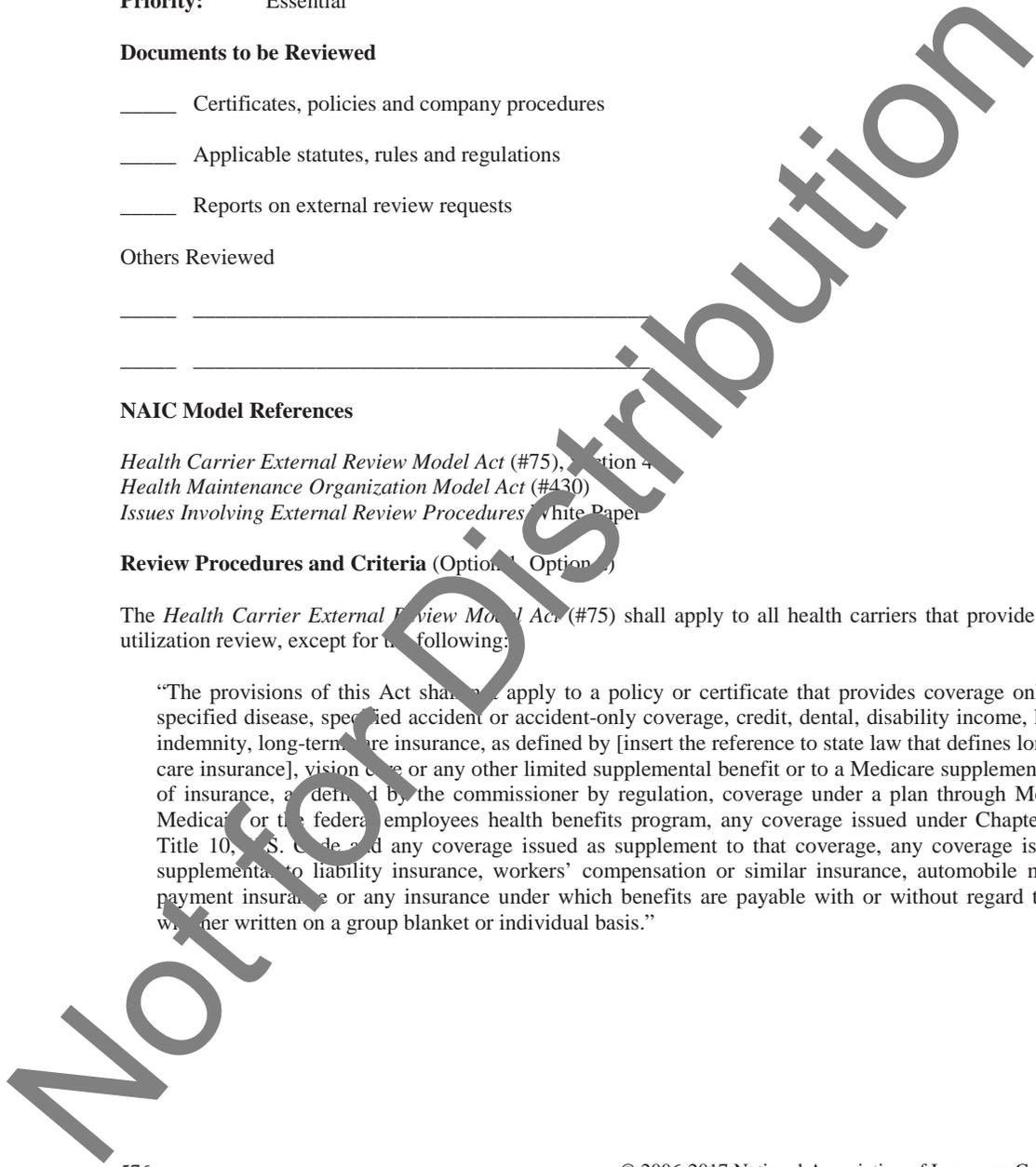
**NAIC Model References**

*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.

Not for Distribution

**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.

Not for Distribution

**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. <b>(Section 2A)</b>			
	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. <b>(Section 2B)</b>			
	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. <b>(Section 2C)</b>			
	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 the Section <b>(Section 4)</b>			
	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. <b>(Section 5A)</b>			

Not for Distribution

**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. <b>(Section 5B)</b>			
	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. <b>(Section 5C)</b>			
	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. <b>(Section 5D)</b>			
	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." 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. <b>(Section 5E)</b>			
	An advertisement that is an invitation to contract <sup>32</sup> 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. <b>(Section 7A)</b>			

<sup>32</sup> 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
	<p>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.” <b>(Section 7B)</b></p>			
	<p>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. <b>(Section 7C)</b></p>			
	<p>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.</p> <p>(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.</p> <p>(2) An advertisement for a policy that provides for stepped 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. <b>(Section 7D)</b></p>			

Not for Distribution

**Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)**

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>An insurer, directly or through its agents or brokers, shall:</p> <p>(1) Establish marketing procedures to assure that any comparison of policies by its agents or brokers will be fair and accurate;</p> <p>(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</p> <p>(3) Establish auditable procedures for verifying compliance with this subsection. <b>(Section 8A)</b></p>			
	<p>In addition to the practices prohibited in [insert reference to state law equivalent to the <i>Unfair Trade Practices Act</i> (#880)], the following acts and practices are prohibited:</p> <p>(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;</p> <p>(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 implicit, or undue pressure to purchase or recommend the purchase of insurance; and</p> <p>(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. <b>(Section 8B)</b></p>			
	<p>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. <b>(Section 9A)</b></p>			

Not for Distribution

## Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>A person shall be deemed a “spokesperson” if the person making the testimonial or endorsement:</p> <p>(1) Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise;</p> <p>(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;</p> <p>(3) Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or</p> <p>(4) Is in any way directly or indirectly compensated for making a testimonial or endorsement. <b>(Section 9B)</b></p>			
	<p>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. <b>(Section 9C)</b></p>			
	<p>The source of any statistics used in an advertisement shall be identified in the advertisement. <b>(Section 10C)</b></p>			
	<p>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. <b>(Section 11B)</b></p>			

## 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 through a combination of policies. <b>(Section 11C)</b>			
	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 identity of the insurer. <b>(Section 14A)</b>			
	Advertisements used by agents, producers, brokers or solicitors of an insurer shall have prior written approval of the insurer before they may be used. <b>(Section 14L)</b>			
	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. <b>(Section 14M)</b>			
	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. <b>(Section 15E)</b>			

**Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)**

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>Advertising File.</p> <p>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 another 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. <b>(Section 18A)</b></p>			
	<p>Certificate of Compliance.</p> <p>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. <b>(Section 18B)</b></p>			
	<p>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:</p> <p>(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</p> <p>(2) Otherwise violates the provisions of this regulation. <b>(Section 5F)</b></p>			

Not for Distribution

## 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. <b>(Section 5G)</b>			
	Covered Benefits. (1) The use of deceptive words, phrases or illustrations in advertisements of accident and sickness insurance is prohibited. <b>(Section 6A)</b>			
	(2) An advertisement that fails to state clearly the type of insurance coverage being offered is prohibited. <b>(Section 6A)</b>			
	(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, 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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			

**Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)**

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>(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. <b>(Section 6A)</b></p>			
	<p>(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:</p> <p>(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;</p> <p>(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</p> <p>(iii) The advertisement prominently displays a total benefit limit that would not, as a general rule, be payable under an average claim.</p> <p>(b) This paragraph does not apply to individual major medical expense coverage, individual basic medical expense coverage or disability income insurance. <b>(Section 6A)</b></p>			
	<p>(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. <b>(Section 6A)</b></p>			

Not for Distribution

## 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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(15) An advertisement that implies that a common type of policy or a combination of common benefits is “new,” “unique,” “a bonus,” “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. <b>(Section 6A)</b>			

## 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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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 policy is a substantial cost in the marketing by direct response. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			

## 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. <b>(Section 6A)</b>			
	(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 or rate 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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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 benefit. This provision shall not apply to institutional advertisements. <sup>33</sup> <b>(Section 6A)</b>			

<sup>33</sup> 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. <b>(Section 6A)</b>			
	(28) An advertisement that describes any benefits that vary by age shall disclose that fact. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			
	(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. <b>(Section 6A)</b>			

Not for Distribution

**Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)**

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>(32) An advertisement, including invitations to inquire<sup>34</sup> 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:</p> <p>(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;</p> <p>(b) The exaggeration of the importance of diseases rarely or seldom found in the class of persons to whom the policy is offered;</p> <p>(c) The use of phrases such as “the finest kind of treatment,” implying that the treatment would be unavailable without insurance;</p> <p>(d) The reproduction of newspaper articles, magazine articles, information from the Internet or other similar published material containing irrelevant facts and figures;</p> <p>(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;</p> <p>(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;</p> <p>(g) The use of phrases or devices that unduly excite fear of dependence upon relatives or charity; and</p> <p>(h) The use of phrases or devices that imply that long sicknesses or hospital stays are common among the elderly. <b>(Section 6A)</b></p>			

<sup>34</sup> 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. <b>(Section 6B)</b>			
	(2) An advertisement that is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy. <b>(Section 6B)</b>			
	(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. <b>(Section 6B)</b>			
	(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.” <b>(Section 6B)</b>			
	(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. <b>(Section 6B)</b>			
	(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 conditions of health, income or other economic conditions, or other underwriting standards of the insurer if that is the fact. <b>(Section 6B)</b>			

## 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. <b>(Section 6B)</b>			
	(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. <b>(Section 6B)</b>			
	(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. <b>(Section 6B)</b>			
	(10) An advertisement that fails to disclose any waiting or elimination periods for specific benefits is prohibited. <b>(Section 6B)</b>			
	(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.” <b>(Section 6B)</b>			

## Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>Preexisting Conditions</p> <p>(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. <b>(Section 6C)</b></p>			
	<p>(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. <b>(Section 6C)</b></p>			
	<p>(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:</p> <p>“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”</p> <p>Or substantially the following statement:</p> <p>“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.” <b>(Section 6C)</b></p>			

## 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. <b>(Section 9D)</b>			
	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. <b>(Section 9E)</b>			
	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. <b>(Section 9F)</b>			

## Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>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.</p> <p>(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.</p> <p>(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. <b>(Section 10A)</b></p>			
	<p>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. <b>(Section 10B)</b></p>			
	<p>An advertisement that uses the word “plan” without prominently identifying it as an accident and sickness insurance policy is prohibited. <b>(Section 11A)</b></p>			

**Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)**

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>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.</p> <p>An advertisement shall not contain statements such as “no red tape” or “here is all you do to receive benefits.” <b>(Section 12A)</b></p>			
	<p>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 coverage. <b>(Section 12B)</b></p>			
	<p>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. <b>(Section 12C)</b></p>			
	<p>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. <b>(Section 12D)</b></p>			
	<p>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. <b>(Section 13B)</b></p>			
	<p>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. <b>(Section 13C)</b></p>			

Not for Distribution

## 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. <b>(Section 14B)</b>			
	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. <b>(Section 14C)</b>			
	An advertisement shall not use the name of a state or political subdivision of a state in a policy name or description. <b>(Section 14D)</b>			
	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. <b>(Section 14E)</b>			
	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. <b>(Section 14F)</b>			
	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. <b>(Section 14G)</b>			

## 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. <b>(Section 14H)</b>			
	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. <b>(Section 14I)</b>			
	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. <b>(Section 14J)</b>			
	An insurer shall not use, in the trade name of its insurance policy, any terminology or words so similar to the name of governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser. <b>(Section 14K)</b>			
	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. <b>(Section 15A)</b>			
	This regulation prohibits the solicitation 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. <b>(Section 15B)</b>			
	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. <b>(Section 15C)</b>			

## 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. <u>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.</u> (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
	<p>(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. <b>(Section 16A)</b></p>			
	<p>(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. <b>(Section 16A)</b></p>			
	<p>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 insurability; 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. <b>(Section 16A)</b></p>			

Not for Distribution

**Checklist of NAIC Advertisements of Accident and Sickness Insurance Model Regulation (cont'd)**

Applies to State?	Review Criteria	Pass	Fail	N/A
	<p>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. <b>(Section 16B)</b></p>			
	<p>C. Special awards, such as a “safe driver’s award,” shall not be used in connection with advertisements of accident and sickness insurance. <b>(Section 16C)</b></p>			
	<p>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. <b>(Section 17)</b></p>			

Not for Distribution

Not for Distribution

## Chapter 20A—Conducting the Affordable Care Act (ACA) Related Examination

### Introduction

The intent of Chapter 20A—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 20A 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 20—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 20A applies only to QHPs; NAIC models related to the ACA are set forth separately under each examination standard in Chapter 20A. 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 20 and Chapter 20A. In the event of duplication or conflict of examination standards between the chapters, examination standards and review criteria located in Chapter 20A—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 16—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 >> Market Regulation 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 Market Conduct Examination Standards (D) Working Group web page, which is found at [www.naic.org](http://www.naic.org) >> **Committees >> Committees, Task Forces & Working Groups >> Market Regulation and Consumer Affairs (D) Committee >> Market Conduct Examination Standards (D) Working Group >> Market Regulation Handbook Updates and Reference Documents**. Please use the user ID and password located at the front of the most recently published *Market Regulation Handbook* when accessing the *Market Regulation Handbook Updates and Reference Documents* link.

### **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 >> Market Regulation 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 at [www.naic.org](http://www.naic.org) >> **Committees >> Committees, Task Forces & Working Groups >> Market Regulation and Consumer Affairs (D) Committee >> Market Conduct Examination Standards (D) Working Group >> Market Regulation Handbook Updates and Reference Documents >> Standardized Data Requests**. Please use the user ID and password located at the front of the most recently published *Market Regulation Handbook* when accessing the *Market Regulation Handbook Updates and Reference Documents* link.

**ACA-RELATED MARKET CONDUCT EXAMINATION STANDARDS**

<b>ACA Provision</b>	<b>PHSA Citation</b>
(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
(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

Not for Distribution

**PROVISION TITLE:** Coverage for Individuals Participating in Approved Clinical Trials

**CITATION:** PHS A §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 requirements 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 PHS A §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 PHS A §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 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 or 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

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**NAIC Model References**

*Individual Market Health Insurance Coverage Model Act (#36)*  
*Small Group Market Health Insurance Coverage Model Act (#106)*

**Other References**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 registers/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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**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 spouse; 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 employer plan, including the dental and vision coverage.

**FAQs:** See the HHS website for 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

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**NAIC Model References**

*Individual Market Health Insurance Coverage Model Act (#36)*  
*Small Group Market Health Insurance Coverage Model Act (#106)*

**Other References**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 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.

Not for Distribution

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 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**PROVISION TITLE:** Direct Access to Providers

**CITATION:** PHS §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, 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 guidance.

**NOTES:**

Not for Distribution

**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

#### **NAIC Model References**

*Individual Market Health Insurance Coverage Model Act (#36)*  
*Small Group Market Health Insurance Coverage Model Act (#106)*

#### **Other References**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

#### **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 or 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 actions 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted as set forth in federal law.

**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

**NAIC Model References**

*Individual Market Health Insurance Coverage Model Act (#36)*  
*Small Group Market Health Insurance Coverage Model Act (#106)*

## Other References

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

## 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**PROVISION TITLE:** Essential Health Benefits

**CITATION:** PHS §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 the 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 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/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

## 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

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

## 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 is 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 rehabilitative 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 health 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 abuse 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 §2706 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 62240), 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
- Substantially equal 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 prescription drug coverage 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state specific requirements to the health reform requirements or create a more generous benefit, and that are not preempted, as set forth in federal law.

Not for Distribution

**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 guidance.

**NOTES:**

Not for Distribution

**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

**NAIC Model References**

*Small Group Market Health Insurance Coverage Model Regulation (#126)*

**Other References**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 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 when 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 provide 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**PROVISION TITLE:** Grievance Procedures

**CITATION:** PHS § 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 PHS § 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 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**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**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**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 filing 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**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**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 appeal 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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.

Not for Distribution

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 service 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**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 market 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 market 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 guidance.

**NOTES:**

Not for Distribution

**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

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

## 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 undue 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 on 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;
- An 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 issue 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, which 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 §147.115, 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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 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

Not for Distribution

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

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

### 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 market 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.

#### Group Plans—Special Enrollment Periods

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 small 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 small employers to enroll at any time during the year, including outside of the annual small group open enrollment period, and that the carrier does not place any unallowable enrollment restrictions on small employers.

Verify that any enrollment restrictions that may be allowable outside of the annual small group enrollment period (such as minimum participation and minimum contribution requirements) are applied by the carrier in a consistent manner to all small 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 toward 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 U.S.C. §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 employee 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 small employers applying for coverage outside of the Nov. 15 to Dec. 15 small 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 to 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 a small employer, that applies for coverage outside of the Nov. 15 to 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, U.S.C. 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 U.S.C. 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 a small 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 a small employer at any time after the small 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 small group market health insurance coverage if the health carrier elects not to offer new coverage to small 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 small employers in the applicable state has provided notice of its election to the commissioner and does not write new business in the small group market in the applicable state for a period of five 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 education 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 material to verify that information provided therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted as set forth in federal law.

**PROVISION TITLE:** Guaranteed Renewability of Coverage (Individual and Small Group Market Health Insurance)

**CITATION:** PHS §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 guidance.

**NOTES:**

Not for Distribution

**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 § 17.140

This standard does not apply to transitional plans

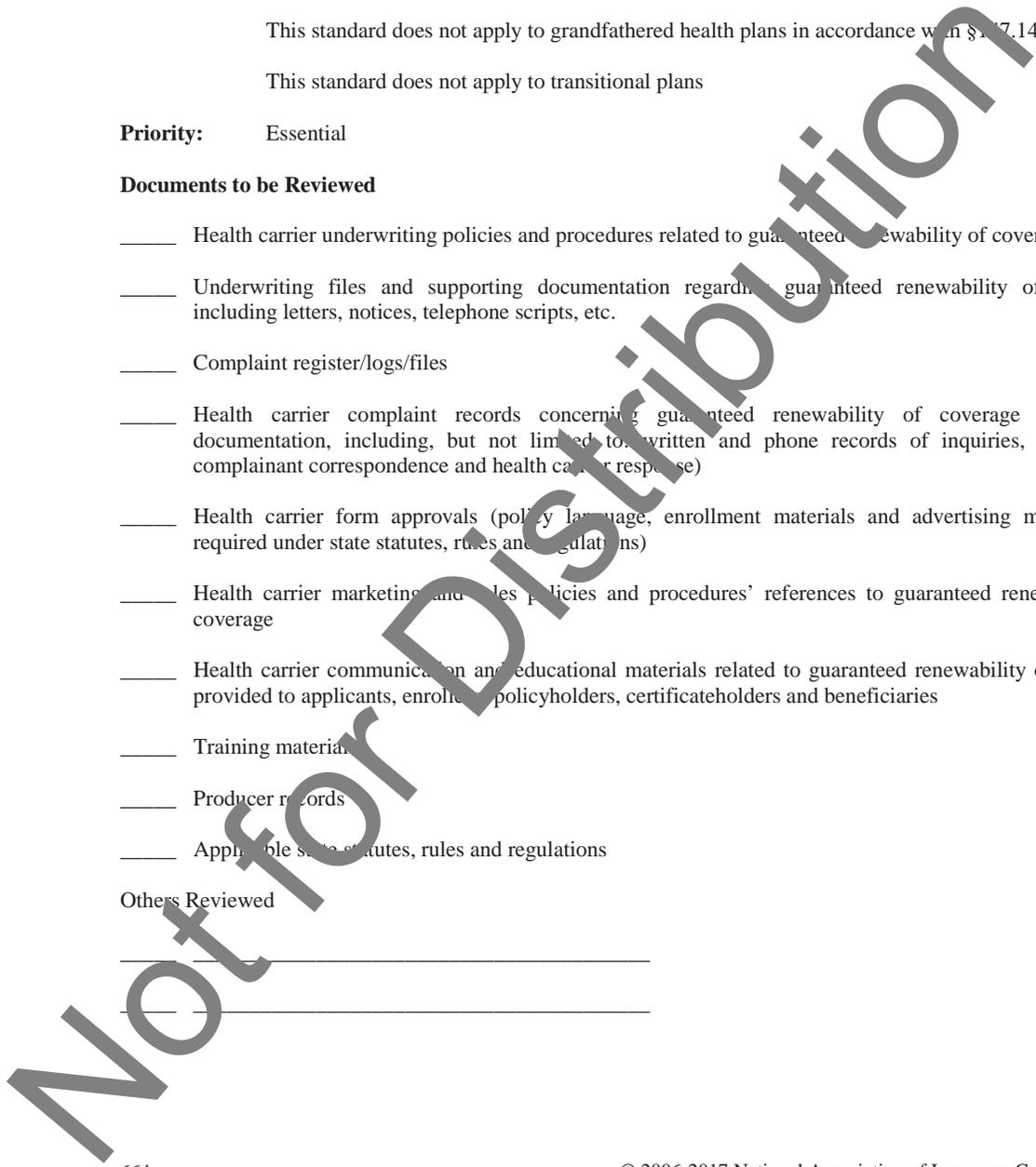
**Priority:** Essential

**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, enrolled policyholders, certificateholders and beneficiaries
- \_\_\_\_\_ Training materials
- \_\_\_\_\_ Producer records
- \_\_\_\_\_ Applicable state statutes, rules and regulations

**Others Reviewed**

\_\_\_\_\_  
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**NAIC Model References**

*Individual Market Health Insurance Coverage Model Regulation (#26)*

*Individual Market Health Insurance Coverage Model Act (#36)*

**Other References**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 policyholder
- 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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

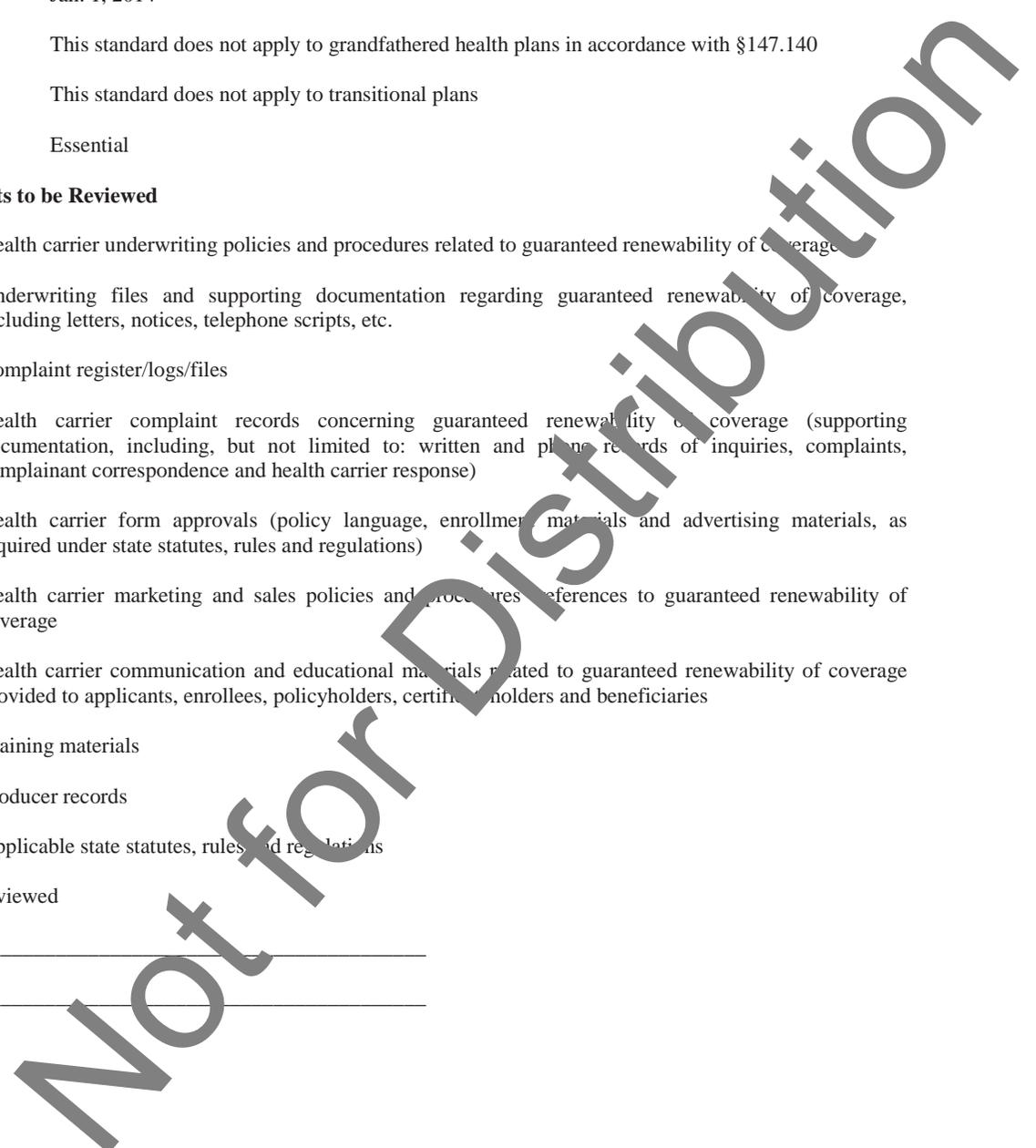
**Documents to be Reviewed**

- \_\_\_\_\_ 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, certificate holders and beneficiaries
- \_\_\_\_\_ Training materials
- \_\_\_\_\_ Producer records
- \_\_\_\_\_ Applicable state statutes, rules and regulations

**Others Reviewed**

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### NAIC Model References

*Small Group Market Health Insurance Coverage Model Act (#106)*

*Small Group Market Health Insurance Coverage Model Regulation (#126)*

### Other References

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

### 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 removal of coverage, or continuation of coverage, in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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, 2010, 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 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 guidance.

**NOTES:**

Not for Distribution

**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 claim 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**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 in proper application of lifetime/annual limits on the dollar amount of essential health benefits for 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 a 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:

- \$50,000, 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
- \$1,000,000, 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 PPACA-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 PPACA-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 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 PPACA-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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**PROVISION TITLE:** Prohibition on Preexisting Condition Exclusions

**CITATION:** PHS A §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).

Notes: 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 20A 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 guidance.

**NOTES:** For additional examination standards related to preexisting condition exclusions, please review the section of Chapter 20—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**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FROs and other federal resource materials

**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 the 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 20—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 90 calendar days, pursuant to 45 CFR §147.104 and §155.420 for qualified individuals (and their dependents, where 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 to 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 toward 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 U.S.C. §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 the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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 pre-existing 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
- \_\_\_\_\_ Applications/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**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 the health carrier error could have been 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted as set forth in federal law.

**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 established 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 (PPACA), 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 guidance.

**NOTES:**

Not for Distribution

**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 ratings
- \_\_\_\_\_ 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**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**Review Procedures and Criteria**

Verify that the health carrier has established written complaint handling policies and procedures regarding compliance with PPACA-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 PPACA-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 PPACA-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 PPACA-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 September 2012, located at [www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date);
- 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](http://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 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 PPACA-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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**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 FAQs website for guidance.

**NOTES:**

Not for Distribution

**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

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**NAIC Model References**

*Individual Market Health Insurance Coverage Model Act (#36)*  
*Small Group Market Health Insurance Coverage Model Act (#106)*

**Other References**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 assistants. (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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). Also, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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**

- \_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

### 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**PROVISION TITLE:** Summary of Benefits and Coverage (SBC) and Uniform Glossary

**CITATION:** PHS A §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 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 SBC 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 those 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 SBC 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

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

### 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 of 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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its system 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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

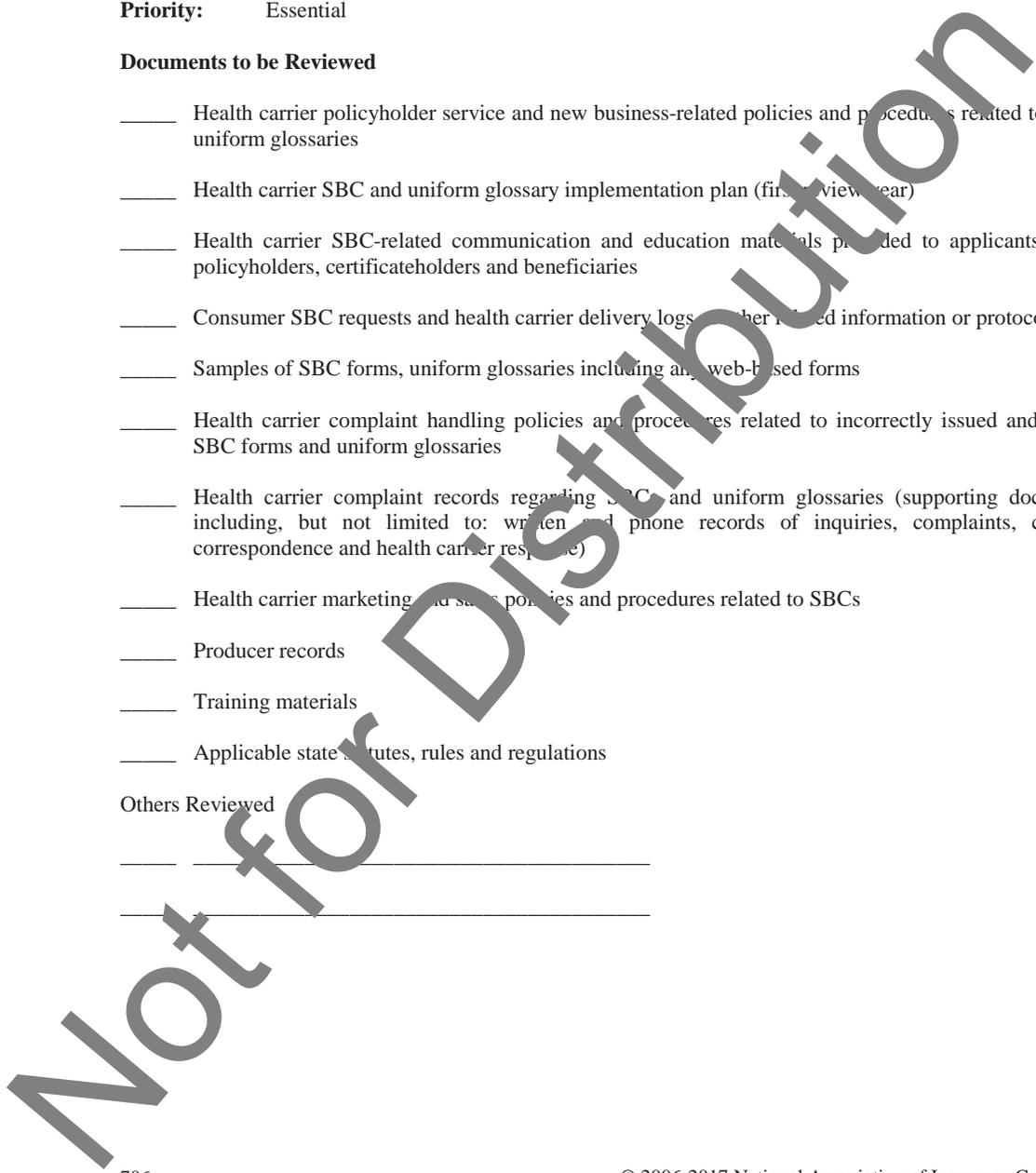
**Priority:** Essential

**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, 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**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). Also determine if the health carrier implemented appropriate corrective actions/adjustments to its system 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 therein 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**PROVISION TITLE:** Utilization Review

**CITATION:** PHS A §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 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 (# 3)*

**Other References**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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, 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 that 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**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**

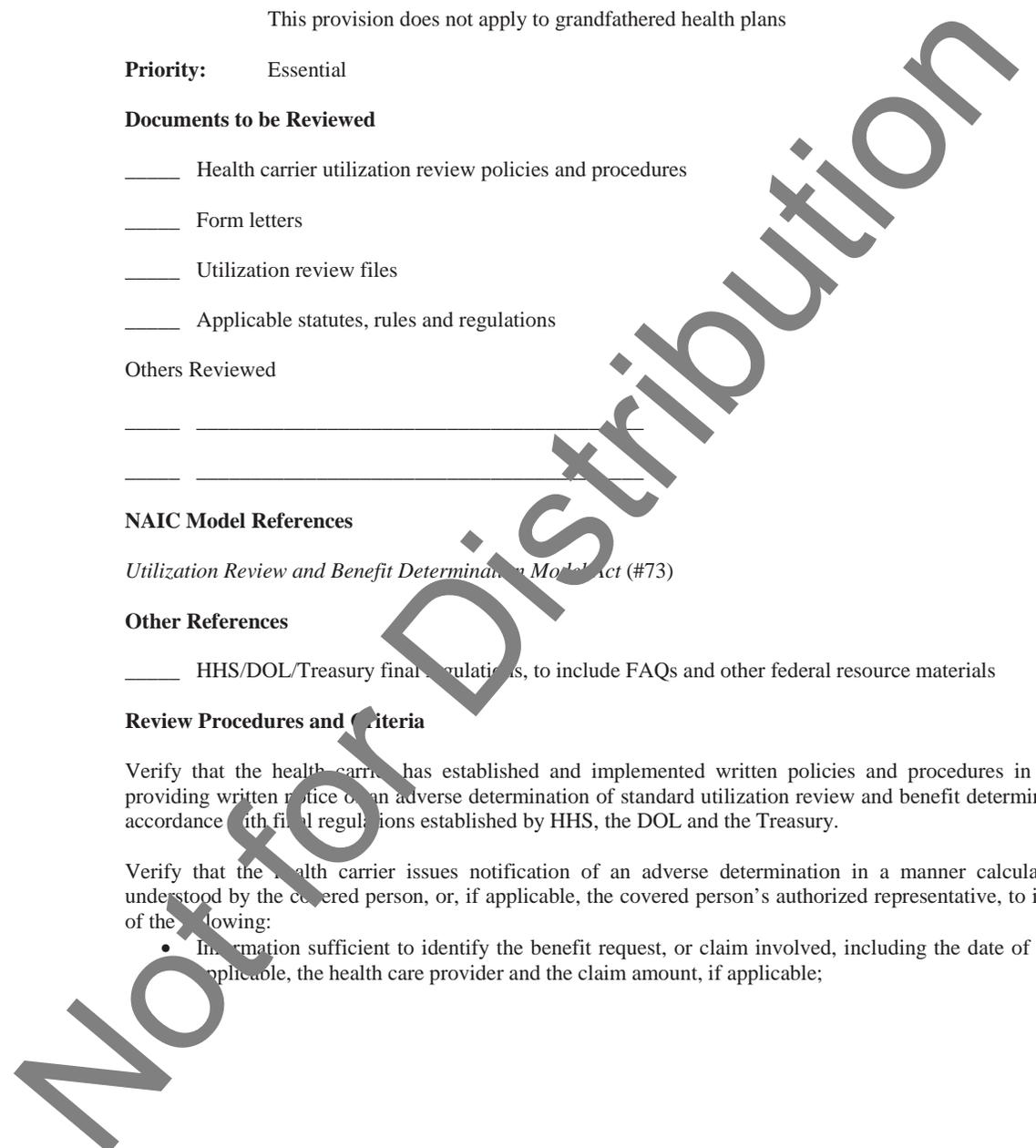
\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 statute, rule 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Not for Distribution

**STANDARDS  
UTILIZATION REVIEW**

**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**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 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 by 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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

**STANDARDS  
UTILIZATION REVIEW**

**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**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

**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 the emergency department of a hospital follows provisions set forth in applicable statutes, rules and regulations.

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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, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

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## Chapter 21—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 Chapter 1—Introduction.

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 written 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 16, General Examination Standards.

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**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)*

**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.

Not for Distribution

**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)*

**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.

Not for Distribution

**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.

Not for Distribution

**STANDARDS  
OPERATIONS/MANAGEMENT**

**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)*

**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.

Not for Distribution

## B. Complaint Handling

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

## C. Marketing and Sales

### 1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the 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 written, verbal and electronic advertising and sales materials.

### 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 so as 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 of 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 + Choice 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.

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.

Not for Distribution

**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 to 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.

Not for Distribution

**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.

Not for Distribution

**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 17C*

**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.

Not for Distribution

**STANDARDS  
MARKETING AND SALES**

**Standard 4**  
**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 17A*

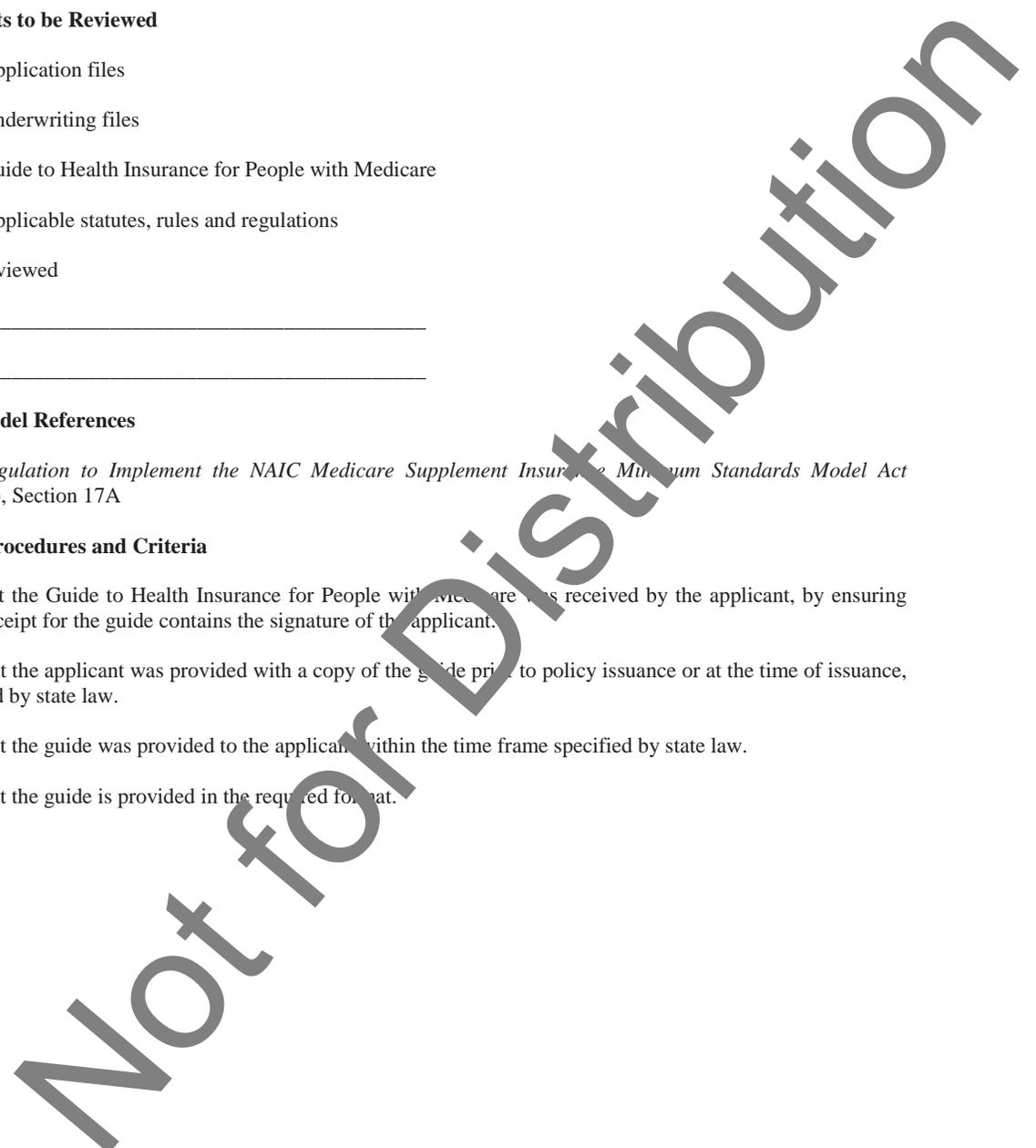
**Review Procedures and Criteria**

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 written, created, designed or presented.

Not for Distribution

**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.”

Not for Distribution

**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.

Not for Distribution

**STANDARDS  
MARKETING AND SALES**

**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.

Not for Distribution

**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

\_\_\_\_\_ \_\_\_\_\_  
\_\_\_\_\_ \_\_\_\_\_

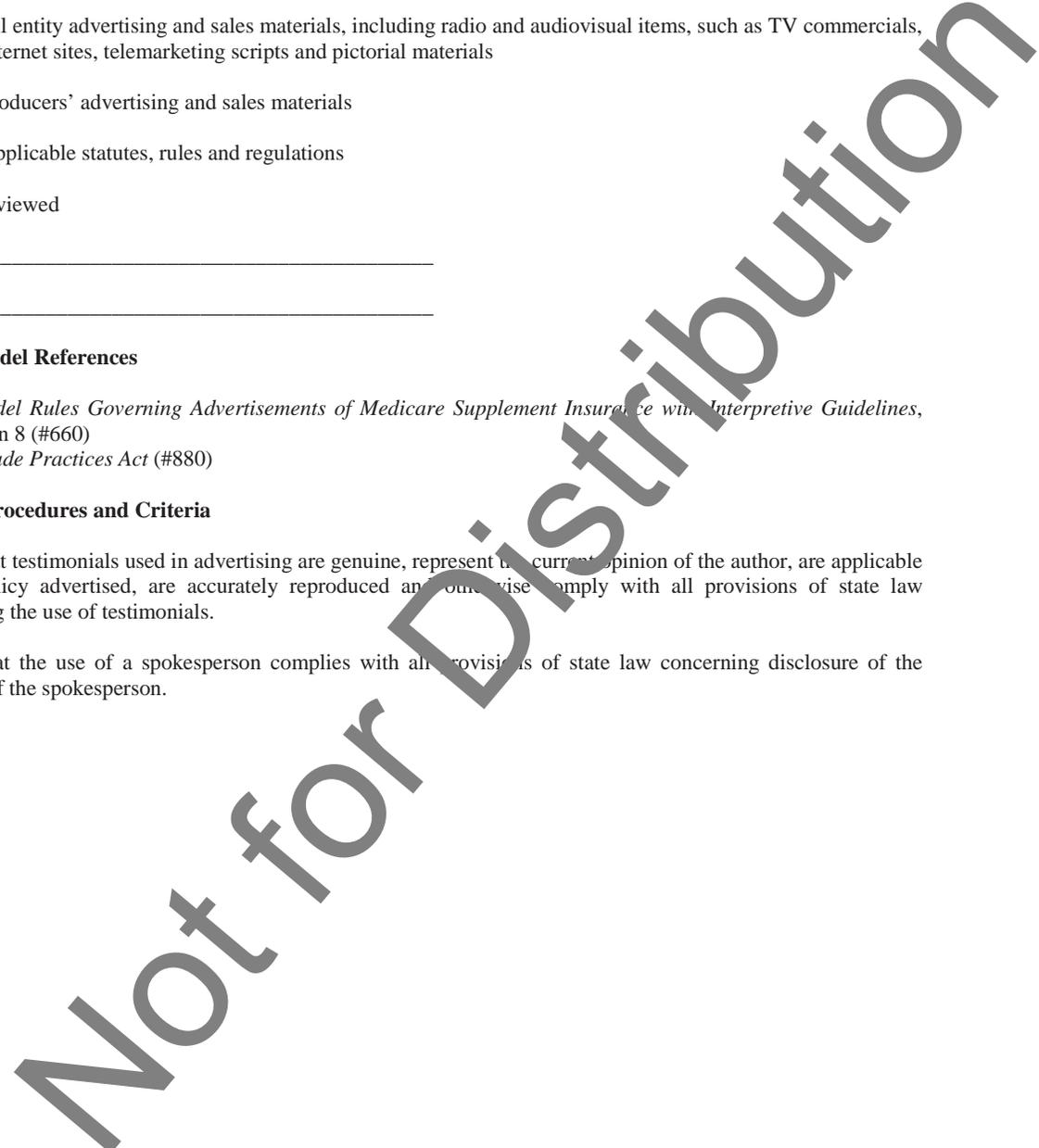
**NAIC Model References**

*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.

Not for Distribution

**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

Not for Distribution

**STANDARDS  
MARKETING AND SALES**

**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.

Not for Distribution

**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.

**STANDARDS  
MARKETING AND SALES**

**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.

Not for Distribution

## **D. Producer Licensing**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

## **E. Policyholder Service**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

## **F. Underwriting and Rating**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

## **G. Claims**

Use the standards for this business area that are listed in Chapter 16—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, claim practices, or provision of services concerning an issuer of a Medicare Select product or network provider.

Note that these definitions may not include all written 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 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 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)*

**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.”

Not for Distribution

**STANDARDS  
GRIEVANCE PROCEDURES**

**Standard 2**  
**The entity develops written 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)*

**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 grievance 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.

Not for Distribution

**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)*

**Review Procedures and Criteria**

The entity maintains a grievance register consisting of written records that document 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 written 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)*

**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.

Not for Distribution

**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)*

**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.

Not for Distribution

## 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 written 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 written 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 ZIP code
- \_\_\_\_\_ 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 Reference**

*Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5*

**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 written 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.

Not for Distribution

**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)*

**Review Procedures and Criteria**

The plan of operation contains evidence of at least the following:

- Covered services are available and accessible through 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 referral for provision of such services outside its network;
- There are written 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 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)*

**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 days 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.

Not for Distribution

**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)*

**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.

Not for Distribution

**STANDARDS  
NETWORK ADEQUACY**

**Standard 5**

**The company executes with each participating provider written 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)*

**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.

Not for Distribution

**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 the 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 service;
- 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.

Not for Distribution

**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)*

**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.

## 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 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 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 standards.

**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 written 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, 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.

Not for Distribution

**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's 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.

Not for Distribution

**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).

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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 (#)*

**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.

Not for Distribution

## **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 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 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 written 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 written 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.

Not for Distribution

**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 written 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 written 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 written 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.

Not for Distribution

**STANDARDS**  
**QUALITY ASSESSMENT AND IMPROVEMENT**

**Standard 3**

**The company files with the insurance commissioner a written 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**

\_\_\_\_\_ Written 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 (#7), Section 5D*

**Review Procedures and Criteria**

Determine if the forms have been filed.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

### **L. Utilization Review**

Check state-specific laws to determine if utilization review is applicable to Medicare supplement insurance within a state.

Not for Distribution

Not for Distribution

## Chapter 22—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 Chapter 1—Introduction.

This chapter applies to all long-term care insurance policies, including qualified long-term care insurance contracts, group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. 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 long-term care insurance examinations. Procedures for conducting other types of specialized examinations may be found in separate chapters.

The examination of long-term care 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. 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 long-term care insurance issues affected by HIPAA include minimum standards for tax-qualified long-term care policies.

### **Long-Term Care Insurance**

Two sections of HIPAA (7702B and 4980C) establish requirements for qualified long-term care insurance contracts and companies issuing those contracts. For the purposes of HIPAA requirements, the following definitions apply: “Qualified long-term care 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 long-term care insurance 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 long-term care insurance products, rates, advertisements and associated forms approved by the Interstate Insurance Product Regulation Commission (IIPRC) 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 IIPRC website, [www.insurancecompact.org](http://www.insurancecompact.org) and the uniform standards are located on its rulemaking record. Compacting states have access through the NAIC System for Electronic Rate and Form Filing (SERFF) to product filings submitted to the IIPRC for approval and use in their respective state or jurisdiction and can also use the export tool in SERFF to extract relevant information. Each IIPRC-approved product filing has a complete reviewer checklist(s) to document the applicable uniform standards compliance review. The IIPRC office should be included when a compacting state(s) is concerned that an IIPRC-approved product constitutes a violation of the provisions, standards or requirements of the IIPRC (including the uniform standards). Under the uniform standards, a long-term care insurance product approved by the IIPRC 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 long-term care insurance product approved by the IIPRC.

### **A. Operations/Management**

Use the standards for this business area that are listed in Chapter 16—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 long-term care insurance to a resident of the state, evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance 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 long-term care insurance 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 required 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 long-term care insurance. 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 long-term care insurance, 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 long-term care, 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 long-term care partnership policy forms certification process in order for long-term care partnership forms to be sold in their state.

Not for Distribution

**B. Complaint Handling**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

**C. Marketing and Sales**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**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 long-term care insurance, 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”;
- Confirmation 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 long-term care insurance 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 long-term care 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).

Not for Distribution

**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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ 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.

**STANDARDS  
MARKETING AND SALES**

**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 (IIPRC) uniform standards for products approved by the IIPRC)
- \_\_\_\_\_ 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 long-term care requirements apply to annuity products with a long-term care 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 application forms for long-term care insurance 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 long-term care 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 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 long-term care 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 long-term care; and
- A statement that any long-term care 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 long-term care 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 long-term care insurance 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 long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

**STANDARDS  
MARKETING AND SALES**

**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 (IIPRC) uniform standards for advertisements approved by the IIPRC)
- \_\_\_\_\_ 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, long-term care insurance 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 longer 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 long-term care 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.

Determine that company procedures and materials relative to long-term care 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.

Not for Distribution

**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 producer has 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.

Not for Distribution

**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.

Not for Distribution

**D. Producer Licensing**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

**E. Policyholder Service**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ 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.

Not for Distribution

**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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ 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 if 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 6 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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ 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 a long-term care 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 notices 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.

Not for Distribution

**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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ 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 long-term care 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.

Not for Distribution

**F. Appeal of Benefit Trigger Adverse Determination**

Use the standard set forth below.

Not for Distribution

**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 a long-term care insurance 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 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 long-term care 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 long-term care insurance 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 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;
- Reinsurance 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. When 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 explanation 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 long-term care policies offered in one state and issued in another state comply with applicable extraterritorial jurisdiction statutes, rules and regulations.

Ensure that any group long-term care 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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ All applications

Others Reviewed

\_\_\_\_\_

\_\_\_\_\_

**NAIC Model References**

**Review Procedures and Criteria**

Determine if the requested coverage is issued.

Determine if the 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.

Not for Distribution

**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 a 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.

Not for Distribution

**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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ 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 (#640)*

**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 noncancelable;
- 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.

A long-term care insurance 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 long-term care 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 long-term care 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 long-term care 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.

Not for Distribution

**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 (IIPRC) uniform standards for products approved by the IIPRC)
- \_\_\_\_\_ 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 long-term care policy with another group long-term care 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 long-term care 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 long-term care 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 elected. The entity shall annually furnish this information to the insurance commissioner in the form 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 on 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 long-term care, 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 long-term care 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.

Not for Distribution

## H. Claims

Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**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 (IIPRC) uniform standards for products approved by the IIPRC)

\_\_\_\_\_ 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 (#80)*

*Long-Term Care Insurance Model Act (#64)*

*Unfair Claims Settlement Practices Act (#810)*

*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 long-term care insurance 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 long-term care 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.

Not for Distribution

## Chapter 23—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 Chapter 1—Introduction.

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 1—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 (#70)*  
*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 16—General Examination Standards.

## **C. Marketing and Sales**

Use the standards for this business area that are listed in Chapter 16—General Examination Standards, in addition to the standards set forth below.

Not for Distribution

**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 (#366)*  
*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.

**STANDARDS  
MARKETING AND SALES**

**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 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<sup>35</sup> (*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 Act* (#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 insured 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).

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<sup>35</sup> 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 16—General Examination Standards.

## E. Policyholder Service

Use the standards for this business area that are listed in Chapter 16—General Examination Standards.

## F. Underwriting and Rating

### 1. Purpose

The underwriting portion of the examination is designed to provide a view of how the 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 premium rates;
- 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 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 of 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 guideline 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<sup>36</sup> 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.

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<sup>36</sup>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.

Not for Distribution

**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 (#335)*

**Review Procedures and Criteria**

All Credit Insurance

Review policies 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 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 policies 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.

Not for Distribution

**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 (#700), 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 up to 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 of 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).

Not for Distribution

**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.

**STANDARDS  
UNDERWRITING AND RATING**

**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.

Not for Distribution

## 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 14—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 and 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.

Not for Distribution

Not for Distribution

## Chapter 24—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 Chapter 1—Introduction.

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 as 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, rules 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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**STANDARDS  
BROKER OPERATIONS/MANAGEMENT**

<b>Standard 3</b> <b>The applicable taxes are reported and are credited to the state.</b>
--

**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.

Not for Distribution

**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.

Not for Distribution

## **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 16—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.

Not for Distribution

**STANDARDS**  
**PLACEMENT, CANCELLATION AND NONRENEWAL**

**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.

Not for Distribution

**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.

Not for Distribution

**STANDARDS**  
**PLACEMENT, CANCELLATION AND NONRENEWAL**

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

## Chapter 25—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 Chapter 1—Introduction.

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 its 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 or 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 Examination Oversight (C) 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 type responses 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; and
- L. Residual Market Functions—Reinsurance Administration.

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 2 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.

### 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.

### 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 contacted 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 10—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 Examination Oversight (C) Working Group, especially when conducting comprehensive reviews. The following special considerations apply:

- 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;
- 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 the insured 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. When calling the examination, states are encouraged to use the NAIC Market Action Tracking System (MATS). Regulator-only communication with members of applicable NAIC Property and Casualty Insurance (C) Committee Advisory Organization Examination Oversight (C) 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 [www.naic.org/committees\\_d\\_mawg.htm](http://www.naic.org/committees_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 services 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 not 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.

### **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 filing. 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 (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 via the Market Conduct Examination Standards (D) Working Group web page which is found at [www.naic.org](http://www.naic.org) >> **Committees** >> **Committees, Task Forces & Working Groups** >> **Market Regulation and Consumer Affairs (D) Committee** >> **Market Conduct Examination Standards (D) Working Group** >> **Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

#### **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 Working Group which adopted the form, the Advisory Organization Examination Oversight (C) Working Group, believes that by identifying operational or staffing level changes in an advisory or statistical organization earlier, the Working Group 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 2015 adopted form) was adopted in 2017 by the NAIC Executive (EX) Committee and Primary. Regulators may access the [2017](#) updated Comprehensive Annual Analysis Form for Advisory

Organizations and Statistical Reporting Agents form via myNAIC at the Market Regulation Handbook link on the StateNet home page. The updated CAA form is located in the Market Regulation Handbook Updates section of the web page.

Non-regulators may access the 2017 updated Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents form via the Market Conduct Examination Standards (D) Working Group web page which is found at [www.naic.org](http://www.naic.org) >> **Committees** >> **Committees, Task Forces & Working Groups** >> **Market Regulation and Consumer Affairs (D) Committee** >> **Market Conduct Examination Standards (D) Working Group** >> **Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

Regulators with an active myNAIC login ID and password may access the 2015 originally adopted Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents electronically:

- Choose StateNet from the myNAIC login categories;
- Select Market Regulation Handbook (located in the Market Regulation section of the StateNet home page); and
- Click on the link Market Regulation Handbook Reference Documents. The Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents is located at the top of the Market Regulation Handbook Reference Documents web page, together with Appendixes F and G referenced above.

Non-regulators may access the 2015 originally adopted Comprehensive Annual Analysis Form for Advisory Organizations and Statistical Reporting Agents via the Market Conduct Examination Standards (D) Working Group web page which is found at [www.naic.org](http://www.naic.org) >> **Committees** >> **Committees, Task Forces & Working Groups** >> **Market Regulation and Consumer Affairs (D) Committee** >> **Market Conduct Examination Standards (D) Working Group** >> **Market Regulation Handbook Updates and Reference Documents**. When accessing the Market Regulation Handbook Updates and Reference Documents link, please use the user ID and password located at the front of the most recently published *Market Regulation Handbook*.

#### 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.

Not for Distribution

**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 in 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 activity and
- Implementation of training materials or employee codes of conduct that address prohibition of anti-competitive activities.

Not for Distribution

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**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.

Not for Distribution

**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 (if 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.

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**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.

Not for Distribution

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**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.

Not for Distribution

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**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.

Not for Distribution

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**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.

Not for Distribution

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**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.

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 9**  
**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 on payment problems.

Not for Distribution

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

<b>Standard 10</b> <b>The advisory organization uses objective and established procedures when administering assigned risks.</b>
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**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.

Not for Distribution

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 11**  
**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.

Not for Distribution

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 12**  
**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**

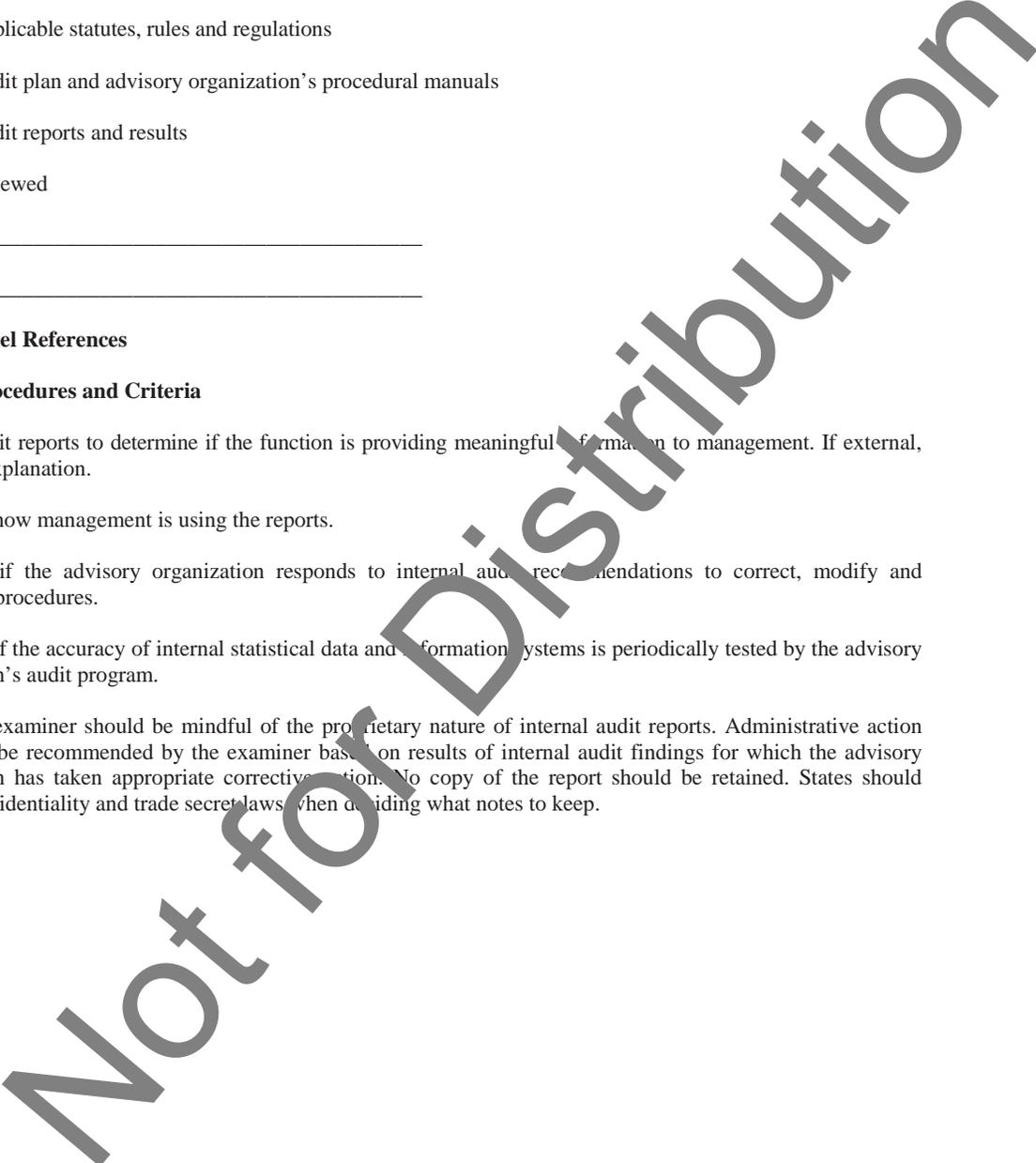
Review audit reports to determine if the function is providing meaningful information to management. If external, obtain an explanation.

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.



STANDARDS

ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE

**Standard 13**  
**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 (#67)*  
*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.

Not for Distribution

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 14**  
**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.

Not for Distribution

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 15**

**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.

Not for Distribution

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 16**

**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* (#310)  
*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.

Not for Distribution

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

<b>Standard 17</b> <b>The advisory organization is appropriately licensed.</b>
---

**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.

Not for Distribution

**STANDARDS**

**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 18**  
**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.

Not for Distribution

**STANDARDS**  
**ADVISORY ORGANIZATIONS OPERATIONS/MANAGEMENT/GOVERNANCE**

**Standard 19**  
**The advisory organization has developed and implemented written policies, standards and procedures for the management of insurance information.**

**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 (#37), 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.

Not for Distribution

## 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.

Not for Distribution

**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, when 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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

## 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.

### 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 a 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.

Not for Distribution

**STANDARDS**  
**DATA COLLECTION AND HANDLING**

<b>Standard 2</b> <b>All data that is collected pursuant to the statistical plan is run through the editing process.</b>
---

**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.

Not for Distribution

**STANDARDS**  
**DATA COLLECTION AND HANDLING**

<b>Standard 3</b> <b>Determine that all databases are updated as needed with all accepted company data.</b>
--

**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.

Not for Distribution

**STANDARDS**  
**DATA COLLECTION AND HANDLING**

**Standard 4**  
**Determine that statistical 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<sup>37</sup>

**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).

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<sup>37</sup> 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.

Not for Distribution

**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.

Not for Distribution

## 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.

Not for Distribution

**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.

Not for Distribution

**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).

Not for Distribution

**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 program or penalty structure, if one exists.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

## **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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

## **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.

### **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.

Not for Distribution

**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 forms, loss costs and accompanying rules.
- \_\_\_\_\_ Other correspondence with individual state insurance departments related to rates, loss costs or forms
- \_\_\_\_\_ 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 forms and loss costs.

Not for Distribution

## **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.

Not for Distribution

**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 standards.

Not for Distribution

**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, rules or loss costs.**

**Apply to:** All advisory organizations

**Priority:** Recommended

**Documents to be Reviewed**

\_\_\_\_\_ Communication with companies regarding changes to applicable forms, rules or loss costs

\_\_\_\_\_ 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 or rating systems, verify that the advisory organization responded accordingly.

Alternatively, provide the advisory organization with a brief questionnaire, asking about procedures for handling such changes.

Not for Distribution

**STANDARDS  
FORM DEVELOPMENT**

**Standard 2**  
**The advisory organization has quality assurance processes in place to review submissions of forms, rates, loss costs or other submissions 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.

Not for Distribution

## **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.

Not for Distribution

**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.

Not for Distribution

## **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.

Not for Distribution

**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, 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.

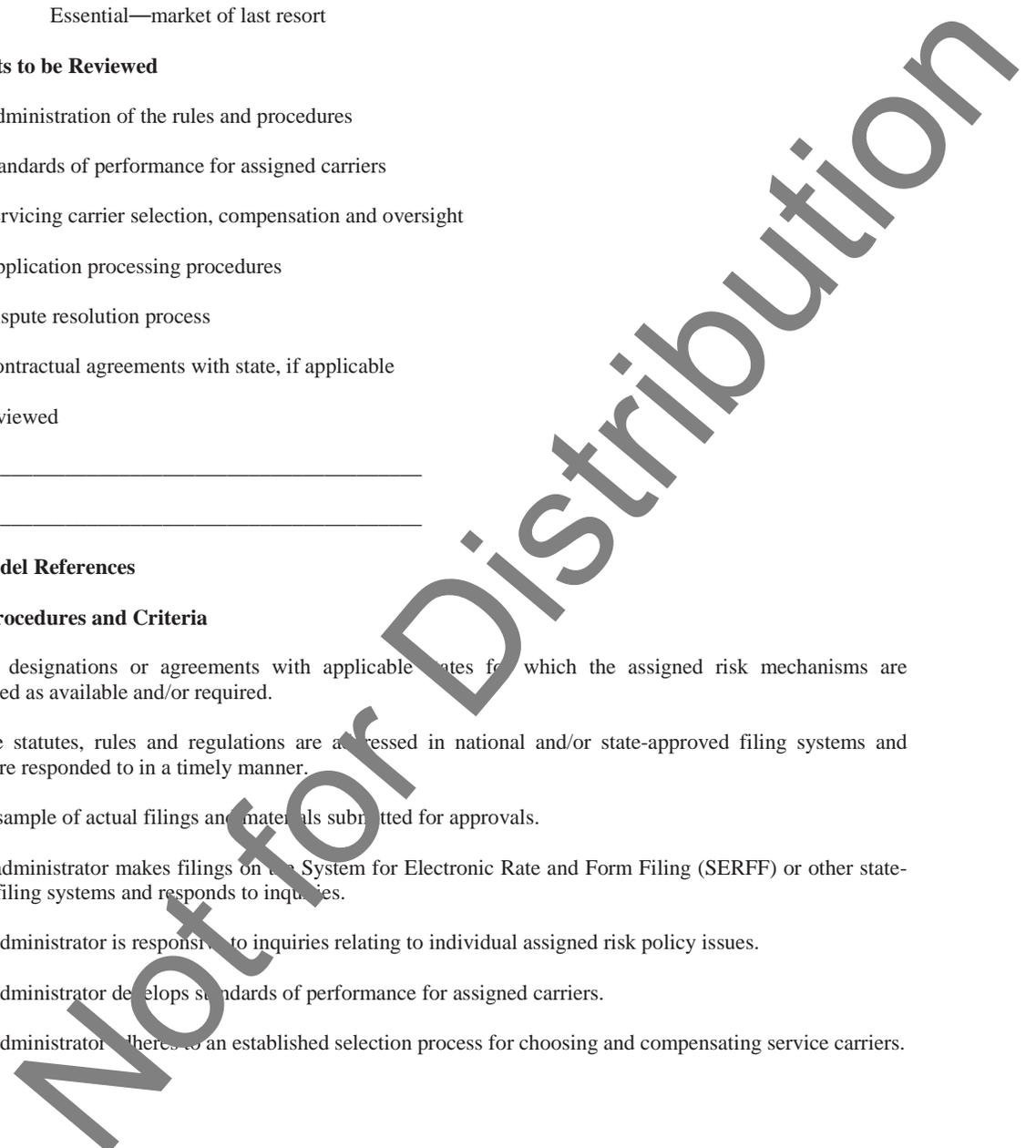
Review a sample of actual filings and materials submitted for approvals.

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.

Not for Distribution

## **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 standards.

Not for Distribution

**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 are 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.

Not for Distribution

## Chapter 26—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 Chapter 1—Introduction.

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 affiliate, 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 16—General Examination Standards, in addition to the standards set forth below.

**STANDARDS**  
**TPA OPERATIONS/MANAGEMENT**

<b>Standard 1</b> <b>The TPA is in compliance with applicable statutes, rules and regulations regarding financial security.</b>
--

**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.

Not for Distribution

**B. Complaint Handling**

Use the standards for this business area that are listed in Chapter 16—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 beneficiary 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 affiliate 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 U.S.C. 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 contract 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**

<p><b>Standard 1</b> <b>Verify written agreement(s) are executed between the TPA and client, applicable insurer or other related entity.</b></p>
--

**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.

Not for Distribution

**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 (#1070)*

*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).

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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 general or other auditing services is allowed.

Compensation may be based on premiums or charges collected or the number of claims paid or processed.

Not for Distribution

**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 a person insurer shall be paid only on drafts or checks of and as authorized by the insurer.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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 (#1000)*

*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.

Not for Distribution

**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.

Not for Distribution

Not for Distribution

## Chapter 27—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 Chapter 1—Introduction.

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 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 12—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 form letters, 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 and 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 16—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 (#67)*
- 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*

**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.

Not for Distribution

## **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.

Not for Distribution

**STANDARDS**  
**VIATICAL SETTLEMENT CONTRACTS AND DISCLOSURES**

**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.

Not for Distribution

## **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.

Not for Distribution

**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.

**STANDARDS**  
**VIATICAL SETTLEMENT TRANSACTIONS**

**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.

Not for Distribution

**STANDARDS**  
**VIATICAL SETTLEMENT TRANSACTIONS**

**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 B and C

**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.

Not for Distribution

**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.

Not for Distribution

**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

- \_\_\_\_\_
- \_\_\_\_\_

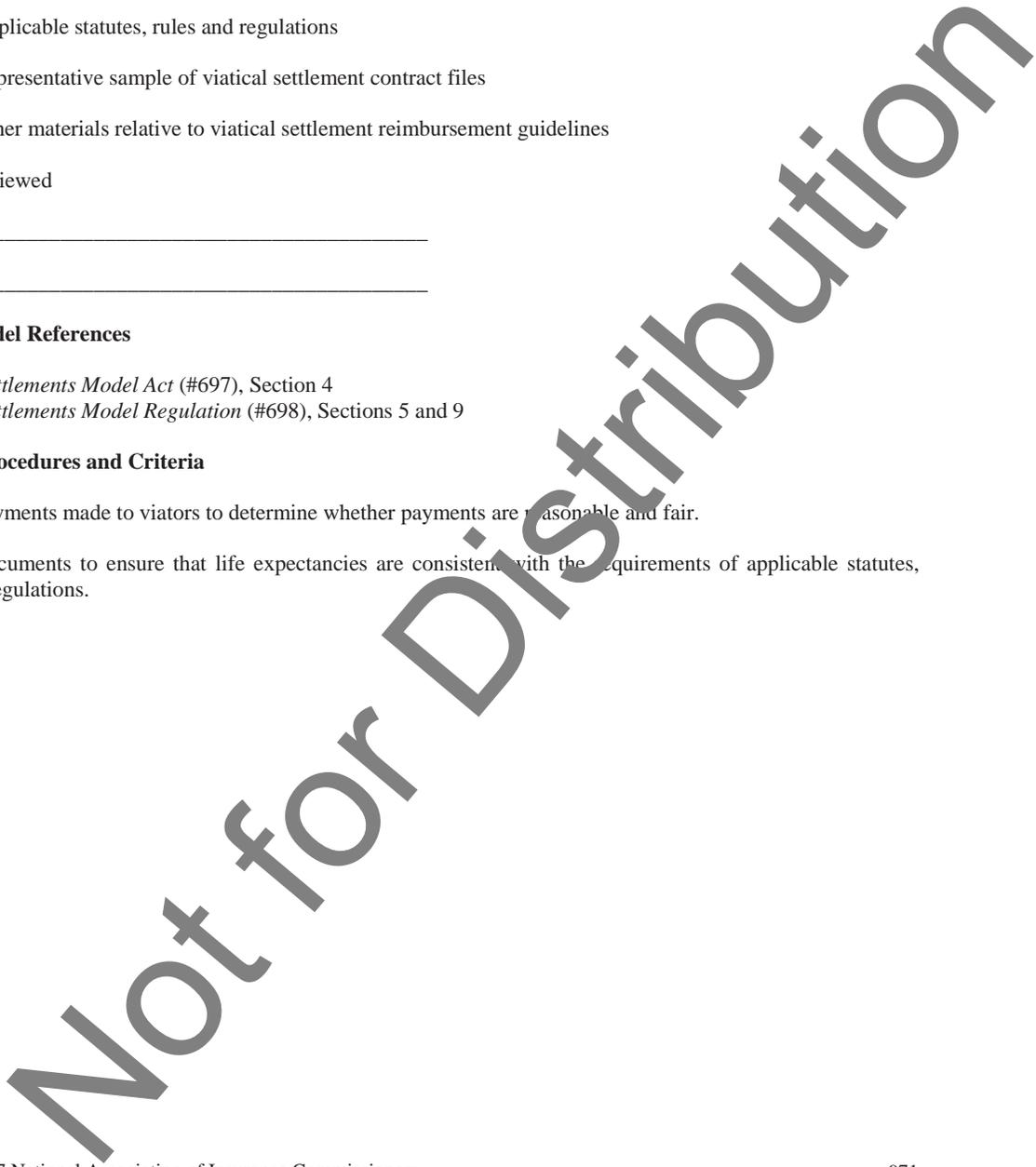
**NAIC Model References**

*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.



**STANDARDS**  
**VIATICAL SETTLEMENT TRANSACTIONS**

<b>Standard 7</b> <b>Verify rescission period refund procedures and timeliness of refunds issued.</b>
--

**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.

Not for Distribution

**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 purchase 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.

Not for Distribution

**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.

Not for Distribution

**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 avoid 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.

Not for Distribution

## **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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**K. Supplemental Checklist for Viatical Settlement Contracts and Disclosures, Standard #2**

Yes	No	Requirement
<b>No later than at the time of application, the viatical settlement provider or the provider's representative shall disclose the following to the viator:</b>		
		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 insured 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.
<b>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:</b>		
		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 rider 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 of 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.
<b>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:</b>		
		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.
<b>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:</b>		
		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 completed 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.

Not for Distribution

**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.

Not for Distribution

**L. Supplemental Checklist for Viatical Settlement Transactions, Standard #5**

Yes	No	Requirement
<b>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:</b>		
		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 U.S.C. §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.

Not for Distribution

**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.

Not for Distribution

**M. Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5**

Yes	No	Requirement
<b>Advertisements shall not make the following representations:</b>		
		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 in other forms of print and electronic media.

Not for Distribution

## Supplemental Checklist for Viatical Settlement Provider Marketing and Sales, Standard #5 (cont'd)

Yes	No	Requirement
<b>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:</b>		
		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 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 a 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.

Not for Distribution

## Chapter 28—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 Chapter 1—Introduction.

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 12—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 lenders, 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 16—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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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 plan, etc.

Not for Distribution

**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.

Not for Distribution

**STANDARDS  
PREMIUM FINANCE AGREEMENTS**

<b>Standard 5</b> <b>The company uses the appropriate forms for premium finance agreements.</b>
--

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

## 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 complaint 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.

Not for Distribution

**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. Review 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 response within the time frame required by applicable statutes, 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.

Not for Distribution

**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.

Not for Distribution

**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.

Not for Distribution

Not for Distribution

## Appendix A: 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 or 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 report 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 unpaid 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

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 code 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 an alphabetical list of all statistical reports published by the NAIC and download these reports for free from StateNet; non-regulators can purchase and download statistical reports and all NAIC publications available to non-regulators from the NAIC Store at <http://www.naic.org/store/index.htm>.

Not for Distribution

## Appendix B: 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 Subsequent 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?

### 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<sup>38</sup>

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?

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<sup>38</sup>When performing a Level 1 Analysis on companies writing long-term care, review earned premium.

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.
- 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?
  - 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.
- 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?
  - 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?
  - 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?
  - 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.
- 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?
  - 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.
- On a national basis, are there any unusual patterns in the amount of resisted claims compared to the total claims for either the entire body of business or an individual line(s) of business?
  - For those claims disposed of or resisted during the current year, are there any unusual patterns in the state of residence of the claimant?
  - 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 regulatory responses (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

## Appendix C: 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.

<b>Area of Review:</b>	<b>Consumer Complaints</b>
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**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/country) 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 90% 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?

<b>Area of Review:</b>	<b>Continuum Activity</b>
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### Suggested Review

Insurance regulators have a broad continuum of regulatory responses available to them when determining the appropriate regulatory response to an identified issue or concern. The continuum of regulatory responses includes such initiatives as office-based information gathering, interview with the company, correspondence, posters 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?

<b>Area of Review:</b>	<b>Examinations</b>
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**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?

<b>Area of Review:</b>	<b>Interdepartmental Communications</b>
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**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 then 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 non-compliant 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 programs: 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?

<b>Area of Review:</b>	<b>Market Analysis</b>
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### 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 ISNet. 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?

<b>Area of Review:</b>	<b>Regulatory Actions</b>
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#### 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 effect 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 violation)?
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.

<b>Area of Review:</b>	<b>Insurance Department Filings (Rates, Rules, Policy Forms, and/or Underwriting Manuals)</b>
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**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 or 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?

<b>Area of Review:</b>	<b>Dispute Resolution Activity</b>
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### 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?

<b>Area of Review:</b>	<b>Financial Analysis</b>
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**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 Receivability):

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.

<b>Area of Review:</b>	<b>Financial Rating Agencies</b>
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**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](http://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](http://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](http://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](http://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](http://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 the 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 rationale 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.

<b>Area of Review:</b>	<b>Geographic Analysis</b>
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### 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 5—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 case;
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](http://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 2010 census can be found at: <http://www.census.gov/2010census/>.

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 indicators? 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 loading practices, underwriting criteria, or other business or marketing practices.

<b>Area of Review:</b>	<b>Human Resource Department</b>
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### 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?

<b>Area of Review:</b> Internet/World Wide Web
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### 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 review, 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 alongside 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?

<b>Area of Review:</b>	<b>Legal Information</b>
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**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. <http://www.classactionlitigation.com/>;
  - b. <https://www.lawyersandsettlements.com/>;
  - c. <https://www.ama-assn.org/litigation-center/>;
  - d. LexisNexis (<https://www.lexisnexis.com/en-us/gateway.page>)—provides access to legal, news, public records and business information; including court and regulatory publications in online, print or CD-ROM formats; and
  - e. Westlaw (<http://legalsolutions.thomson.com/law-products/>)—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?

<b>Area of Review:</b> NAIC Bulletin Boards
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**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?

<b>Area of Review:</b>	<b>Other Governmental and Quasi-Governmental Agencies</b>
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**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 advisers, 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](http://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 and 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](http://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](http://www.jointcommission.org).

5. **Better Business Bureau (BBB); and**

The BBB is a voluntary system of regional BBBs. The BBB collect information about companies who are members or nonmembers of the BBB and make Reliability Reports on companies (complaint information filed by consumers with the BBB) available to the public on its website ([www.bbb.org](http://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 "clear" 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 regulator 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? 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 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?

<b>Area of Review:</b>	<b>Producer Licensing</b>
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#### **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?

<b>Area of Review:</b>	<b>State-Mandated Items (Reports, Data Requests, Surveys and Exhibits)</b>
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### 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?

<b>Area of Review:</b>	<b>Trade Publications &amp; Other Media Sources</b>
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### 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 an 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 [www.kpmg-institutes.com/](http://www.kpmg-institutes.com/); and
  - b. *KPMG Global Media Insurance Newsletters*, 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 <http://www.kpmg.com/Global/en/industry/Insurance/Pages/mergers-acquisitions-for-insurers.aspx>;
5. [www.findarticles.com](http://www.findarticles.com/);
6. [www.insure.com](http://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 (<http://legalsolutions.thomsonreuters.com/law-products/>)—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? If 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?

<b>Area of Review:</b>	<b>Voluntary Accreditation/Certification Programs</b>
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### 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 ([www.ncqa.org](http://www.ncqa.org)) and the Utilization Review Accreditation Commission ([www.urac.org](http://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.

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## Appendix D: Core Competencies

<i>General Topic/Area</i>	<i>Standards/Comments</i>
<b>1. Resources Core Competencies</b>	
<b><i>Regulatory Authority</i></b>	<p>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.</p> <p>Measures should include:</p> <ul style="list-style-type: none"> <li>• Statutory authority to perform the continuum of regulatory responses;</li> <li>• Ability to access records;</li> <li>• Ability to keep records confidential; and</li> <li>• An unfair trade practices act and unfair claims settlement act substantially similar to the NAIC model.</li> </ul>
<b><i>Staff &amp; Training</i></b>	<p>The Department of Insurance should have staff sufficient to perform the continuum of regulatory options including market analysis, market conduct examinations and market conduct investigations. On an ongoing basis, appropriate market analysis should be performed to identify regulated entities of concern. Appropriate prioritization of further investigation and continuum options should be pursued effectively and timely to protect the interests of consumers.</p> <p>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.</p>

<b>1. Resources Core Competencies, cont'd</b>	
<i>Contract Examiner</i>	<p>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.</p> <p>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.</p>

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<b>2. Market Analysis Core Competencies</b>	
<b><i>Data Collection</i></b>	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.
<b><i>Analysis</i></b>	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.
<b><i>Market Analysis Chief</i></b>	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.
<b><i>Market Analyst</i></b>	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.

<b>3. Continuum Core Competencies</b>	
<p>The Continuum of Regulatory Responses is a means of moving from market analysis to regulatory response. The continuum is a spectrum of regulatory tools to address actions necessary as a result of analysis of specific regulatory concerns regarding the conduct of a regulated entity. Specific examples of the continuum and recommended goals to consider when determining the nature of the regulatory response are discussed in the Continuum of Regulatory Responses chapter of the <i>Market Regulation Handbook</i>. Each Department of Insurance should evaluate and document market problems using the continuum of market regulatory responses.</p>	
<b>Market Conduct Examinations</b>	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 <i>Market Regulation Handbook</i> .
<b>Investigations</b>	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.
<b>Consumer Complaints</b>	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.

<b>4. Interstate Collaboration Core Competencies</b>	
<b>Interstate Collaboration</b>	<p>Interstate collaboration may be accomplished by the following:</p> <ul style="list-style-type: none"> <li>• Participation with the Market Actions (D) Working Group to include, but not be limited to, participation in calls and surveys;</li> <li>• Timely entry and participation in the NAIC databases;</li> <li>• Notifying the Collaborative Action Designee or Market Analysis Chief of the domestic Department of Insurance when considering one of the continuum of regulatory responses;</li> <li>• Verifying the Department of Insurance can ensure the confidentiality of materials and data as necessary; or</li> <li>• Following the collaborative actions guidelines for recommendations to the Market Actions (D) Working Group.</li> </ul>
<b>Collaborative Action Designee</b>	The Collaborative Action Designee (CAD) is the one contact identified by the Director/Commissioner of each state/district/territory to have the responsibility for all communications related to interstate collaboration. The Department of Insurance should have an appropriate staff member assigned as the CAD to assure support and participation in multistate collaborative actions.

**Competency: Resources**  
**SubSection: Regulatory Authority**

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

The following standards apply to this competency:

**Standard One. The Department of Insurance has the necessary authority to implement the continuum of regulatory options.**

The Department of Insurance should have authority to examine regulated entities whenever it is deemed necessary. Such authority should include complete access to the regulated entity's books and records and, if necessary, the records of any 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 claim settlement act substantially similar to the NAIC model shall be part of state law.

**Competency: Resources**  
**SubSection: Staff and Training**

The Department of Insurance should have staff sufficient to perform the continuum of regulatory options including market analysis, market conduct examinations and market conduct investigations. On an ongoing basis, appropriate market analysis should be performed to identify companies of concern. Appropriate prioritization of further investigation and continuum options should be pursued effectively and timely to protect the interests of consumers. Departments of Insurance should ensure that staff 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. 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 of 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.

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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 data 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 DOJ's 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.

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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 on 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;

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- 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 for 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 Pages 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 Regulatory Options. Departments of Insurance should be mindful that findings that suggest potential solvency concerns should be promptly reported to the appropriate financial regulation staff.

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

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

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

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

The following standards apply to this competency:

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

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

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

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

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

**Competency: The Continuum**  
**SubSection: Market Conduct Examinations**

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

The following standards apply to this competency:

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

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

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

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

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

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

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

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

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

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

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

The preliminary information shall contain the following information:

- General instructions;
- The scope of the examination;
- The materials requested to perform the examination;
- Data 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 Eight.** 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 Nine.** The Department of Insurance shall provide an opportunity for a pre-examination conference with the regulated entity coordinator and key personnel to clarify expectations prior to the commencement of the examination.

**Standard Ten.** The Department of Insurance shall develop a system for exchanging information with the regulated entity that advises them of the errors and other problems developed during the examination. The state should be mindful of 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 Eleven.** Each Department of Insurance shall develop a procedure for document handling, including the removal of original documents, where that is necessary, to a location other than the Department of Insurance.  
To address the issue of confidentiality, original work paper documents shall remain at the Department of Insurance, especially if the examiner is a contracted employee of the state Department of Insurance.
- Standard Twelve.** The Department of Insurance shall use documented sampling guidelines or develop their own scientifically-based sampling programs.
- All sampling methods should be random;
  - If using a method other than the NAIC sampling guidelines, the method shall indicate the confidence levels, tolerable error rates and include extrapolation;
  - All sampling methods shall avoid pre-selection; however, stratified sampling is allowed; and
  - The nature of the sampling method chosen should be disclosed to the regulated entity that is the subject of the examination.
- Standard Thirteen.** The Department of Insurance shall offer to conduct an exit conference at the end of an examination.  
The exit conference should offer the following:
- The examination status and proposed findings;
  - The report process; and
  - An explanation of any post-examination billing.
- Standard Fourteen.** The Department of Insurance shall utilize the standard report format found in the *Market Regulation Handbook*.  
Each report shall at a minimum include the following:
- Title page;
  - Table of contents;
  - Salutation;
  - Foreword;
  - Scope;
  - Executive summary;
  - Results of previous examinations;
  - Pertinent facts of the current examination;
  - Summarization; and
  - Appendices.
- Standard Fifteen.** The Department of Insurance shall utilize a standardized timeline as required by the state's statute or the NAIC Model Law on Examinations.
- The draft report is delivered to the regulated entity within 60 days of completion of the examination;
  - The regulated entity must respond with comments to the Department of Insurance within 30 days;
  - The Department of Insurance has 30 days to informally resolve issues and prepare a final report (unless there is a mutual agreement to extend the deadline); and

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

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

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

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

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

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

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

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

**Competency: The Continuum**  
**SubSection: Investigations**

Investigations should be conducted in accordance with the Market Regulation Investigation Guidelines chapter in the *Market Regulation Handbook*. If applicable, investigations should be posted in 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 (Complaint 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 regulatory responses.

**Standard Seven. If the investigation and/or the option chosen from the continuum of regulatory responses determines that further action is necessary to correct the deficiency and/or regulatory 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 individual 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 procedure 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 to 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 ARTT criteria.

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

**Standard Six. Compliance 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 regulatory responses;

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

Not for Distribution